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Advance Care Planning in Whatcom County, WA: Opportunities for Evaluation and Expansion

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The information in this report was gathered from numerous interviews, conversations and documents. Great effort was made to ensure the accuracy of the information by seeking verification and inviting review of the drafts, and apologies are extended in advance for any errors or oversights.

Advance Care Planning in Whatcom County, WA: Opportunities for Evaluation and Expansion

EXECUTIVE SUMMARY

Numerous organizations and individuals in Whatcom County, Washington have been promoting advance care planning (ACP) Washington since 2012. In 2018 the Chuckanut Health Foundation provided funding to conduct an evaluation of advance care planning activities and their impact across all participating organizations. This report summarizes the evaluation goals, methods and findings. Based on the identified challenges and opportunities, recommendations are laid out for establishing ongoing, community-wide ACP evaluation, increasing integration of advance care planning into local healthcare and social service delivery, and expanding community outreach and education.

BACKGROUND

In 2012 the Whatcom Alliance for Health Advancement (WAHA) launched a community-based ACP initiative that sought to activate the community in planning for end-of-life care. While WAHA modeled some aspects of the initiative on the Respecting Choices® First Steps program from LaCrosse, Wisconsin, a unique feature of the initiative was the focus on community-based education and action. More commonly, advance care planning efforts are based in and driven by medical/clinical systems.

Interest in care for serious illness and end-of-life continued to grow, and in 2014 WAHA convened a community task force that wrote a Blueprint for Creating a Community of Care and Support for People with Serious Illness that outlines steps to become a community of excellence for those with serious illness or facing death.

The Blueprint has five pillars: Advance Care Planning, Clinical Care, Provider Education, Community Culture and Activation, and Financial Sustainability, and many organizations and individuals are now involved with implementing various aspects of the Blueprint.

A NOTE ABOUT WAHA

In June 2019, the Whatcom Alliance for Health Advancement was permanently closed due to funding limitations.

In the area of advance care planning, WAHA's three most significant functions were:

1) Community education and outreach.
2) Providing facilitated ACP conversations (group and individual), including training, supporting, and coordinating volunteers.
3) Convening the Northwest Life Passages Coalition.

In July 2019, the Northwest Regional Council (NWRC) committed to continuing the community-based ACP work previously led by WAHA. Going forward, the NWRC will be coordinating ACP education, outreach, and facilitation services, as well as the convening the NW Life Passages Coalition.

The Blueprint Task Force subsequently developed into the ongoing Northwest Life Passages (NWLP) Coalition, which provides a platform for Blueprint implementation by strengthening partners' shared commitment to the vision, facilitating coordination among programs and initiatives and fostering ongoing learning and innovation. Coalition members include healthcare and social service providers, educators, and community leaders with a range of expertise.

In recent years, the number of organizations and individuals promoting and facilitating advance care planning (ACP) in Whatcom County has further increased, and communities in other parts of the state are expressing interest in this work. However, in spite of the activity in Whatcom County, to date there hasn't been a systematic approach to measuring ACP activities across all organizations involved in this work, and the impact these activities are having on community culture and the completion of advance directives (ADs).

Appendix 1 presents a timeline and milestones of ACP efforts in Whatcom County.[1]

EVALUATION PROJECT AIMS

While an array of Whatcom County organizations and individuals have been involved with ACP, not all of this activity has been documented, and the documentation that does exist was specific to the organization or program leading the activity. In the Spring of 2018, WAHA and the Palliative Care Institute (PCI) began to design an evaluation that would capture a **collective** picture of ACP in Whatcom County, across all organizations known to be involved in this work in some way, with the ultimate goals of identifying opportunities to improve on-going evaluation, as well as programming. The Chuckanut Health Foundation provided funding for the evaluation design, data collection and reporting.

The three primary aims of this evaluation were to:

- Quantify and describe the current ACP educational activities and services assisting people with the ACP process, as well as their scope and the number of participants. This includes "hardwiring" in healthcare and social service organizations, or built-in ways to systematically prompt and/or document ACP conversations or completed advance directives.
- Identify successes and strengths which can be built upon or expanded, and gaps or weakness that need to be addressed.
- Develop a framework for shared data collection across local entities doing ACP work in order to build a community-wide system for ongoing evaluation of ACP processes and outcomes.

METHODOLOGY

Because data collection has been inconsistent to date, the decision was made to establish a community-wide baseline by quantifying ACP activity for calendar year 2018. Data were collected and compiled in January-May, 2019 using interviews, organizational records, and aggregated reports from electronic medical records. In addition, surveys that had been completed by participants in community education activities and facilitated ACP sessions were reviewed.

Data collection and compilation were challenged by several variables. First, detailed records have not

A NOTE ABOUT DEFINITIONS

The definitions of "educational presentation," "group education" "group facilitation" are not well-defined across organizations, introducing some error into how these activities are categorized and quantified.

Appendix 7 included definitions established by Honoring Choices PNW in 2018; these could be adopted or modified for use in Whatcom County.

[1] Dr Marie Eaton and Dr Sean Bruna are currently writing a paper that describes the development of Whatcom County's work related to serious illness and end-of-life care, and identifies community factors that facilitated or hindered these efforts.

been kept of ACP activities, so there are gaps and inconsistencies in the data available. Secondly, there is not a standard set of measures, resulting in “apples and oranges” data and preventing comparisons and aggregation.

The evaluation was carried out in the context of the NWLP Coalition and relied heavily on information and input from Coalition members and other partners engaged in ACP work. Results of the NWLP’s Community Conversation on Community Culture and Activation pillar of the Blueprint (Fall 2018) were also reviewed. The ACP “Disappearing” Task Force, a group coordinating ACP activities under the umbrella of the NWLP Coalition, provided guidance for the methodology, supplied much of the information related to educational activities, and gave input into the recommendations.

The evaluation work plan developed by WAHA and PCI is in Appendix 2.

It is important to note that the ACP work in Whatcom County is very dynamic, and that changes in organizations’ programming and documentation occurred even in the months between the development of the evaluation plan and the time data collection began.

KEY FINDINGS

- Whatcom County has a high level of community and clinical based ACP activity, with significant coordination among organizational and individual efforts. The NWLP Coalition and ACP Task Force are the primary vehicles for coordination and collaboration, and therefore important assets to improving efforts and seeing how the "whole is greater than the sum of the parts."

- In addition to the work of organizations and agencies, there is impressive involvement from volunteers and advocates who provide community education and individual and group ACP facilitation.

- Currently there is no coordinated mechanism to collect and compile data from all organizations and individuals participating in ACP activities to see a community-wide picture, so there is room for improvement in this area. Along the same lines, it would be beneficial to increase the capacity to report the collective work to a broader range of partners and stakeholders.

- Whatcom County doesn't have a way to measure the community-wide rate of ADs on file, i.e. percent of the county's population (vs. a specific clinic population) with an AD on file. PeaceHealth's service as the repository for any community member's AD presents a unique opportunity to establish a procedure to measure this rate and track it over time.

- Whatcom County's two largest healthcare organizations have higher levels of ACP "hardwiring" (built-in ways to systematically prompt and/or document ACP conversations). Healthcare organizations that are smaller, have fewer resources, and serve younger populations have less developed hardwiring, as do social service organizations. A platform for sharing approaches to hardwiring could benefit all organizations, especially social service and smaller healthcare organizations.

- Underserved, marginalized or minority populations remain underrepresented as audiences for community education and ACP facilitation. A "take it to where they are" approach could make outreach more effective, as well as training and capacity building for existing community-based roles (Faith Community Nurses, community health workers, promotores de salud, community health representatives, and others).

- A set of basic measures has been established for calendar year 2018, which going forward could be used as a baseline.
    - **Community education:** An estimated 3,400 community members participated in over 130 educational events, organized and presented by eleven different organizations and individuals.
    - **ACP facilitated sessions:** 530 participants (305 in group sessions, 225 in individual sessions); two organizations provided this service.
    - **Service provider hardwiring:** More difficult to quantify, the twelve healthcare and social service organizations reviewed have variable levels of ACP hardwiring. They are listed below, and Appendix 6 contains detailed information on each organization.
    - **Advance Directive completion rates:** A community-wide rate could not be established. There are many challenges with the existing measures; these are described in the report, along with a possible approach to attaining these data.

ADVANCE CARE PLANNING ACTIVITIES IN 2018

Community Education

Over 130 presentations, workshops, interactive activities related to ACP were provided in Whatcom County in 2018, or 2-3 per week on average, with 3,038 documented participants. Since there were some events for which the number of attendees was not recorded, a conservative estimate is that at least 3,400 people participated in a community ACP education event in 2018.

Eleven different organizations and individuals organized and led educational sessions for health and social service providers and the general public in a variety of community settings. Many of the organizers and presenters were community ACP advocates volunteering their time.

"Community Education"

For the purposes of this evaluation, "community education" refers to presentations, classes, workshops or other activities that explore general end-of-life and ACP concepts. The ACP process may be explained, but community education **does not include** working on completing a specific AD document or discussion of values, wishes and goals of care.

In general, the goal of community education is to raise awareness about and motivate action related to ACP.

The public events included variety of formats such as presentations, panel discussions, workshops and hands-on creative activities.

Some highlights:

- **"Make an Empathy Card"** booth at the Bellingham Farmer's Market and **"Write A Legacy Letter"** session at the local Food Co-op.
- **Hello Game** workshops, in partnership with the Hospice Foundation of America (HFA). HFA was pilot testing its *Hello Game,* an end-of-life conversation tool, to assess its impact on advance care planning behaviors in underserved populations.
- **Not If But When: Books for Young People about Death and Loss** held at the Bellingham Public Library.
- **What's Up Doc? We're Dying to Talk** event focused on younger adults. Over two hundred people participated, a result of extensive outreach to the local colleges and universities and raffle drawings for five $1,500 scholarships sponsored by the Chuckanut Health Foundation.
- **Rotary Club Series** – thirteen presentations from a variety of presenters, organized by a community volunteer.
- **Advance Care Planning + Dementia** (ACP+D) workshops led by two community members trained as advance care planning facilitators and experienced in working with people with dementia and their caregivers.
- **Realities of Advanced Medical Interventions** presentations, originally developed by two local intensive care unit nurses and now coordinated by a community ACP advocate and taught by a retired nephrologist and registered nurse.

See Appendix 3 for a full list of community education presentations, including audiences or locations.

WAHA distributed hard-copy surveys at the end of its educational sessions in 2018. Responses from 106 participants indicate that 93 respondents (88%) felt the presentation was "Very useful. I learned many new things." In addition, 12 respondents (11%) regarded it as "Somewhat useful. I learned a few new things." Of the 106 participants, two thirds did not have an AD. The most frequently mentioned responses to the question, "What are you likely to do in the next month or two related to advance care planning?" were "Talk with my loved ones," "Complete an advance directive," and "Recommend this workshop to others."

See Appendix 4 for the survey WAHA used with participants of community education events.

Advance Care Planning Facilitated Sessions

WAHA and PeaceHealth are the two Whatcom County organizations that provided ACP facilitation to the public in 2018. WAHA began offering individual sessions to community members in 2013; in 2018 PeaceHealth began offering individual sessions to PeaceHealth patients, as well as "Your Voice, Your Choice" group sessions open to all community members (not just PeaceHealth patients). The positive response to the group sessions prompted WAHA to start using this format as well. Both organizations use trained community volunteers in addition to staff, and provide this service free of charge.

"Facilitated ACP Group Sessions"

For the purposes of this evaluation, "facilitated ACP group sessions" refers to classes, workshops, or discussions that **do include** working on completing a specific AD document or discussion of values, wishes and goals of care.

In general, the goal of facilitated ACP group sessions is to assist participants with completing their AD.

In 2018, 530 people participated in facilitated sessions, as detailed below.

