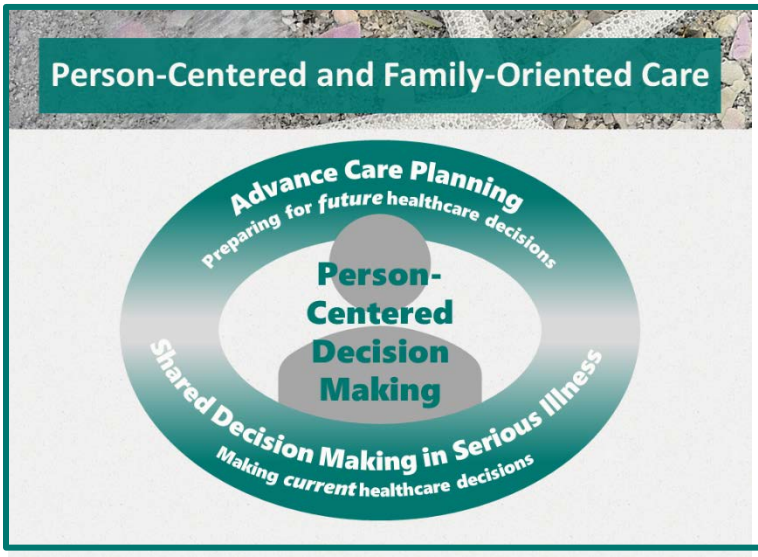
Respecting Choices®
PERSON-CENTERED CARE

A System for Person-Centered Decision Making that Transforms Healthcare

The goal of Respecting Choices (RC) is to support organizations and communities keep a promise to those they serve—a promise to know and honor individuals' preferences and decisions. Person-centered care has been defined as "care…ensuring that patient values guide all clinical decisions."[1]

We believe the most important attribute of person-centered care is **person-centered decision making**—the active engagement and support of individuals on their journey through the decision-making process, ensuring that their goals, values, and beliefs guide all clinical decisions.

Respecting Choices has two programs that work together to embed person-centered decision making as a standard: **Advance Care Planning (ACP)** and **Shared Decision Making in Serious Illness (SDMSI).**



Advance care planning (ACP) promotes conversations designed to ***prepare individuals and their families for future healthcare decisions.***

Shared decision making in serious illness (SDMSI) focuses on the interaction between individuals and their physicians – to assist patients with serious illness ***make current healthcare decisions***.

The Synergies of ACP + SDMSI

Each of our programs is designed to integrate with the other, creating an interprofessional approach that supports individuals through their decision-making process by using consistent language, strategies, and processes across sites of care and over time.

Each program addresses key elements beyond education, focusing on systems to support the process, such as documentation systems, metrics, leadership engagement, and sustainability plans.

Implementation of the RC program provides patients with an informed, timely, and specific decision-making process, resulting in improved outcomes.

Evidence-Based Outcomes

Improved outcomes demonstrated when using the RC model are multifaceted. This evidence-based program has been successfully implemented in various settings, from small critical access hospitals to complex multi-region integrated health systems and from local faith-based organizations to state-wide partnerships. Demonstrated outcomes include the following:

- Individualized, person-centered planning discussions facilitated in a consistent and standardized manner across all care settings[2,3,8]
- Provision of care and treatment that is consistent with patient goals and values[3,4,6]
- ACP plans that are clear and available to healthcare providers[4-6]

- Specific and easy-to-understand plans integrated into medical decision making[4-6]
- High patient and family satisfaction with ACP conversations[9-14]
- High satisfaction with hospital care in general[7,9]
- Decreased decisional conflict[9]
- Increased surrogate understanding of patient's goals of care[10]
- Increased congruence in patient and surrogate decisions[10-14]
- Positive impact on family members through reduced stress, anxiety, and depression in surviving relatives[9,15]
- Increased prevalence of planning in racially, ethnically, and culturally diverse communities[11-24,16-18]
- Increased hospice use at end of life[8,15]
- Increased hospital CPR success (alive at discharge), decreasing CPR prevalence with associated poor outcome[19]

Experiential Evidence

Respecting Choices has 20+ years of experience working with over 300 healthcare organizations and communities to implement this model of person-centered decision making. Experience across diverse populations and settings has led to these experiential conclusions:

- Clinician competency and comfort level with conversations improved by developing and enhancing communication and facilitation skills
- Patient goals of care clarified by exploring the concept of "living well" (i.e., experiences most important to give life meaning)
- Time spent by physician and healthcare team on crisis end-of-life decision making (e.g., family meetings, conflict resolution) shifted to time spent on early and effective planning conversations
- Patients' goals and decisions translated into written plans to guide clinical decision making
- Specific guidance in making clinical decisions provided as patients live with advanced illness
- Timely and appropriate referrals for other needed services (care coordination) promoted
- Moral distress of healthcare providers and clinicians working with patients and surrogates on end-of-life decision making decreased
- Delivery of a consistent patient and clinician experience standardized through a systems approach

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