Trends in Advance Care Planning:
Increasing Quality of Care Outcomes without Increasing Costs

Presented By:
L. Scott Brown, MyDirectives.com
Introduction
Who Needs Advance Care Planning?
A Story: Shirley Izena Tevebaugh
A Story:  Shirley Izena Tevebaugh
Who is this?
Who is this?
Advance Care Planning: 2008 Report to Congress

- Paper-based advance directives do not affect care.
- Paper-based advance directives are flawed.
- Preferences stated actually impede decision-making.
- Patients don’t get the care they want.

**Result:** Undue suffering and wasted resources.
Why Is Advance Care Planning Important?
Advance Directives: Some Statistics

• 18 – 36% have advance directives.

• 5% have their directives available when needed.

• 25% of doctors know their patients have directives on file.

• Most directives are of little or no value.

• $68 Billion Per Year
Advance Care Planning: Consumer and Patient Perspective

96%

81%
Advance Care Planning: Consumer and Patient Perspective

71%
Advance Care Planning: Consumer and Patient Perspective

0.7% to 2.0%
Advance Care Planning: The Baylor Scott & White Case Study

What if Doctors Don’t Know or Act on ACP/AD?

- 2/27/13: 88 yo AA female with advanced Alzheimer’s dementia admitted with severe TBI.
  - ICU. No MD note reflects any ACP/AD.
  - Pneumonia, delirium, intubation, restraints. 2 daughters fight over plan of care.
- 3/5/13: SPC consulted and finds:
  - Admission patient data (CPP) indicating patient has ACP/AD and contact info!!!
  - SPC obtains copy of living will: “I do not want life-sustaining treatment (including artificial delivery of food and water) if...comatose...vegetative...burdens of treatment outweigh benefits...I do not want any aggressive treatment plan that may only cause me to die in a hospital, prolong my suffering, etc.”
- 3/8/13: SPC negotiates withdrawal of vent, transfer to hospice
- BAD week (unwanted interventions, suffering, costs) before hospice—which could have been known in the ED!
- WE FAILED THIS PATIENT AND FAMILY!
- What if Eclipsys had automatically made visible the fact of an ACP/AD on admission and every time the EMR is opened? What if a doctor had to fill in something for ACP/AD on every admission order set or admission H&P or consult?
Advance Care Planning: The Baylor Scott & White Case Study

So what if there is no ACP?
A Tale of Two Deaths

- 95 yo dementia, sees MD 2 x yr.
- Nausea/emesis - EMS to ED.
- Cardiac arrest in transport. CPR initiated.
- Patient on vent in ICU x 4 days. Family angry! PC Consult.
- WLST on day 5
- Bad Death
  - Patient/family trauma
  - Staff moral distress
  - Hospital mortality
  - Medicare costs for non-beneficial treatment
- WE FAILED PATIENT AND FAMILY!
- What if Centricity had prompted the doctor to engage in ACP?

- 92 yo dementia, sees MD 2 x yr.
- Fractured pelvis - EMS to ED.
  - 10 years earlier, patient/family/doctor did advance care planning and created Living Will and OOH-DNR.
- Directives given to EMT & ED
- Cardiac/respiratory distress in ED. Comfort meds. DNAR.
- Good death
  - Little suffering
  - Staff relieved.
  - No hospital mortality!
  - Low cost to Medicare.
  - Family at peace and thanking physicians for good death!
- Should we reward the doctor who engages in ACP? Why or why not?
High-Quality Advance Care Planning: The Benefits to Patients

• Ventilator – Seven times less likely.

• Attempts at CPR – Eight times less likely.

• Less likely to die in a hospital.

• Nursing home residents.

• Personal values honored.
High-Quality Advance Care Planning: The Benefits to Healthcare Providers

• Lower costs of care.

• Reduced hospital bed-days.

• Improved symptoms and reduced caregiver distress.
What is the Future of Advance Care Planning?
Advance Care Planning: Current Trends – Meaningful Use

Improving quality of care and safety: Care planning

<table>
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<tr>
<th>Functionality Needed to Achieve Goals</th>
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<tr>
<td>• <strong>Core for EHs</strong>, introduce as <strong>Menu for EPs</strong></td>
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<td>• Record whether a patient 65 years old or older has an advance directive</td>
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<td>• Threshold: Medium</td>
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<td>• <strong>Certification Criteria</strong>: CEHRT has the functionality to store the document in the record and/or include more information about the document (e.g., link to document or instructions regarding where to find the document or where to find more information about it).</td>
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<tr>
<th>Focus Area</th>
<th>Type</th>
<th>Provider use effort</th>
<th>Standards Maturity</th>
<th>Development</th>
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<td>• CDS</td>
<td>Hospital</td>
<td>Low</td>
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Advance Care Planning: Current Trends – Heath IT Standards

Advance Directives

- Provider accesses the Advance Directive information from the HIE or AD repository. The document includes a link to the most current version of the patient-managed Advance Directive document. Link enables clinician to verify that directives on file (pulled from HIE/or repository) are current.
Advance Care Planning: Current Trends – Health IT Standards

Value Set Authority Center
US National Library of Medicine

 HL7

HIMSS
transforming health through IT™

LOINC®
Logical Observation Identifiers Names and Codes

IHE
Integrating the Healthcare Enterprise

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Advance Care Planning: Current Trends – Healthcare Providers

What’s your Plan B?