Advance Care Planning Facilitated Group and Individual Sessions, 2018		
	Number of participants in facilitated **group** sessions	Number of participants in facilitated **individual** sessions
PeaceHealth	242	63
WAHA	114	111
Total	**305**	**225**

WAHA data indicate that for the people they assisted, a minimum of two visits were needed to complete their AD – an initial facilitated session, followed by further discussion and/or an appointment to have the completed AD notarized. Both WAHA and PeaceHealth have arrangements for providing notary services free of charge.

PeaceHealth began sending an electronic survey to participants in the group sessions to gather feedback about the session and AD completion. Anecdotally, the response is positive, with a relatively high number (40-50%) of respondents reporting they have completed their ADs.

See Appendix 5 for the survey PeaceHealth sends out to participants of ACP sessions.

WAHA has used a post facilitation evaluation in the past, but did not administer it in 2018 due to limited staff capacity. In early 2019, WAHA began using a survey developed and co-branded by Honoring Choices PNW.

Service Provider "Hardwiring"

In addition to community education and facilitated ACP sessions, this evaluation sought to describe the ways in which healthcare and social services "hardwire" ACP into their patient/client care.

To understand current hardwiring and identify opportunities to increase such systems, interviews were conducted with key personnel of twelve of Whatcom County's largest organizations providing health and social services. Standardized interviews elicited organizations' current practices, barriers, and opportunities related to ACP service delivery, hardwiring and data collection. Information was collected from the following organizations:

"Hardwiring"

"Hardwiring" includes anything that systematically prompts patients/clients or providers to initiate or continue a conversation regarding ACP, or document completed ADs. It could be as simple as including a question about ADs on a health history form, or more complex such as features within an electronic medical record.

Hardwiring reduces the dependence on individual providers' ability and/or inclination to remember and prioritize ACP conversations with patients/clients, thereby increasing the frequency with which the topic is raised.

1. Compass Health
2. Faith Ministries Network
3. Family Care Network
4. Lummi Tribal Health Center
5. Nooksack Tribe Heath Center
6. Northwest Regional Council
7. PeaceHealth
8. Sea Mar Community Health Center
9. Student Health Center at Western Washington University
10. Unity Care Northwest
11. Whatcom Alliance for Health Advancement
12. Whatcom County Emergency Medical Services

Please see Appendix 6 for detailed information on each of these organizations' ACP activities.

Planned Parenthood was also contacted, but reported having no ACP hardwiring in place. Urgent care clinics, skilled nursing facilities and assisted living communities were not included in this evaluation; however, learning about these facilities' ACP hardwiring could identify additional opportunities for prompting and supporting ACP conversations.

General Themes Regarding "Hardwiring:"

Practices:
There is a wide range of the degree of hardwiring reported by health and social service organizations. Some organizations currently do not have any ACP prompts built into their systems. Not surprisingly, large organizations such as PeaceHealth and Family Care Network have more hardwired components, and a stronger focus on feedback loops to generate data on ACP activity at the clinic or provider level. It appears that organizational leadership's prioritization of and support for such system changes is key.

Barriers and Challenges:
The most commonly identified challenges to initiating ACP conversations with patients and clients were 1) Limited time during patient/client interactions, and 2) Lack of comfort and skill with engaging in ACP conversations. Confusion about where and how to document such conversations in electronic medical records, and where to place completed directives, was another theme. Having a specific, clearly defined field(s) in the electronic medical record appears to be helpful, and this also allows for data retrieval. It's likely that organizations that are part of larger systems (e.g. PeaceHealth, Sea Mar, Compass Health) will have more challenges to modifying forms or adding electronic medical records, as such changes generally need to be implemented system-wide. However, these organizations also may have more resources to do.

Opportunities:
Overall, hardwiring is an approach that all organizations could expand, and perhaps the pooled information in this report will help facilitate those expansions. With each organization at a different place in terms of its hardwiring, expansions would need to be tailored to each organization's specific systems and capacities. The Recommendations section below includes more about possible opportunities.

Advance Directive Completion and Filing Rates

In addition to measuring activities to promote ACP, it is obviously important to measure the number of people who actually have an AD stored in a place that is accessible to healthcare providers.

PeaceHealth routinely tracks the number of patients ages 18 and older seen in the hospital and PHMG/outpatient clinics in the previous three months who had an AD (including POLST forms) on file. For each of the last four months of 2018, 24% of patients seen (total seen =7,448 patients per month on average) had an AD on file. Earlier months of 2018 showed 21-22% of patients with one of these documents on file, indicating a slight increasing trend over the year.[2]

Family Care Network also tracks patients with completed ADs on file in the practices' electronic medical record, counting both POLST forms and ADs. As of April 10, 2019, 13% of FCN patients age 55+ seen in the previous 2 years (n=34,578) had a completed directive on file. Family Care Network also sends their patients' completed ADs for storage in PeaceHealth's electronic medical record.

Of note, while both PeaceHealth and Family Care Network track AD completion rates, different ages and timeframes are used; standardizing these measures would allow data comparison or aggregation (see Recommendation IA.2, below).

For both organizations, only patients with ADs uploaded into the medical records are counted. Patient reports of completed ADs at home, in a safety deposit box, or with a family member or attorney are not measured.

While the majority of Whatcom County residents are patients at either Family Care Network or PeaceHealth, the current data tracked by these organizations only tell us the percent of **their patient population** with ADs.

However, PeaceHealth's electronic medical record serves as the repository for **any** community member's AD, regardless of if they are a patient at PeaceHealth, which is a tremendous service to the community. For those who are not PeaceHealth patients, a record is created into which AD forms can be uploaded and stored – and retrieved by doctors in the Emergency Department or inpatient setting. Since PeaceHealth St Joseph Medical Center is the only hospital in Whatcom County, this provides a highly centralized storage and retrieval system for ADs[3]. This is particularly significant because Washington State does not have a state wide registry.

PeaceHealth's service as the community's central AD repository presents an opportunity for establishing a county-wide measure (see Recommendation IC.1, below).

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[2] It should be noted that PeaceHealth did much work in 2018 (continuing into 2019) to clarify and standardize AD filing, storage, and retrieval in its electronic medical record. For 2018, it's possible that data are variable due to establishing new protocols; once these protocols become standard practice, comparing rates across months and years will be more reliable.

[3] It is reported that from 2013 to 2016, the number of ADs and POLSTs received by PeaceHealth medical records department was regularly submitted to WAHA; while a useful measure, it wasn't a **county-wide rate** of AD completion.

RECOMMENDATIONS

I. Implement Ongoing Community-Wide ACP Evaluation

The following recommendations will help Whatcom County establish community-wide data collection, analysis and reporting of ACP activities, allowing the community to see progress over time, recognize gaps, and identify opportunities for improving efforts.

It's critical that any measures and methodology adopted strike a balance between being meaningful, robust, and practical/feasible for all partners.

Recommendation IA - Standardize data collection across organizations.

IA.1 – Define a set of measures for ACP education and facilitation that all people involved with these efforts can commit to collecting and reporting on an on-going basis. The measures should align with those developed by Honoring Choices PNW.[4] A possible set of measures is outlined in Appendix 7, along with the Honoring Choices PNW definitions for ACP activities.

IA.2 – Standardize the measures used by healthcare organizations to track the AD completion rates for their patient populations. For example, use the same age category (e.g., 18+ or 55+), and same time frame (e.g., patients seen in the last three months or 12 or 24 months).

IA.3 – Design a mechanism for collecting and compiling the data in an efficient and timely manner, and ensuring that data are reported to Whatcom County organizations and stakeholders.

Early conversations with Honoring Choices PNW suggest they may able to play a role with standardizing data collection; such a partnership should be explored further.

Recommendation IB - Develop a tool to measure the near-term impact of facilitated ACP sessions.

IB.1 – In partnership with Honoring Choices PNW, develop and pilot test a survey for participants of facilitated group and individual ACP sessions. Survey elements could include ACP activation levels,[5] self-report of AD completion and filing, barriers and facilitators to completing ADs, and suggestions regarding ways to improve ACP sessions.

IB.2 – Develop survey protocol (email message regarding survey, timing post-session, other variables), establish clear roles in regards to data collection, collation, analysis and reporting, and implement standardized surveying.

During conversations in Spring 2019, Honoring Choices PNW expressed interest in partnering with Whatcom County developing and piloting a survey.

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[4] In late 2018-early 2019, several Whatcom County organizations formalized partnerships with Honoring Choices PNW. Partnership agreements include data collection and reporting expectations, increasing the importance that any measures selected for Whatcom County align with those established by Honoring Choices PNW.

[5] Measures of ACP activation have been validated by R. Sudore et al. See the article in J Pain Symptom Manage. 2017 Apr; 53(4): 669–681.e8. and the Advance Care Planning Engagement Survey.

Recommendation IC - Establish a measure of community-wide rates of ADs filed at PeaceHealth.

IC.1 – Leverage the working relationship between the NWLP Coalition and PeaceHealth to discuss ways extract the data needed to measure AD completion rates. The two organizations have worked together effectively in the past to address issues related to filing and storing ADs for all Whatcom County residents.

II. Further Integrate ACP into Healthcare and Social Service Delivery

The following recommendations will help healthcare and social service organizations increase the integration of ACP into their service delivery, thereby promoting ACP to their patients and clients.

Recommendation IIA - Support individual organizations and agencies to add "ACP hardwiring."

IIA.1 – Consider an ad hoc "hardwiring" work group, perhaps under the umbrella of the NWLP Coalition, to share practices and develop solutions together. Among medical providers, Whatcom County's federally qualified community health centers in particular could benefit from this kind of exchange and support.

IIA.2 – Take advantage of the capacities of electronic medical records to embed prompts, designate fields, document, and generate referrals and patient education/resources.

IIA.3 – For organizations using EPIC (PeaceHealth currently, Sea Mar starting in Fall 2019), implement the ACP module and explore ways EPIC can share filed ADs across organizational lines. PeaceHealth plans to add the ACP module in 2020.

IIA.4 – Continue to develop data sharing platforms such as Image Trend used by the GRACE Program (Sea Mar/Whatcom EMS) to increase providers' access to ADs. In addition to the technology for these platforms, this will require a spirit of collaboration and partnership to establish the necessary data sharing agreements.

IIA.5 – Explore options for patients/clients to upload completed ADs via patient portals or other electronic means.

Recommendation IIB – Continue and expand provider and staff training.

IIB.1 – Provide training and mentoring for medical providers to continue to increase their comfort and skill with engaging in ACP conversations. Providers in smaller healthcare organizations appear to lack training and would especially benefit from it.

IIB.2 – Provide training for other staff in healthcare and social service organizations, e.g., clinical staff other than physicians, administrative staff, billing personnel, and roles such as case managers or community health workers. PeaceHealth is currently expanding training to a broader range of clinical staff, and could share challenges and lessons learned.

IIB.3 – Foster a more collective approach to training, e.g. more training opportunities in which providers from all healthcare organizations can participate, or ways for providers to share expertise and address challenges.

IIB.4– Implement campaigns that encourage or incentivize employees to complete their own ADs, such as the 2019 "I've Got Mine" campaign centered at PeaceHealth St Joseph Medical Center. Completing their own ADs increases employees' awareness of the ACP process and could increase promoting ACP to patients/clients (verifying this logic would be an excellent research project).

Recommendation IIC - Explore models that don't rely solely on medical providers.

IIC.1 – Capitalize on medical providers' credibility and influence by increasing the frequency with which they ask about or recommend ADs, but shift more responsibility for actual ACP conversations to care coordinators, community health workers, faith community nurses or others whose roles allow them to spend more time with patients/clients.

IIC.2 – Expand the cadre of active volunteer facilitators by providing training, on-going professional development and support, and a variety of opportunities to use their skills.

