Lessons Learned from an Advance Care Planning Intervention for Minority Hospitalized Older Adults
University of Rochester Medical Center, Rochester, NY

Project Aim: To ensure low-income and minority elderly hospitalized patients and their health care proxies (HCP) are fully informed about their ability to make future treatment decisions.

Background

- Aggressive end-of-life care is the default in American hospitals unless limits are set, but not everyone wants this approach
- Discussion about preferences with primary care provider (PCP) before hospitalization or medical crisis is ideal
- Racial/ethnic minority and impoverished patients often lack consistent PCP and opportunities to understand and engage in ACP
- Routine in-hospital inquiries about ACP are frequently cursory especially in this “hard-to-reach” group
- A hospital stay represents a window of opportunity for more robust engagement
- Likelihood of future care consistent with preferences is increased when wishes are documented

Methods

Phase 1: Preparation: Two facilitated focus groups with patients and/or family caregivers from minority communities (Total N = 21) sought recommendations for best practices; responses were thematically analyzed.

Phase 2: Active Intervention: Two project-dedicated trained social workers approached eligible patients about 3 days prior to hospital discharge to engage in ACP conversations.

- Patient eligibility for intervention: Hospitalized patients ages > 65 being discharged home, no previous palliative care referral, members of racial/ethnic minority or Medicaid-eligible, and prior approval of treating team
- For this study, ACP documents included: Health Care Proxy, Living Will, or Medical Orders for Life Sustaining Therapy forms
- Follow-up included ensuring next-of-kin knew of patients’ wishes; patients were given a copy of all completed ACP documents; and copies were uploaded into electronic health record and sent to PCP (if identified)

Stakeholder Recommendations for Engaging in Advance Care Planning (ACP) Conversations

- **Approaches**
  - Build rapport/relationship before launching into this sensitive topic
  - Acknowledge difficulty of hospitalization and other life challenges
  - Frame ACP as empowerment and a gift for patient’s family rather than hospital requirement or obligation

- **Cultural and Religious Considerations**
  - Context of faith-based values and spirituality
  - Family values and dynamics – learn from patient which family or community members should be present
  - Help patients understand “You own this document”

- **Language is crucial**
  - Show concern/respect for patient as a person
  - Personalize the conversation, use titles like Mr., Mrs.
  - Emphasize flexibility: ability to change your mind
  - Literacy: don’t assume people can read and write
  - Provide ACP counseling in patient’s primary language

- **Timing**
  - No expectation for immediate decision
  - Allow patient to choose site, time and pace of discussion
  - Be willing to revisit the topic as needed
  - Provide follow-up contact info in case of questions that arise

- **Turn-offs**
  - Too much information delivered too fast
  - Condescending or hurried tone
  - Lack of choices
  - Not listening to patient or family concerns
  - Pressure to make a decision or sign name without fully understanding ramifications of ACP

Findings

<table>
<thead>
<tr>
<th></th>
<th>Total N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>439</td>
<td>53.4%</td>
</tr>
<tr>
<td>Male</td>
<td>384</td>
<td>46.6%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>475</td>
<td>57.7%</td>
</tr>
<tr>
<td>White</td>
<td>315</td>
<td>38.3%</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>4.0%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino/a</td>
<td>52</td>
<td>6.3%</td>
</tr>
<tr>
<td><strong>Status of ACP at First Contact</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No current ACP documents</td>
<td>460</td>
<td>55.9%</td>
</tr>
<tr>
<td>Outdated forms required changes or discussion</td>
<td>81</td>
<td>9.8%</td>
</tr>
<tr>
<td>Current ACP document, no intervention needed</td>
<td>257</td>
<td>31.2%</td>
</tr>
<tr>
<td>Declined any discussion</td>
<td>25</td>
<td>3.0%</td>
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<tr>
<td><strong>Follow-up outcomes for those with no current ACP document</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A new ACP was completed</td>
<td>399</td>
<td>86.7%</td>
</tr>
<tr>
<td>Patient still contemplating ACP specifics</td>
<td>23</td>
<td>5.0%</td>
</tr>
<tr>
<td>Patient did not complete, no follow-up requested</td>
<td>38</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Conclusions

The majority of high-risk, vulnerable hospitalized patients did not have any future care documents at initial contact. A dedicated and sensitive approach to ACP discussions among at-risk hospitalized patients who have not previously completed any future directives is both feasible and achievable in hard-to-reach populations.

Authors

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