When we are sick, we normally do whatever it takes to get well. Let’s call that Plan A. But what if Plan A doesn’t work?

Would your loved ones or doctors know your Plan B?

Help your family* and help yourself** with a Living Will today!

A living will helps you tell others how you wish to be treated if in the future you are so sick that you can no longer communicate. Free resources to help you make a living will or other advance directive are available. Baylor provides information on issues associated with serious illness as well as the Texas Living Will and other advance care planning documents. These materials can be most helpful to persons who are more comfortable working with paper-based documents. Go to:

http://www.baylorhealth.com/mydecisions

For those who prefer an even more on-line based approach, go to:

www.MyDirectives.com

Here you will find an excellent on-line advance care planning tool allowing you to create a universal digital advance directive. Once you create your living will with this service, you may digitally sign it, have it witnessed, store it on-line and share it with your care providers via electronic means.

* Someday almost all of us will have a serious illness. 80% of persons with serious illness will lose the ability to communicate and make treatment preferences known at some point. Families who must make decisions for their loved one’s without the guidance of a living will describe facing these decisions as one of the most difficult burdens they have ever faced.

** Patients with serious illness and a living will experience less pain and other suffering, receive treatment more consistent with personal values, and experience lower costs of care at life’s end.

• Integration with Palliative Care Programs
• Presence on Home Page and Advance Care Planning Literature
• Roll-Out to Employees, Physicians and Patients
• Integration into Electronic Health Record and Patient Portal Platforms
• Joint Advocacy, Research and Grant Opportunities
Advance Care Planning: Current Trends – Accountable Care Organizations

• ACO Focus: Patient and family satisfaction with care.

• Re-think the definition of “outcomes.”

• MyDirectives®

• ACO adoption of advance care planning solutions.
Advance Care Planning: Current Trends – Health Information Exchanges

Maryland Statewide Advance Directives Registry
Now Available to Consumers and Health Care Professionals

MyDirectives
MyDirectives.com is a free, web-based service that helps consumers create, update, and share their personalized advance directive online.

What is an Advance Directive?
An advance directive allows you to decide what kinds of treatment you do or do not want, particularly in a medical emergency or near the end of your life; you can also appoint someone to make health care decisions for you should you be unable to do so yourself.

CRISP
The Chesapeake Regional Information System for our Patients (CRISP) is the State-Designated Health Information Exchange (HIE) for Maryland.

What is an HIE?
An HIE connects authorized health care practitioners and enables them to share patients’ electronic health information securely across different health care organizations.

If you are a Maryland Consumer
Regardless of your age or health status, having an advance directive will help give you confidence that your wishes will be respected.

If you are a Health Care Practitioner
MyDirectives enables timely access to patients’ advance directives online. You can now obtain advance directives online.

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Advance Care Planning: Current Trends – American Medical Association

The New York Times

Coverage for End-of-Life Talks Gaining Ground

Dr. Joseph Hinterberger discussed end-of-life care with Mary Ann Zebrowski. If reimbursed, "I’d do one of these a day," he said.

HEATHER AINSWORTH FOR THE NEW YORK TIMES

By PAM BELLUCK

AUGUST 30, 2014

DUNDEE, N.Y. – Five years after it exploded into a political conflagration over "death panels," the issue of paying doctors to talk to patients about end-of-life care is making a comeback, and such sessions may be covered for the 50 million Americans on Medicare as early as next year.
Advance Care Planning: Current Trends – Federal Legislation

- HR 1173 – Personalize Your Care Act of 2013
- SB 2240 – Medicare Choices Empowerment & Protection Act
- SB 1439 – Care Planning Act of 2013
Conclusion – Brave New World

- 75 million “Baby Boomers”
- $4.8 Trillion and $1 Trillion
- “The truth will set you free . . .”
- Extending lifespans, but . . .
Conclusion – Brave New World

• Everyone 18 and over has a high-quality advance directive.

• No more surprises for loved ones and healthcare providers.

• Messages for caregivers.

• 24/7 accessibility, worldwide.

• Triple Aim achieved.
Questions & Answers

Thank you!