III. Expand ACP Community Outreach and Education

The following recommendations will help increase the reach and impact of community outreach and education around advance care planning.

Recommendation IIIA – Centralize information about ACP education and facilitation.

IIIA.1 -- Create a centralized web-based resource to make information about all ACP educational events and services more accessible (the PCI website does this to some extent, but there is room for improvement). A NWLP Coalition website would be a logical place for this information.

IIIA.2 – Compile a single listing of all classes, presentations, and events scheduled during a specific time frame (quarterly, for example) that can be used efficiently generate press releases, submission to community calendars, or hard-copy posters or flyers for distribution.

Recommendation IIIB – Intensity outreach efforts.

IIIB.1 – Take more ACP presentations and activities to where people are already gathered, including faith communities, community or senior centers, or neighborhood association meetings, as well as less formal settings such as book groups.

IIIB.2 – Increase focus on relationship-building and connection with Whatcom County's underserved and marginalized populations. Listening and learning will inform what approaches to awareness raising and education will be more effective, and what kinds of supports are needed.

IIIB.C – Identify and engage communities' natural helpers and informal leaders to expand community-based support for ACP. These people could be involved in neighborhood associations, condo or homeowner associations, school or church activities, service clubs or other volunteer roles.

Recommendation IIIC – Continue to support and grow collaboration.

IIIC.1 – Continue convening the NWLP Coalition and ACP Task Force in order to enhance collaboration around ACP, palliative care and end-of-life issues. These groups serve as vehicles for program, system and policy improvements, and create a shared voice for problem solving and advocacy.

IIIC.2 – Increase planning, coordination and evaluation for a community campaign around National Healthcare Decisions Day. This could help ensure shared goals, clarify the messaging, delineate roles and responsibilities among partners, assess the impact, and potentially generate greater levels of sponsorship.

IIIC.3 – Establish relationships with attorneys and financial planners and foster ongoing communication among people in the legal, financial and medical aspects of end-of-life planning. Such collaboration would help "de-silo" these areas and improve systems for developing, filing and retrieving ADs.

IIIC.4 – Research current practices in skilled nursing facilities, assisted living communities and adult family homes and explore opportunities for expanding ACP education for patients, families and staff. These are highly regulated environments; this could encourage hardwiring, since standardized processes could help both achieve goals of care and meet licensure requirements.

Appendix 1
Timeline and Milestones for Advance Care Planning Work in Whatcom County

2012

- WAHA initiated End of Life Choices program, hired ACP Coordinator
- ACP Coordinator completed Respecting Choices train-the-trainer program in LaCrosse WI

2013

- Death Café started – has met monthly since then
- Started presentations at Village Books' January "Resolutions Day" – has continued every year since then
- WAHA developed ACP planning kit for community members and professionals., including an ACP road map, reflections book, wallet card, and advance directive form.
- WAHA trained twenty-nine Advance Care Planning Facilitators.

2014

- First Palliative Care Initiative conference – has been held annually since then
- Blueprint for Creating a Community of Care and Support for People with Serious Illness published
- Family Care Network adopted ACP as a strategic priority; referral pathway to WAHA established in electronic medical record
- NWLP members participated in Honoring Choices statewide task force/planning group

2015

- Realities of Advance Medical Interventions presentations started – has continued since then
- NWLP Coalition formed, an outgrowth of the Blueprint Task Force.
- WAHA ACP Coordinator trained by Respecting Choices to train facilitators
- WAHA trained thirty-five Advance Care Planning Facilitators

2016

- Honoring Choices PNW roll out with PeaceHealth St Joseph Medical Center as one of its first pilot sites
- Advocacy for HR 1676 Palliative Care and Hospice Ed Training Act
- Family Care Network trained all staff throughout the clinic network
- WAHA trained six Advance Care Planning Facilitators

2017

- Blueprint revised
- Palliative Care Institute established at WWU (outgrowth of Palliative Care Initiative)
- ACP series in Whatcom County Libraries, supported by End of Life Washington
- PeaceHealth hires ACP Coordinator, the first in the PeaceHealth system
- WAHA trained seven Advance Care Planning Facilitators

2018

- PeaceHealth started offering free monthly classes for community members and PeaceHealth caregivers
- ACP+Dementia classes started
- PeaceHealth and WAHA established formal partnership with Honoring Choices PNW and adopt the Honoring Choices PNW advance directive form
- For the first time, the NWLP Coalition was financially supported by Coalition members
- WAHA trained nine Advance Care Planning Facilitators

Appendix 2

Advance Care Planning Evaluation Work Plan

Whatcom Alliance for Health Advancement & Palliative Care Institute

TIME FRAME: November 2018-June 2019

Context

A number of different organizations have promoted and facilitated advance care planning (ACP) in Whatcom County in recent years. The Northwest Life Passages (NWLP) Coalition brings together medical providers, caregivers, educators, faith communities and others to create a more cohesive approach to the community's ACP and palliative care efforts. However, to date there hasn't been a systematic approach to measuring ACP activities across all organizations involved in this work, and the impact these activities are having on the completion of advance directives (ADs).

Elements of an ACP System

"The Five Promises of an Advance Care Planning System" (Respecting Choices®) outlines five key components that together comprise a **system** of community-based advance care planning. The NWLP Coalition has adopted this system-focused framework, and modified the promises into **Five Commitments:**

Commitment #1 – to educate our community and initiate conversations about Advance Care Planning
Commitment #2 – to provide assistance in the development and completion of advance directives
Commitment #3 – to assure that plans are complete and clearly understood
Commitment #4 – to develop and maintain a system to store plans and retrieve them when necessary
Commitment #5 – to appropriately follow your plan

Evaluation Scope

This evaluation project led by the Palliative Care Institute (PCI) and Whatcom Alliance for Health Advancement (WAHA) directly evaluates activities related to Commitments #1 and #2. Working on the first two commitments will likely identify gaps and opportunities around Commitments #3 and #4, which can inform policies, practices, and future evaluation. Commitment #5 – advance directive adherence – requires the more complex methodology of chart auditing, and is not within the scope of this evaluation.

The evaluation will be carried out in the context of the NWLP Coalition and will rely heavily on information and input from Coalition members and other partners engaged in ACP work.

Overarching Aims

1. Quantify and describe the current number, scope, and level of participation in ACP educational activities and services assisting people with the ACP process (community-wide, across all organizations and programs).
2. Identify successes and strengths which can be built upon or expanded, and gaps or weakness that need to be addressed across all five Commitments.
3. Develop a framework for shared data collection across local entities doing ACP work in order to build a community-wide system for ongoing evaluation of ACP processes and outcomes.

Advance Care Planning Evaluation Work Plan

Whatcom Alliance for Health Advancement & Palliative Care Institute

Part I: ACP Activities and Services

Deliverable: A summary report including a) existing ACP activities, b) strengths and gaps in Whatcom County, and c) recommendations for advancing ACP efforts.

Commitment #1 – Educate our community and initiating conversations about Advance Care Planning.

Goal	Metrics	Data Source	Collection method	Lead	Timeframe
1.1: Understand the current number and type of programs and activities in Whatcom County designed to educate, raise awareness, and motivate action regarding advance care planning, and the participation in such activities.	*Quantitative:* • Number of programs and activities provided. • Number of participants in educational programs. • Demographic and other characteristics of participants, if available.	• NWLP members • Disappearing Task Force members • PCI website • WAHA database	Interviews/ conversations/ discussions	Project Coordinator	Nov-Dec 2018
1.2: Understand the places and ways ACP conversations are **systematically initiated**, i.e. "hardwired" in healthcare or other settings.	*Quantitative:* • Number of practices or agencies with "hardwired" conversation initiation. *Qualitative:* • Types of "hardwiring" being used (question on client forms, EMR prompts, etc.) • Barriers to conversation initiation in these settings. • Existing and potential supports for conversation initiation (provider training, billing opportunities, etc.)	Medical directors or clinic managers from • Community Health Centers • Tribal clinics • Family Care Network • PeaceHealth • Other providers (Planned Parenthood, WWU Student Health Center, etc.)	Interviews/ conversations/ discussions	Project Coordinator	Nov-Dec 2018

Commitment #2 – Provide assistance in the development and completion of Advance Directives.					
Goal	**Metrics**	**Data Source**	**Collection method**	**Lead**	**Timeframe**
2.1: Understand the availability and scope of **advance care planning assistance** (individual-focused, using a specific process and/or document) in Whatcom County, and utilization of such services.	• Number and types of services provided. • Number of people who participate in an advance care planning session. • Number of people who participate in more than one advance care planning session.	ACP Disappearing Task Force members PCI website WAHA services database	Interviews/ conversations/ discussions Database reports		Nov-Dec 2018
2.2: Quantify the **AD completion and filing** rates for people who participate in advance care planning assistance in Whatcom County.	• Number of **completed** advance directives (ADs) post session *(and **rate** of completion)*. • Number of ADs **completed and filed** with medical provider or PHSJMC post session (and **rate** of completion and filing).	Community members/ clients WAHA Services Database PeaceHealth HIM Family Care Network EMR	Survey post individual assistance (tool already developed and tested by PCI) HIM/EMR reports		Jan-Mar 2019

Part II: Evaluation Framework

Deliverable: A framework for ongoing community-wide evaluation of ACP processes and outcomes, including specific measures, data sources, timelines, and partner roles.

Goal	**Steps**	**Lead**	**Timeframe**
Establish ACP measures for Whatcom County	• Define menu of potential measures • Prioritize with partners based on importance, feasibility, and other criteria	Project Coordinator	April-June 2019
Create evaluation plan	• Building on learnings from Part I, outline a plan for regular collection and analysis of ACP data • Refine plan with community partners involved with ACP • Secure partner commitments to specified roles and tasks • Establish coordination and oversight for ongoing evaluation	Project Coordinator	April-June 2019

ACP Evaluation Project Work Plan – FINAL (4th revision 8/2018, approved 11/2018)

