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 inquires about ACP are frequently cursory especially in this "hard-to-reach" group
- A hospital stay represents a window of opportunity for more robust discussion
- 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 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

Phase 1: See center panel

Phase 2: Ongoing intervention provided to **823** hospitalized patients to date

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Outdated documents required changes or discussion	81	9.8 %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

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

Susan Ladwig, MPH; Kate Woodard, LMSW;
Yazira Herzog, BSW; Timothy Quill, MD, MACP, FAAHPM

Contact: Susan_Ladwig@urmc.rochester.edu 585-276-3683

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