Appendix 3 - Advance Care Planning Community Education, Whatcom County 2018

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
Jan 2018	Death Café	7	Moles Funeral Home	Sandy Stork	
Jan 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey
1/15/18	Realities of Advance Medical Interventions	20	Unity Spiritual Center	Rebecca Rech Cutler	
1/17/18	Panel Discussion: PeaceHealth – Rumors and Realities	80	Moles Funeral Home	Palliative Care Institute & PeaceHealth	End of Life Washington partner/panelist
1/18/18	PHSJMC Patient Advisory Group		Health Education Center	PeaceHealth	Hilary Walker
Feb 2018	Death Café	8	Moles Funeral Home	Sandy Stork	
Feb 2018	Bellingham Covenant Church	30	Bellingham Covenant Church	Health Ministries Network	Caregiver Group
2/21/18	Defining Hope	132	Pickford Film Center	Palliative Care Institute	Film screening & discussion
2/22/18	ACP for PeaceHealth Providers		PHSJMC, Internal Med Provider Group	PeaceHealth	Hilary Walker
2/26/18	End-of-Life Conversation Presentation	14	Eleanor Apartments	Whatcom Alliance for Health Advancement	
March 2018	Death Café	14	Moles Funeral Home	Sandy Stork	
March 2018	Speaking of Dying	4		Nancy Simmers	
March 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey
3/3/2018	The Heart-Kidney Connection	85	Mended Hearts Meeting	Dr. Bill Lombard	
3/6/18	Not If But When: Books for young people about death and loss	21	Bellingham Public Library	Palliative Care Institute	
3/15/18	ACP for PeaceHealth caregivers		In-Patient Care Management Staff	PeaceHealth	Hilary Walker
3/21/18	What's Up Doc: We're Dying to Talk	215	Emphasis on reaching younger people; Health Education Center	Micki Jackson/ Palliative Care Institute/Whatcom Alliance for Health Advancement/ others	Raffle drawing for five $1500 scholarships for NWIC, WWU, BTC, WCC or SVC students
3/22/18	Nursing In-Service		United General	PeaceHealth	Hilary Walker
3/23/18	Presentation to Health Ministries Network	25	Health Education Center	Marie Eaton	
3/29/18	Whatcom Council on Aging group presentation		Bellingham Senior Activity Center	PeaceHealth	Hilary Walker
3/29/18	PHMG Provider meeting		PHMG, Center for Senior Health	PeaceHealth	Hilary Walker, Dr Gib Morrow
Q1, 2018	Realities of Advance Medical Interventions			Dr. Bill Lombard &/or Rebecca Rech Cutler	Micki Jackson coordinates the Realities presentations.
Apr 2018	Death Café	20	Moles Funeral Home	Sandy Stork	
Apr 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
4/6/18	Nursing staff at Peace Island		PeaceHealth Peace Island Hospital	PeaceHealth	Hilary Walker
4/11/18	End-of-Life Conversation Presentation	13	Community Co-Op	WAHA	
4/13/18	Chaplaincy Department meeting		PHSJMC, Chaplains	PeaceHealth	Hilary Walker
4/15/18	Beginning to Talk About the End	5	Whatcom Hospice	Palliative Care Institute	Exploring death through a creative lens
4/16/18	Advance Care Planning 101	12	Deming Library	WAHA	
4/16/18	Advance Care Planning 101	11	WWU	WAHA	
4/18/18	ACP for PeaceHealth Providers		PHSJMC, Hospitalists	PeaceHealth	Hilary Walker, Dr Gib Morrow
4/29/18	Advance Care Planning 101	8	Lynden Library	WAHA	
5/1/18	Advance Care Planning 101	10	Community Food Co-Op	WAHA	
May 2018	Death Café	14	Moles Funeral Home	Sandy Stork	
May 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey
5/1/18	Elder Service Providers Luncheon	40		Health Ministries Network & Palliative Care Institute	
5/2/18	Legacy Letter Workshop	10	Bellingham Food CO-OP	Palliative Care Institute	
5/4/18	Advance Care Planning 101	2	Bellingham Public Library	WAHA	
5/9/18	ACP for PeaceHealth caregivers		PHMG, Orthopedics and Third Surgical Joint Center	PeaceHealth	Hilary Walker
5/11/18	PCI Spring Conference – Holistic Pain Management: Promising Alternatives to the Opioids	130	Bellingham Technical College	Palliative Care Institute	
5/16/18	Advance Care Planning 101	25	WCC 2nd year nursing students	WAHA	
5/23/18	Signature Home Health caregivers		Home Health caregivers	PeaceHealth	Hilary Walker
Jun 2018	Death Café	15	Moles Funeral Home	Sandy Stork	
Jun 2018	Speaking of Dying	2		Nancy Simmers	
Jun 2018	Silverado Caregiver Conference	20	Silverado	Health Ministries Network	Kate Massey
Jun 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey
6/6/18	Advance Care Planning 101	2	Brookdale Senior Living	WAHA	
6/6/18	Advance Care Planning 101	18	Bellingham Covenant Church	WAHA	
6/11/18	Advance Care Planning 101	1	WECU Ferndale	WAHA	
6/13/18	Advance Care Planning 101	4	Sumas Library	WAHA	
6/14/18	Advance Care Planning 101	8	Lummi Island Library	WAHA	
6/19/18	Advance Care Planning Presentation	6	Whatcom Co Health Dept	WAHA	
6/20/18	Advance Care Planning Presentation	10	Whatcom Co Health Dept	WAHA	
6/21/18	Whatcom Assisted Living Association		Brookdale Senior Living	PeaceHealth	Hilary Walker

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
Q2, 2018	Realities of Advance Medical Interventions			Dr. Bill Lombard &/or Rebecca Rech Cutler	Micki Jackson coordinates the Realities presentations.
Jul 2018	Death Café	12	Moles Funeral Home	Sandy Stork	
Jul 2018	Caregiver Support Group	4		Health Ministries Network	Kate Massey
7/9/18	ACP brief introduction	5	PHSJMC, Food Services	PeaceHealth	Hilary Walker
7/23/18	NW Life Passages Coalition Community Conversation: Outpatient Palliative Care	55	Health Education Center	Northwest Life Passages Coalition	
7/26/18	Advance Care Planning + Dementia (ACP+D)	5	Whatcom Hills Waldorf School	Adrienne Doucette & Denise Weeks	
7/1/18	Death Café	12	Moles Funeral Home	Sandy Stork	
7/9/18	ACP brief introduction	5	PHSJMC, Food Services	PeaceHealth	Hilary Walker
7/23/18	NW Life Passages Coalition Community Conversation: Outpatient Palliative Care	55	Health Education Center	Northwest Life Passages Coalition	
7/26/18	Advance Care Planning + Dementia (ACP+D)	5	Whatcom Hills Waldorf School	Adrienne Doucette & Denise Weeks	
August 2018	Death Café	19	Moles Funeral Home	Sandy Stork	
8/3/18	Woodrose Senior Apartments	3		WAHA	
8/6/18	Rotary Club Series	75		Micki Jackson	Presenter: Heather Flaherty, Raptor Group, RiverStyx Foundation
8/13/18	Rotary Club Series	125		Micki Jackson	Presenter: Dr. Bree Johnston, U of Arizona College of Medicine
8/20/18	Rotary Club Series	75		Micki Jackson	Presenter: Hilary Walker, ACP Coordinator PeaceHealth St. Joseph Medical Center
8/21/18	Everson Library	4		WAHA	
8/22/18	Senior Center Health Fair presentation	25	Bellingham Senior Activity Center	Marie Eaton	
8/25/18	Make an Empathy Card		Bellingham Farmer's Market	Palliative Care Institute	
8/27/18	Rotary Club Series	125		Micki Jackson	Presenter: Dr Bill Lombard, DaVita Mt. Baker Kidney Center
8/30/18	Advance Care Planning + Dementia (ACP+D)	13	Whatcom Hills Waldorf School	Adrienne Doucette & Denise Weeks	
Sept 2018	Death Café	18	Moles Funeral Home	Sandy Stork	
9/6/18	Ferndale Library	4		WAHA	

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
9/7/18	South Whatcom Library	3		WAHA	
9/10/18	Rotary Club Series	125		Micki Jackson	Presenter: Dr Gib Morrow, PeaceHealth Physician Champion, Honoring Choices Initiative
9/11/18	ACP for PeaceHealth Providers	15	PHMG, Cardiology	PeaceHealth	Hilary Walker & Dr Gib Morrow
9/12/18	ACP for PeaceHealth Providers	10	PHMG, Neurology	PeaceHealth	Hilary Walker & Dr Gib Morrow
9/17/18	Rotary Club Series	125		Micki Jackson	Presenter: Dwight Moore, Ph.D, industrial psychologist, End of Life Washington volunteer
9/17/18	Blaine Library	5		WAHA	
9/20/18	Eleanor Apartments/Mercy Housing	30	Low-income seniors	WAHA & Palliative Care Institute	Meal provided
9/24/18	Rotary Club Series	125		Micki Jackson	Presenter: Ross Fewing, MA, M.Div, Director of Mission & Ethics Integration, PeaceHealth Northwest Network
9/27/18	Advance Care Planning + Dementia (ACP+D)	8	Whatcom Hills Waldorf School	Adrienne Doucette & Denise Weeks	
9/27/18	Villa Santa Fe Apartments/Mercy Housing	13	Migrant/seasonal farmworkers	WAHA & Palliative Care Institute	Meal and childcare provided
9/28/18	Lummi Nation	15		WAHA	
Sept 2018	Death Café	18	Moles Funeral Home	Sandy Stork	
Q3, 2018	Realities of Advance Medical Interventions			Dr. Bill Lombard &/or Rebecca Rech Cutler	Micki Jackson coordinates the Realities presentations.
Oct 2018	Death Café	14	Moles Funeral Home	Sandy Stork	
10/1/18	First Congregational Church	40	First Congregational Church	Health Ministries Network	Watched & discussed film Being Mortal
10/1/18	First Presbyterian Church	10	First Presbyterian Church	Health Ministries Network	Kate Massey
10/1/18	Rotary Club Series	75		Micki Jackson	Presenter: Kendra Cristelli, Executive Director, Support Officers Community Care
10/3/18	Sumas Library	4		WAHA	

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
10/5/18	Alzheimer's Society Annual conference	30		PeaceHealth	Hilary Walker
10/6/18	Whatcom National Alliance for Mental Illness Fair Stigma Stop	70		WAHA	
10/8/18	Rotary Club Series	75		Micki Jackson	Presenter: Josselyn Winslow, founding member of the Alzheimer Society of Washington
10/11/18	Revitalizing the Love of Life		Sylvia Center for the Arts	Palliative Care Institute	
10/11/18	Whatcom Community College	34		WAHA	
10/15/18	Rotary Club Series	75		Micki Jackson	Presenter: Thom Barthelmess, Youth Services Manager, Whatcom County Library System
10/18/18	Alzheimer's Society of Whatcom County	8	Senior Support Services Group	PeaceHealth	Hilary Walker
10/19/18	Dr. Ravi Ranvindra: Daily Dying, The Gateway to Living Well	100	Bellingham Unitarian Fellowship	Palliative Care Institute	
10/19/18	Da Vita Kidney Center	15		WAHA	
10/22/18	NW Life Passages Coalition Community Conversation: Community Education and Activation	25	Health Education Center	Northwest Life Passages Coalition	
10/22/18	Rotary Club Series	75		Micki Jackson	Presenter: Gurpreet Dhillon, PeaceHealth, Director Cancer Center, Palliative Care, and Hospice
10/24/18	Elder Luncheon Service Providers	30		WAHA	
10/25/18	Advance Care Planning + Dementia (ACP+D)	4	Whatcom Hills Waldorf School	Adrienne Doucette & Denise Weeks	
10/25/18	PeaceHealth Stroke Support Group	10		WAHA	
10/25/18	Upper Skagit Tribe Women's Fair	20		WAHA	
10/26/18	Deming Library	5		WAHA	
10/29/18	Rotary Club Series	75		Micki Jackson	Presenter: Jack Lee, volunteer Patient Ambassador at PeaceHealth St. Joseph Medical Center
10/30/18	What's Next -- A Healthier You	50	Bellingham Senior Center	WAHA	
Nov 2018	Death Café	10	Moles Funeral Home	Sandy Stork	

Date	Class/Presentation/Workshop	# of participants	Location/Audience	Organizer/Presenter	Notes
11/1/18	Blaine Library	2		WAHA	
11/5/18	Rotary Club Series	75		Micki Jackson	Presenter: Barry Meyers, Certified Elder Law Attorney
11/6/18	PEBB retiree presentation	17		WAHA	
11/8/18	Ferndale Library	4		WAHA	
11/9/18	Community presentation		Bellingham Congregational Church	PeaceHealth	Hilary Walker
11/13/18	Recompose: Alternative Body Disposition		WWU	Palliative Care Institute	
11/13/18	Whatcom Falls Neighborhood Association	15	Kulshan Middle School	WAHA	
11/13/18	Point Roberts Library	5		WAHA	
11/16/18	Da Vita Kidney Center	4		WAHA	
11/16/18	Lummi Island Library	5		WAHA	
11/16/18	First Congregational Church	14		WAHA	
11/17/18	Volunteer training		PHSJMC, Hospice and Palliative Care	PeaceHealth	Hilary Walker
11/20/18	Whatcom Chapter of Medical Assistants		Whatcom Community College	PeaceHealth	Hilary Walker
11/27/18	Community Health Classes	20	Western Washington University	WAHA	
11/30/18	ACP in Acute Care Setting		PHSJMC, Care Management team	PeaceHealth	
12/7/18	Da Vita Kidney Center	4		WAHA	
12/13/18	Eleanor Apartments	5		WAHA	
12/14/18	GoWish (Spanish)	15	Lynden Catholic Church	WAHA	
Q4, 2018	Realities of Advance Medical Interventions			Dr. Bill Lombard &/or Rebecca Rech Cutler	Micki Jackson coordinates the Realities presentations.
2018 TOTAL PARTICIPANTS		**3,038**			

Appendix 4 – WAHA Advance Care Planning Workshop Evaluation Survey

WAHA Advance Care Planning Workshop Evaluation

Location:________ Date________ Name(s) of Presenters: ___________

Thank you for participating in today's dialogue. We want to learn more about your experience and how we can better serve the community.

If you are not able to complete the evaluation at the event, please send evaluation to:

WAHA 800 East Chestnut St LL Suite 2
Bellingham, WA 98225

1. **What was your reason(s) for attending this presentation? *Check all that apply.***
   - ☐ I want to be prepared for the future.
   - ☐ I thought it sounded interesting.
   - ☐ I have completed documents in the past and want more current information.
   - ☐ I'm currently coping with declining health, or the declining health of someone important to me.
   - ☐ My doctor suggested it. Doctor's name_____________________________
   - ☐ Other (please specify): __________________

2. **How useful was the information that was presented? *Check the statement that best applies.***
   - ☐ Very useful. I learned many new things.
   - ☐ Somewhat useful. I learned a few things.
   - ☐ Not useful. I didn't learn anything new.
   - ☐ I was confused or overwhelmed by what I heard.
   - ☐ Other: ______________________________________

3. **Do you already have an advance directive?**

   ☐ **Yes**
   If yes, does your doctor have a copy?
   ☐ **Yes** ☐ **No**
   If yes, have you discussed it in detail with your health care agent?
   ☐ **Yes** ☐ **No**
   If yes, does your local hospital have a copy?
   ☐ **Yes** ☐ **No**

   ☐ **No**

PLEASE ALSO COMPLETE OTHER SIDE→

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ACP Presentation + Workshop Evaluation Rev 1.2018

4. **After attending this presentation, what are you likely to do within the next month or two related to advance care planning? *Check all that apply.***
   - ☐ Make an appointment to talk with a facilitator
   - ☐ More thinking and/or reading
   - Talk about this topic with:
     - ☐ my health care agent
     - ☐ my loved ones
     - ☐ my doctor or other health care professional
     - ☐ my spiritual advisor
   - ☐ Complete an advance directive
   - ☐ Review my advance directive
   - ☐ Make sure a copy of my advance directive is on file at the hospital
   - ☐ Recommend this workshop to others
   - ☐ Other (please specify): ________________________

5. **What are some barriers you face related to advance care planning? *Check all that apply.***
   - ☐ I don't want to upset my loved ones
   - ☐ I don't think it's necessary; my family will work it out
   - ☐ I don't have anyone I can ask to be my health care agent
   - ☐ My loved ones are not ready to have this kind of conversation
   - ☐ I'm not ready to have this kind of conversation
   - ☐ I need more information about how to start the conversation
   - ☐ Confused or overwhelmed by the process
   - ☐ Procrastination
   - ☐ Other: ________________________________

6. **What did you like best about the presentation?**

7. **How can we improve this workshop?**

8. **Other comments?**

Please assist us with the following information. Information is not shared and is kept confidential.

Zip Code: __________ **Gender:** ___________
Your Current Age: _____ or ☐ 18-34 ☐ 35-50 ☐ 51-64 ☐ 65-74 ☐ 75 -84 ☐ 85+
Race/ethnicity: ______ **Hispanic/Latino? Y or N** **Enrolled tribal member? Y or N**
Served in US military? Y or N Language(s) spoken at home? _____________

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Appendix 5

On-line Survey to Participants

in PeaceHealth's "Your Voice, Your Choice" Workshops (facilitated group ACP conversations)

Note: This survey is sent via Survey Monkey, so the formatting is somewhat different than it appears here.

Your Voice, Your Choice

Feedback from class on advance directives.

We are grateful you joined us for the Your Voice, Your Choice class on completing your advance directive. Thank you, in advance, for taking a moment to complete the survey below to help us track how effective our class is and how to make this offering most successful.

1. We know that completing an advanced directive document can be challenging, so we would like to know if you have been able to complete the document?
   - Yes
   - No

2. If you were not able to complete the advanced directive document, what barriers have there been to completing it?

3. Did you file your advance directive with your doctor?
   - Yes
   - No

4. If you were not able to file your advanced directive with your doctor, what are your barriers with this?

5. Did you file your advance directive with your local hospital?
   - Yes
   - No

6. If you were not able to file the Advanced Directive with your hospital, what are your barriers to sharing this document?

7. Does your healthcare agent have a copy of your advance directive?
   - Yes
   - No

8. If your Healthcare Agent does not have a copy of your Advanced Directive, what are your barriers to sharing this document?

9. Do you have any feedback that would help make these workshops more successful?

Appendix 6 - Healthcare and Social Services Organizations' "Hardwiring" for Advance Care Planning

Compass Health, Whatcom County

Information provided by Charissa Westergard, Director of Healthcare Integration, Brandon Foister, Outpatient Services Director

General Information: Compass Health provides a wide-range of behavioral health services for clients of all ages in Snohomish, Skagit, Island, San Juan, and Whatcom counties. Compass Health offers crisis services, community outreach and support, ongoing clinical care, and pharmacy services for people with mental health issues and substance use disorders.

In Whatcom County Compass has 12 clinicians in the outpatient clinic, about 6 FTE psychiatric physicians and ARNPs, plus 17 staff providing emergency/crisis services.

Current service delivery practices	Barriers or challenges	Opportunities to Improve or Expand
Client intake processes have several built-in prompts for asking about ADs; see below. As a whole, Compass staff have not had training in ACP.	Traditionally, ACP has been considered a medical issue, and medical care and behavioral healthcare have operated in separate siloes.	Effective July 2019, service delivery changed to a more whole-person care model – part of statewide managed care shift. While this transition is challenging in the near-term, in the long-term increased integration of behavioral and medical care represents an opportunity for an expanded focus on ACP.
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities**
Compass Health is a Washington Health Homes (HH) agency, which provides care coordination to people with Medicaid who meet clinical and healthcare utilization criteria. Health Home Care Coordinators are required to discuss ACP within the first year of a client's enrollment in the program, and Compass Health strives to complete this within the first 3 months. ACP conversations are documented in clients' medical records and any completed ADs are uploaded. In the outpatient clinic setting, the health intake questionnaire includes ADs as a required field (electronic form). If the client has a completed AD, Compass tries to get a copy to upload into the health record (via DocuWare).	While processes prompt asking about ADs, in general staff members have little knowledge about the ACP, so their ability to explain the process or answer clients' questions is therefore limited.	Training for staff would increase their understanding of the ACP process, AD documentation/forms, and resources available to clients. Compass Health has a "Clinical Resource Hour" for staff every two weeks, and would welcome a presenter for an introduction to ACP. More in-depth training could be provided for key staff roles or for those with a special interest in the topic.

Compass Health, Whatcom County		
The encounter screening form used by Emergency Services staff also asks about ADs, though it's not mandatory to collect this information. If clients don't have ADs, staff generally suggest they discuss this with their primary care provider.		
Current Data	**Barriers or Challenges**	**Opportunities**
It's unclear if it's possible for Compass to query its electronic medical record regarding ACP conversations or completed ADs on file to assess the frequency of these conversations or a completion rate for their client population.		Explore ways to measure ACP conversations and/or rates of ADs on file, as an internal organizational feedback loop on the level of ACP engagement with clients.

Family Care Network

Information provided by Nancy Stothart, Clinical Services Manager (outgoing), Heather Maddox, Clinical Services Manager (incoming), Dr Chao-ying Wu, Dr James Hopper.

General Information: Family Care Network (FCN) is system of primary care medical clinics in Whatcom and Skagit Counties. There are eleven practices in communities throughout Whatcom County, plus an urgent care center. Skagit County has two practices and an urgent care center.

Family Care Network has long been involved with Whatcom County's advance care planning efforts. Family Care Network physicians were instrumental in launching WAHA's End of Life Choices program in 2012 and the adoption of the Respecting Choices® First Steps facilitation model. Family Care Network providers also participated in the development of the NW Life Passages Blueprint for Creating a Community of Care and Support for People with Serious Illness.

In 2016 FCN adopted ACP as a strategic priority, and in 2016-2017 all FCN staff and providers received training around ACP. Goals were to ensure that staff at all levels of the organization had an understanding of what ACP is, why it's important, FCN's goal of increasing rates of FCN patients with completed directives on file, and how to provide patients with basic information.

As of 4/10/19, 13.2% of FCN patients age 55+ seen in the previous 2 years (n=34,578) have a completed directive on file in FCN's electronic medical record.

Current service delivery practices	Barriers or challenges	Opportunities
FCN is focusing its ACP efforts on patients age 55+. There is a particular effort to increase ACP services for people age 65+, partly because of these services are now reimbursed by Medicare. There are two kinds of patient visits for which ACP is "built in": • **Medicare Wellness Visit** (people with Medicare, 65+). • **Medicare Comprehensive Health Visit.** Starting in January 2019, Kaiser and Humana Medicare Advantage Plans reimburse for this appointment. It is more comprehensive than the standard Medicare wellness visit and includes cognitive assessment, depression screening, and goal setting as well as advance directives. Two FCN clinics are piloting having an RN do these visits, and an evaluation is expected to be conducted in the fall of 2019. Well Adult Visit (adults of all ages) MAY include discussion of advance directives, depending on the	There are no trained ACP facilitators in clinics – and this model may not be realistic, due to lack resources (namely staff time) at the clinic level. Though all providers have received ACP training, there remains a wide variance among individual providers in terms of how much they address ACP. Provider and staff turnover, and resulting need for continual training, is a challenge. "Tracking" and following up on ACP conversations is difficult – a challenge, as it's well recognized that multiple conversations are generally required before patients complete their AD.	Having FCN dedicated hospitalists provides a strong "feedback loop" because they are doing care in which they are seeing firsthand situations which are impacted by ADs or the lack of ADs. They tend to advocate for AD/ACP to their clinic-based colleagues. This is potentially an internal resource/strength that could be leveraged and could possibly be a topic for a case review session. Reimbursement offers an incentive to provide and bill for ACP services; training and/or reminding providers to bill may be needed. Embed ACP as a standard component of training/orientation for all new providers and staff (already in development). There is a relatively low rate of AD completion among FCN providers and staff. Focusing on promoting ACP within FCN could be a strategy for making ACP more "real" and increasing conversations with patients. Heather Maddox, FCN's new Clinical Services Manager who started in May 2019, has a background in palliative care and

Family Care Network		
provider, the patient's diagnosis/medical situation, and the patient's interest (i.e., if they ask about it). When patients bring in completed ADs or POLSTs, they are scanned into the patients' electronic medical record, and a copy is mailed to the hospital to be filed there. There is a plan in place to support hospitalists' and Clinical Home Team providers' documentation and billing for ACP conversations. FCN has a branded FCN ACP brochure for providers and staff to give to patients (created in April 2019).		hospice work. This will be an asset to FCN's efforts to continue and expand its focus on ACP. Starting in 2020, ADs will be one of FCN's quality measures (part of a population health initiative headed by Dr. Poudre).
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities to improve or expand**
Within Centricity, FCN's EMR, providers can check a box for patient instructions so that ACP resources are printed and given to patients. There is also there is a direct link to the Honoring Choices Pacific Northwest AD form than can be printed and given to patients. Centricity also has a built-in referral pathway to WAHA for advance care planning facilitation. ACP referrals are routed directly to WAHA's printer and WAHA contacts the patient to schedule an ACP session. FCN has a preventive care dashboard, which generates recommended preventive care based on the patient's age, gender and diagnoses. About 4-6 recommendations pop up for each patient, and serve as a reminder to both providers and patients. The clinic assistant reviews preventive care recommendations with patients at every visit, and they are printed and given to patients to increase their engagement in their care. Starting sometime in 2019, AD will be added as a preventive care		For staff who have a particular interest in or passion for ACP and received additional training, ideally they would have a title that indicates that specialty focus, and be provided extra time and/or compensation to do ACP in the clinics. (At one time nurses trained in ACP had conversations with patients following a physician visit, but this process has not continued). At the community level, it would be helpful to have a entity to coordinate the aspects of ACP that are used across all community organizations doing ACP, rather than relying on each practice or organization to develop their own amongst all the many other services they provide. A clearing house of central coordinating entity to do the "heavy lift." The ability to import ADs from EPIC/PeaceHealth St Joseph Medical Center into patients' electronic medical records at FCN would be extremely useful.

Family Care Network		
recommendation and will pop up for patients age 55+. The preventive care dashboard is reported to be one of FCN's most effective interventions for preventive measures. The FCN new patient form asks about advance directives. Automated appointment reminder calls ask patients over age 50 to bring any advance directive they may have to their appointment, in addition to their medication list.		
Current Data	**Barriers or Challenges**	**Opportunities**
The presence of AD forms (including POLSTs) on file in Centricity is the primary measure FCN uses to assess progress around ACP. Meridios software is used to query and retrieve data from Centricity. Centricity does not have "obs terms" that allow tracking of ACP conversations. However, the number of conversations can be determined by CPT codes used for billing. The FCN intranet has a feature that shows data for key quality measures, both by clinic and by provider. Patients with an AD on file is one of the measures. This provides a quick feedback loop about these measures. A clinician can pull up individual patient charts to identify ADs; however, currently there is no mechanism to ascertain how many ADs are on file in the system as a whole.	The EMR field "Directives" is where any kind of AD is placed. It is limited to text only, resulting in variability in the terms people use to describe forms placed there. This impedes efficient querying of these data. In addition, it is not always clear what the forms are until they are opened.	Though not a current practice, CPT codes used to bill for ACP conversations could be tracked and compared to specific patients who have ADs in their chart. Anecdotally, it's reported that "many" conversations are needed to achieve a completed AD, and actually measuring this may be of value (though perhaps more for planning educational programs than providing clinical care). Being able to see the data on ADs on file by provider and clinic provides the opportunity to learn from those with high numbers (what are those providers and clinics doing that others could learn from and replicate?)

Health Ministries Network

Information provided by Amelia Vader, Executive Director

General Information: The Health Ministries Network (HMN) is a non-profit organization based in Bellingham but serving four northwest Washington counties. Nurses who are members of faith communities serve as health resources for their congregations, as well as other community members who seek assistance. "Health Ministers," who are not necessarily health professionals, also provide support to congregation members. Nurses and Health Ministers are volunteers, and trained by the Westberg Institute which is certified by the American Nurses Association to train in the faith community nurse model.

In 2018, a permanent executive director was hired after several years of transition, and HMN's programs and services – including advance care planning – are re-vitalized and expanding. HMN became a formal partner with Honoring Choices PNW in March 2019.

Current service delivery practices	Barriers or challenges	Opportunities
Individual nurses and health ministers provide ACP education and assistance as part of their activities within their congregations. Lenten series resources are offered for Christian churches to facilitate end-of-life discussion during the Lenten season. https://www.healthministriesnetwork.net/lent In December of 2018, 15 active nurses and health ministers participated in a "Your Voice Your Choice" ACP workshop provided by PeaceHealth. In addition to learning more about ACP, many participants completed their own advance directives. In early 2019, 13 active nurses and ministers received a full 2-day training from Honoring Choices PNW to become workshop facilitators themselves.	Faith community nurses and health ministers provide their services at no cost to clients. Thus, they are in high demand, have many responsibilities within their congregation, and serve many people. Facilitating ACP is only one of the many activities that comprise their holistic approach to health. Faith community nurses in other areas of the country are compensated for their time; however, here that is not the norm.	Share experience of ACP work with Whatcom Community Health Worker Network. The intensive ACP training nurses and ministers recently received increased their knowledge, skills and comfort, which will likely translate into improved and/or expanded ACP work.
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities to improve or expand**
Faith community nurses and health ministers do not currently use a standardized intake or assessment form. Some use the FICA [***F**aith and belief; **I**mportance, **C**ommunity; **A**ddress in Care*] Spiritual Assessment Tool, but it does not address ACP.	Lake of an assessment tool or documentation system that is used by all faith community nurses and ministers.	

Health Ministries Network		
Current Data	**Barriers or Challenges**	**Opportunities**
In January 2019 HMN launched new on-line reporting for nurses and ministers, so the data collected is more standardized than in the past. The new system includes a dedicated section for documenting ACP activity. Data points collected are: • Number of hours for ACP conversations and sessions (group and individual) • Individual ACP: Number of people served with ACP • Group ACP: total number of sessions and total number of participants. These data align with data that Honoring Choices PNW has started collecting from partner organizations.	Reporting is ultimately voluntary. The new on-line system may interfere with consistent reporting until people get accustomed to it.	New ability to more accurately quantify ACP services, and begin to see trends over time. Possible to aggregate HMN data with those from PeaceHealth and WAHA, who are also HCPNW partner organizations.

Lummi Tribal Health Center

Information provided by Chris Hawk, MD

General Information: The Lummi Tribal Health Center (LTHC) provides medical, dental, mental health and preventive healthcare to members of the Lummi Nation and other American Indians and Alaska Natives.

Current service delivery practices	Barriers or challenges	Opportunities to Improve or Expand
The LTHC has been involved with palliative care and end-of-life planning efforts in a variety of ways. In 2018 a workgroup was formed and began developing a Lummi-specific advance directive document, including elements of the Lummi language and culture, and using images in addition to text. This document has not been finalized.	Staff turnover, other health issues are higher priority; historical trauma adds additional complexity around decisions for serious illness and end-of-life care.	This workgroup could possibly be reconvened in the future. A social worker recently joined the clinic staff, which may yield some valuable learning about the role social workers can play with ACP.
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities**
The LTHC uses an electronic medical record which contains a Yes/No field regarding completed advance directives. Advance directives can also be uploaded into patients' records. Tracking documents used for home visits also have ACP areas, and are used consistently, though by fewer providers.		
Current Data	**Barriers or Challenges**	**Opportunities**
To date data regarding AD's have never been extracted from the electronic medical record, and it's unclear if the functionality to do so exists. Some chart review was recently done looking at qualitative aspects of ACP.		

Nooksack Indian Tribe Health Center

Information provided by Sara Sheaffer, DO

General Information: The Nooksack Indian Tribe Health Center provides ambulatory healthcare to members of the Nooksack Indian Tribe and the Tribal Member community. In addition to medical care, other services include dental care, community health/nursing, mental health counseling, chemical dependency counseling, and community health prevention and education.

Advance Care Planning at the Nooksack Medical Clinic

Current service delivery practices	Barriers or challenges	Opportunities to Improve or Expand
The health center works closely with Becky Bendixen, Tribal Outreach Coordinator at the NW Regional Council, to provide ACP services to patients. Several educational opportunities are offered each year, and individual patients may be referred to Becky.		
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities**
Currently there are no prompts regarding ADs in the health center's electronic medical record.		
Current Data	**Barriers or Challenges**	**Opportunities**
Currently no data regarding ACP or ADs are collected.		

Northwest Regional Council

Information provided by Kate Massey, Family Caregiver Support Program and Elizabeth Anderson, Health and Human Services Planner

General Information: The Northwest Regional Council (NWRC) is an association of county governments serving a four-county region (Island, San Juan, Skagit counties in addition to Whatcom County). The NWRC is a regional governmental agency and the board of directors is composed of two elected officials from each of the four counties.

The NWRC also serves as the Area Agency on Aging (AAA) for Northwest Washington, implementing state and federal programs for older adults and people who need supportive services commonly referred to as community-based care. For example, NWRC offers or funds Senior Information & Assistance, Congregate Meals, Meals on Wheels, Respite Care, Adult Day Services, Case Management and Family Caregiver Support. The goal of community-based care programs and services is to help older adults and adults with disabilities live in their homes and communities for as long as possible, postponing or eliminating the need for residential or institutional care (such as nursing homes.)

NWRC leaders were involved in developing the NW Life Passages Blueprint for Creating a Community of Care and Support for People with Serious Illness and the NWRC is a member of the Northwest Life Passages Coalition. The NWRC's Area Plan for 2016-2019 includes advance care planning in alignment with the Blueprint.

As of July 2019, the NWRC will be coordinating Whatcom County's community-based ACP work and convening the NW Life Passages Coalition due to the closure of the Whatcom Alliance for Health Advancement.

Current service delivery practices	Barriers or challenges	Opportunities
Aging and Disability Resources or ADR (information and referral services for older adults and people with disabilities) can provide callers with a list of attorneys who can assist with ACP. Three staff members (one in Family Caregiver Support, one in Tribal Outreach and Assistance, and one in Title 19 Case Management Unit are trained ACP facilitators. In addition to providing services to clients, they have endeavored to educate co-workers about the importance and process of ACP. Case Managers (the bulk of NWRC staff) have ACP training and have a working knowledge of the value of it and ways to assist. Asking clients about their AD is not mandatory (unlike voter registration or some immunizations) so engaging in ACP conversations depends on the individual staff member, the needs and interest of the client, the time available, and other factors.	There is a lack of funding for ACP education and support – a potential barrier for any agency/organization doing this work.	Expand referrals to community-based ACP services, in addition to attorneys (especially important with NWRC's need to be cautious about "advising" clients). Leverage referral relationships with attorneys to promote and implement ACP training for the legal community. Add the requirement that Case Managers ask all clients about ADs (recognizing that such a change would need to be made at the state level; since this is a DSHS program, questions and procedures are required to be standardized across the state). (i.e., an in-house requirement). Consider offering the AD from Honoring Choices Pacific Northwest as another option for a more thorough ACP process. Consider integrating ACP into already-established client groups such as caregiver support groups (as has been done in the past).

Northwest Regional Council		
NWRC staff generally guide clients to the Washington State Medical Association AD form. In general, staff are very cautious with providing services that could be interpreted as advising people on how to complete their AD. NWRC promotes using the Shared Care Plan document, which indicates if the client has an AD, and where it is stored. Information about ACP resources is often included in NWRC's outreach at senior centers, faith communities, employer-sponsored health fairs and other community locations.		To the extent possible, the experience and learning WAHA gained from its community-based ACP work will be transferred to the NW Regional Council.
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities to improve or expand**
NWRC is a Washington Health Homes (HH) agency, and it is mandatory for HH Care Coordinators to ask each client if they have completed an AD, and if they would like assistance with any aspect thereof. Care coordinators offer supports through NWRC including conversations with the client, facilitating conversations with healthcare providers and/or family, provision of simple documents, and arranging for witnesses and a notary—in the NWRC office or community locations (including the client's home).		Consider requiring other direct-service programs to ask clients about ADs and offer supportive services (i.e., expand Health Home practice to other programs).
Current Data	**Barriers or Challenges**	**Opportunities**
Some data are tracked by the NWRC database, such as when ACP information is presented as part of community education or outreach. However, it is unclear exactly what data are tracked or how it might be accessed.		Join partners who are determining ACP measures for Whatcom County to 1) assess the capacity of the NWRC database to track these measures, and 2) contribute to deciding what measures and data collection and reporting processes are feasible.

PeaceHealth, Whatcom County

Information provided by Hilary Walker, Advance Care Planning Coordinator

General Information: PeaceHealth in Whatcom County includes the county's only hospital PeaceHealth St Joseph Medical Center, out-patient primary and specialty care practices at PeaceHealth Medical Group, and Whatcom Hospice.

PeaceHealth provided financial support for early ACP efforts led by the Whatcom Alliance for Health Advancement starting in 2012, and individual PeaceHealth providers and staff have long been involved with ACP work, including participating in the development of the NW Life Passages Blueprint for Creating a Community of Care and Support for People with Serious Illness in 2014. However, establishing the position of a full time ACP Coordinator in December 2017 marked the beginning of PeaceHealth's intensified local efforts to expand and improve ACP for PeaceHealth and the community at large. The progress made by the ACP Coordinator in Whatcom County has spurred PeaceHealth to pursue hiring ACP Coordinators in its other networks (two in Southwest Washington ACP and one in Oregon) to lead improvements such as standardizing workflows, coordinating provider education and resources, and conducting group classes. Along with an increased investment in ACP activities, PeaceHealth also began offering out-patient palliative care services in 2018, demonstrating commitment to a range services for serious illness and end-of-life care.

Current service delivery practices	Barriers or challenges	Opportunities
Starting in late 2017, PeaceHealth has done much work in several key areas: 1) Clarifying and standardizing PeaceHealth's filing, storage and retrieval of advance directives in its electronic medical record. 2) Training for PeaceHealth providers around advance directives, POLST, and ACP, including a campaign urging providers/caregivers to complete their own advance directives, and working with PHMG cardiology, other and other clinics to embed ACP into their workflow. 3) Community presentations and education. Between April 2017 and December 2018 an estimated 100 people participated in educational presentations. 4) Facilitation of free individual ACP sessions by provider referral for patients at PeaceHealth Family Medicine and Center for Senior Health, and for chronic care management patients at Internal Medicine. From April 2017 to December 2018, 111 people participated in individual sessions. 5) Group ACP sessions open to all community members. Group sessions guide participants through an advance directive and provide notary services on-site. From April 2017 to December 2018, 63 people participated in group sessions.	The size and complexity of the PeaceHealth system can make it challenging to change practices at the local level.	In September 2018, PeaceHealth starting keeping specific counts of participants in community education sessions, which will increase accuracy going forward.

PeaceHealth, Whatcom County

Current Hardwiring (systematic initiation of ACP conversations)	Barriers or Challenges	Opportunities to improve or expand
Working with the education team to train all front desk staff in asking about ACP documents and additional of an ACP fact sheet in all Medicare adult well visit packets. In 2018, training on billing for ACP began for all Whatcom clinics, both specialty and primary care and hospitalists at St Joseph Medical Center. As of June 2019, there is a "hard stop" requiring caregivers to ask about ACP and provide educational materials for all patients admitted to hospitals throughout the PeaceHealth system.		There are plans to share ACP billing expertise by expanding training to the family Care Network and community health center providers in 2020. PeaceHealth will start using EPIC's ACP module in Spring 2020 which will add capacities such as ease of finding specific ACP documents, all ACP notes in one common location, documents able to be viewed and edited in My Peacehealth (patient portal). PeaceHealth just started pulling these data on a regular quarterly basis in 2018, so the focus on these data is increasing.
Current Data	**Barriers or Challenges**	**Opportunities**
PeaceHealth tracks the number of patients 18 years and older seen in BOTH hospital and PHMG/outpatient clinics in the previous 3 months who had an advance directive on file (includes advance directive and POLST) For the last four months of 2018, 24% of patients seen (an average of 7,448 patients per month) had at least one of these documents on file. Earlier months of 2018 showed 21-22% of patients with one of these documents on file, indicating a slight increasing trend over the year. In 2018, PeaceHealth also starting conducting an on-line survey for participants of its facilitated group ACP sessions (see Appendix 5).	While PeaceHealth serves as the community's AD repository, it has been challenging to extract data to quantify the number of *Whatcom County residents* that have an advance directive on file there in order to establish a community-level AD completion rate.	PeaceHealth just started pulling these data on a regular quarterly basis in 2018, so the focus on these data is increasing. EPIC (PeaceHealth's electronic medical record) serves as the repository for all community members' advance directives. For those who are not PeaceHealth patients, a record is created so advance directives can be uploaded and stored. This provides a highly centralized community storage and retrieval system for advance directives and holds the potential to measure the AD completion rate at a community level.

Sea Mar Community Health Center, Whatcom County

Information provided by Dr Ione Adams, Medical Director and Aaron Ignac, Clinic Manager

General Information: Sea Mar Community Health Center is part of a large network of federally qualified health centers in Western Washington. Sea Mar provides medical, dental and behavioral healthcare, as well as an array of preventive, community outreach and social service programs. In Whatcom County, medical clinics are located in Bellingham and Everson.

Sea Mar Whatcom has 11 Providers and 11,900 patients. The patient population is extremely diverse, with many different languages and cultures. As at all federally qualified health centers, many patients – though certainly not all – are lower income and experience multiple barriers to healthcare and other needs. This adds complexity to providing healthcare, including ACP services.

Current service delivery practices	Barriers or challenges	Opportunities
Currently conversations about ACP are inconsistent, and depend primarily on the individual provider, the health status of the patient, and other variables. Currently none of Sea Mar's staff or providers have been trained to be ACP facilitators.	▪ ACP is not a high priority, partly because older adults are a relatively small portion of Sea Mar's patient population. ▪ Lack of time/staff capacity. ▪ Confusion regarding POLST vs. advance directives. ▪ Availability of AD documents in languages other than English. ▪ ACP is not a "pay-for-performance" service. ▪ Lack of knowledge about when and how to bill Medicare for ACP services. ▪ Language and cultural barriers. Sea Mar has multiple providers who are bilingual English-Spanish, but patients also speak Russian, Punjabi, Mayan dialects, and other languages. In addition, "it's not just the words" – cultural beliefs and practices around death and dying may be different. Providers don't know what those differences are, or how to approach the conversation sensitively.	Provide training at annual Sea Mar provider meeting (providers from all clinics in Western WA) with a focus on cross-cultural considerations. Train non-medical staff in ACP facilitation to create in-house services that require less time from medical providers (though staff capacity remains an issue).
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities to improve or expand**
The patient information form doesn't include a question about advance directives. For patients with Medicare managed care plans, ACP is included in the standard annual exam and	Any significant changes require system-wide implementation (it's difficult to make changes just for Whatcom clinics).	

Sea Mar Community Health Center, Whatcom County		
can be billed for. It's unclear if or how regularly Sea Mar bills Medicare for ACP services.		
Current Data	**Barriers or Challenges**	**Opportunities**
Sea Mar uses AllScripts EMR software. There are multiple places within the EMR that providers can note ACP conversations, so different provides make those notes in different places. Because there is not a designated field, it's not possible to generate accurate data on the volume or frequency of ACP conversations. Advance directives and POLSTs can be scanned and uploaded to a specific place in the EMR, so the number of patients with document(s) on file could be available. No data was available at the time of assessment due to upcoming change in EMR.		In Fall 2019, the entire system of Sea Mar clinics will be changing to EPIC (the electronic medical record used by PeaceHealth St Joseph Medical Center). This change may open up several possible opportunities related to ACP: ▪ Sea Mar providers may be able to view advance directives on file at PeaceHealth. ▪ EPIC has an ACP module that could be added/implemented for use at Sea Mar. ▪ Work toward alignment between Sea Mar and PeaceHealth around ACP practices, data collection, and reporting (potential to aggregate data?).

Unity Care Northwest

Information provided by Jenn Trujillo de Good, Clinical Data and Informatics Manager

General Information: Unity Care Northwest (UCNW) is a Whatcom County non-profit healthcare organization. As a Federally Qualified Health Center, UCNW is committed to providing services regardless of patients' insurance status or ability to pay and many patients – though certainly not all – are lower income. UCNW has clinics in Bellingham and Ferndale that offer primary medical, dental, and behavioral healthcare for children and adults. The Bellingham clinic also has a pharmacy and on-site lab services.

UCNW has 15 medical providers and sees about 11,900 patients a year (9,500 in Bellingham and 2,400 in Ferndale). As at all Federally Qualified Health Centers, UCNW patients often experience barriers to healthcare and have other needs such as housing, transportation, or food. This adds complexity to providing healthcare, including ACP services.

Current service delivery practices	Barriers or challenges	Opportunities
Currently initiating conversations about ACP at UCNW are not part of standardized clinic processes, and depends on the individual provider, the health status and interest of the patient, the time available, and other factors. UCNW does not provide Medicare Wellness visits at this time. The patient health history or patient screening form does not include a question about ADs, and no providers or staff members have received training in ACP facilitation.	Limited time in appointments, and multiple and/or complex needs of patients. Providers are uncertain about how to approach conversations about ACP. Lack of available programs and services to which to refer patients for assistance with completing ADs, coupled with the view that it's preferable to not raise issues with patients if resources or referrals can't be offered.	Provider and/or staff training in initiating and engaging in ACP conversations with patients. Increased communication and connection with local ACP efforts to increase awareness of ACP issues and resources. "Passive" ACP promotion such as brochures in waiting areas and exam rooms, or slides on electronic screens in waiting rooms.

Current Hardwiring (systematic initiation of ACP conversations)	Barriers or Challenges	Opportunities to improve or expand
The UCNW electronic medical record includes a Community Resource Guide that can generate information about and referrals to community programs and services. In 2018 WAHA was added to this Guide to assist with referrals for ACP services. The visit summary given to patients at the end of their appointment can also include information and referral generated from the Community Resource Guide.		UCNW is considering revisions to some of its patient screening forms, and a question about ADs could be added. UCNW's electronic medical record is very adaptable, so it's fairly easy and quick for staff to add or change fields and content.

Current Data	Barriers or Challenges	Opportunities
Currently no data regarding ACP or ADs are collected.		

Whatcom Alliance for Health Advancement

Information provided by Australia Hernández Cosby, Programs Manager

As of June 30, 2019, the Whatcom Alliance for Health Advancement is permanently closed due to funding limitations. The information below on current practices, hardwiring and data was gathered prior to the announcement of the closure.

General Information: The Whatcom Alliance for Health Advancement (WAHA) is a community-based non-profit organization in Whatcom County with the mission of connecting community members to care and improving the local healthcare system. WAHA's direct client services include providing free, unbiased, and confidential information to help people get, keep and use healthcare coverage, assistance with navigating the healthcare and social service systems, and advance care planning. WAHA's work with the local healthcare system drives toward improving healthcare quality and patient satisfaction while reducing cost.

As one of its healthcare system improvement initiatives, WAHA launched an advance care planning program in 2012 focused on activating the community in planning for end of life. This involved training community members in ACP facilitation, conducting community education, and working with healthcare providers. In 2014, WAHA convened the community task force that wrote Blueprint for Creating a Community of Care and Support for People with Serious Illness in, and has convened the Northwest Life Passages Coalition since then.

Current service delivery practices	Barriers or challenges	Opportunities
WAHA coordinates a cadre of ACP volunteers who provide facilitated group and individual ACP sessions as well as community education. Between 2012 and June 2018, 2,144 people attended a WAHA community presentation or educational session. Between 2012 and 2018 WAHA trained 118 ACP facilitators, an average 16-17 per year. In addition, 305 people were trained in an "ambassador" role to do presentations, outreach, and referral to ACP services (but not facilitate ACP sessions). All WAHA direct service staff are trained ACP facilitators. Between 2012 and June 2018 WAHA staff and volunteers served1,335 clients with facilitated ACP sessions. The average rate for completing an AD was 27%. Interestingly, some years the rate was as high as 44%, while other years it was as low as 16%. This variability is attributed to different levels of outreach, education and services in response to funding fluctuations.	WAHA closure will leave a significant gap in ACP programs and services.	The NW Regional Council is assuming coordination of community-based ACP work in Whatcom County; to the extent possible, WAHA's experience and learning will be transferred to NWRC staff.

Whatcom Alliance for Health Advancement

Current Hardwiring (systematic initiation of ACP conversations)	Barriers or Challenges	Opportunities to improve or expand
WAHA's general client intake form includes a question about advance directives, and responses are recorded in the client database. Educational and promotional materials regarding ACP are provided in English, Spanish, and Punjabi. WAHA has a Business Associate agreement with Family Care Network allowing direct ACP referrals from FCN's EMR to WAHA's printer. For some years, WAHA contacted referred patients to schedule an ACP session. However, in 2018 there was only one direct referral from Family Care Network, and due to limited staff capacity, working closely with FCN on increasing referrals was not prioritized.		
Current Data	**Barriers or Challenges**	**Opportunities**
WAHA's data collection has varied over the years depending on the staffing level for ACP work. Evaluation survey responses from 106 participants of educational presentations in 2018 provide information about reasons for participation, advance directive status, barriers to completing ADs, and ACP activation. See Appendix 4 for this survey tool. Overall, however, survey administration and analysis has been inconsistent due to lack of capacity. In early 2019, WAHA became a partner with Honoring Choices Pacific NW, and began collecting data to report to HCPNW. As a part of this, WAHA also started using HCPNW's evaluation form for group sessions.	Lack of program staff and administrative support has been a significant barrier to consistent data collection, analysis, and sharing.	

Whatcom County Emergency Management Services

Information provided by Mike Hilley, EMS Manager

General Information: The Whatcom County Emergency Management Services (EMS) and Trauma Care Council works to reduce morbidity and mortality associated with trauma and acute illness in Whatcom County. The Council is comprised of ambulance and aid services, hospital and pre-hospital medical providers, consumers, law enforcement and government agencies involved in the delivery of trauma care and emergency medical services. EMS Administration, a department within the Whatcom County Government, is responsible for the high level administrative functions needed to ensure integrated and uniform county-wide emergency services.

EMS is a key partner of Whatcom County's Ground-Level Response and Coordinated Engagement (GRACE) Project. GRACE is a community-based effort to serve individuals who are using crisis services and law enforcement in frequent, yet ineffective ways, and provide intensive, coordinated services to these "familiar faces." GRACE seeks to improve inter-agency communication, care management and supportive services to improve the health and wellness of these vulnerable community members.

There are fourteen fire districts in Whatcom County, with about 600 Emergency Medical Technicians (EMTs). In addition, Bellingham Fire District has 35-38 paramedics who provide more critical care, and the Ferndale Fire District has 10-12 paramedics.

Current service delivery practices	Barriers or challenges	Opportunities
POLST Forms EMTs can act according to a POLST, since it is a physician's order. They cannot act on an advance directive. EMTs will generally ask immediately about a POLST (commonly referred to by EMTs as a "do not resuscitate" or DNR) in two situations: 1) Calls when people are dying/very seriously ill/close to death. 2) Calls to SNF or ALF. In these cases, a POLST is usually in patients' chart for that facility; the dispatcher may be able to provide the patient's DNR status to the EMTs during transport. If it's not a critical/close to death situation, e.g., a fall, EMTs don't routinely ask about POLST or ADs.	**POLST Forms** If a patient has documented DNR status, EMTs "know what to do." If not, and other parts of the POLST are filled out, there tends to be confusion about how to proceed. It's unclear what training local EMTs received when the POLST was first introduced, but it's probable there was little or none. There are also DNR orders that AREN'T POLST forms, left over from pre-POLST days but still valid, on which DNR is a simple "Yes/No." These are more straightforward to interpret.	**Training** Paramedics tend to be models/teachers for EMTs, so focusing on training paramedics could also impact EMTs' knowledge and practices. Possible ways to expand training: ▪ Create a POLST/AD module to embed into the new Bellingham Technical College paramedic program (web-based, in person, or a combination). ▪ Include ACP in monthly continuing education sessions for paramedics. ▪ Train the GRACE Project team in advance care planning. ▪ For EMTs, make better use of existing module(s) on POLST/AD used in EMT/Basic Life Support training.
Training Paramedic training is 2,500 hours, most often resulting in an associate degree. Bellingham Technical College recently started a paramedic/Associate of Applied Science program; the first cohort of students will finish in Fall 2019.	In WA State paramedics are certified, not licensed. This makes them ineligible to bill for services other than transporting patients to the ED – one of several factors that incentivize transporting patients.	The BTC paramedic program is envisioned to be a regional training center, serving other north sound counties in addition to Whatcom. Having this program at a local institution offers excellent opportunities for partnerships related to advance care planning.

Whatcom County Emergency Management Services		
EMT training is 120-140 hours and is conducted by Senior EMT Instructors and Basic Life Support Evaluators authorized by WA state. Ongoing training consists of six online modules plus on-site in-person sessions.		Whatcom County will be switching to a new EMT training platform that will better meet local needs, probably in early 2020.
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities to improve or expand**
EMS recently began using the patient record system Image Trend, which for the first time allows personnel to look up and enter patient information on a tablet while in the field. The Bellingham Fire District started using Image Trend in early 2018; county districts began in early 2019. GRACE Project team members all use Image Trend for their care coordination. However, GRACE will be moving to a different care coordination product that will integrate with Image Trend Currently Image Trend doesn't include any questions or designated fields as to whether the patient has a POLST. This could be added as an optional item, or with a "validation rule" which would make it a required field. It may be possible to apply a validation rule only to patients over a certain age. Image Trend also allows photos and documents to be uploaded into the patient record.	Validation rules in effect increase the acuity of an item, and not everything can be high acuity. EMS tries to use validation rules very judiciously.	The ability to access Image Trend in the field greatly increases the ease and speed of entering and retrieving patient data, which could greatly enhance interactions around POLST/ADs. Possible ways to embed POLST into Image Trend: ▪ Add an assessment question as an optional or required field (even an optional field would make it more visible to EMTs, possibly prompting them to ask more consistently). ▪ Upload a photo of a POLST. Routinely adding POLSTs would increase EMTs' access to these documents, as well as reinforce their importance to patients. Image Trend interfaces with the care coordination software used by Pathways Hub of the North Sound Accountable Communities of Health. This may present an opportunity to bring ACP into the Pathways care coordination system. Efforts are underway to develop an interface between Image Trend and EPIC (the electronic medical record used by PeaceHealth St Joseph Medical Center). If this were accomplished, theoretically advance directives on file at PeaceHealth would be visible to EMTs.
Current Data	**Barriers or Challenges**	**Opportunities**
Currently, EMS doesn't routinely track data regarding POLSTs, ADs, or ACP. While it's possible search the narrative portion of the record by keyword, the absence of a designated field makes it difficult to accurately determine the number or percentage of patients that have a POLST.		

Western Washington University Student Health Center

Information provided by Renée Wilgress, ARNP

General Information: The Western Washington University (WWU) Student Health Center is a primary care medical clinic serving WWU students. The health center provides preventive healthcare and management of health concerns, illnesses and injuries with the goal of supporting student success academically, physically and emotionally. There are nine regular providers who deliver care to about 10,000 patients per year. The majority of patients are age seventeen to early thirties, with a few in their mid-thirties or older.

Current service delivery practices	Barriers or challenges	Opportunities to Improve or Expand
Providers at the WWU Student Health Center currently do not have routine ACP conversations with patients, except for perhaps in occasional, unusual circumstances. The health center does not offer general physicals or well-adult visits, and these would be the type of services into which ACP templates and protocols would be embedded. Given the young patient population, in the case of major accidents or serious illnesses providers would initiate full treatment. Further medical decisions would be made by the patient's parent(s).		
Current Hardwiring (systematic initiation of ACP conversations)	**Barriers or Challenges**	**Opportunities**
Currently the health center systems do not include mechanisms that directs providers to ask about, discuss, or document ACP conversations or advance directives.		
Current Data	**Barriers or Challenges**	**Opportunities**
Currently no data regarding ACP or ADs are collected.		

Appendix 7 – Possible ACP Measures and Activity Definitions

Measures of ACP Activity to Consider for Community-Wide Use in Whatcom County

Community Education			
Current Data	**Basic Measures**	**Additional Measures**	**Ideal Measures**
Inconsistent/variable[6]	*Number of presentations *Number of attendees/ participants Clear differentiation between community education, provider education, and group ACP facilitation.	ADD: • Date • Location/audience • Number of Hours • Topic/activity (presentation, panel discussion, movie, performing arts…) • Presenter/organizer	ADD: Survey results from participants

ACP Facilitation			
Current Data	**Basic Measures**	**Additional Measures**	**Ideal Measures**
Inconsistent/variable	*Number of group ACP sessions *Number of attendees/ participants *Number of individual ACP sessions	ADD: *Number of participants with healthcare advocate present *Number of ADs submitted by participants (participants' AD completion rate) Number of trained and active facilitators	ADD: Survey results from participants, including self-report of AD completion.

Completed Advance Directives			
Current Data	**Basic Measures**	**Additional Measures**	**Ideal Measures**
Inconsistent/variable	PeaceHealth and Family Care Network continue to measure completion rates in their patient population, **using the same criteria** (same age range, time frame in which clinic visit occurred, definition of what constitutes an AD, etc.).	ADD: Additional healthcare and social service organizations adopt same measure.	**AD completion rate for Whatcom County**, based on ADs stored in PeaceHealth's electronic medical record. I.e. For a specific age range, numerator = number of records with AD on file and denominator = number of Whatcom County residents.

*Measures established by Honoring Choices PNW in 2018 for partner organizations.

Healthcare/social service integration ("hardwiring")

Current data are subjective, due to lack of definition of what constitutes a "hardwiring" element.

One option would be to define hardwiring elements and measure the number in each organization, tracking over time. If data were shared among organizations, a sense of competition could result that could be helpful – or potentially harmful to collaboration.

[6] Some **individual organizations** have consistent internal data; however**, as a community** ACP data collection is inconsistent.

ACP Activity Definitions Established by Honoring Choices Pacific Northwest To Consider for Community-Wide Use in Whatcom County

Activity	Definition/Description
ACP Conversation	Include "meaningful ACP conversations" with a certified facilitator that typically encompass: ensure understanding of ACP, explore experiences, values, and goals, identify a healthcare agent, discuss the severe permanent brain injury scenario, and assist with communicating goals and preferences.
Individual Participants	Include anyone who directly participated. For example, if the conversation was with a couple and both participated in discussing their personal wishes, they should count as two conversations (both of which had a healthcare agent present). If the conversation was with a couple but focused on one person with the other as healthcare agent, it should count as one conversation (with healthcare agent present). Repeat participants should be counted for each conversation they participate in.
Group Participants	For group conversations, count all participants. Be sure to use the HCPNW sign-in sheet to ensure proper tracking of the number of people who had a healthcare agent present. If two people come together as either other's agents they will count as two participants, and two participants who had a healthcare agent present. Repeat participants should be counted for each conversation they participate in.
Advance Directives	Include any format of advance directive returned as a result of an individual or group ACP conversation (e.g. Honoring Choices PNW advance directive, Five Wishes). Enter the estimated date when the advance directive was stored in the EMR.
Educational Presentation	Educational presentations on ACP are informational for any audience, and do not include elements of a group conversation such as explore experience, values, and goals, discuss the severe permanent brain injury scenario, and assist with communicating goals and preferences.

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An executive summary of this report, as well as a version without appendices, are also available.

For more information, please contact:
Melody Woodrich-Fernando, NW Regional Council Community Programs Director, at woodrmm@dshs.wa.gov
Marie Eaton, NW Life Passages Coalition Chair, Palliative Care Institute Community Champion, at eaton@wwu.edu