

Assessing Progress in End-of-Life and Serious Illness Care

National Academy of Medicine

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Communication & Advance Care Planning

REPORT-OUT TEMPLATE

Overall takeaways (briefly characterize discussion overall—did anything surprise you? What did you find most encouraging?)

- Importance of moving upstream
- Access to information in all clinical settings
- Utilizing health information systems and ensuring interoperability
- Importance of inclusivity of all health care professionals and other professionals
- Importance of inclusive, interdisciplinary education for practicing physicians and those in graduate medical, nursing, social work, etc.

Chief barriers identified by both groups

- Accessibility
- Fragmentation of care
- Lack of quality metrics
- Accountability and responsibility for workflow
- Lack of education materials that meet the needs of vulnerable individuals (hearing impaired, visually impaired, incapacitated patients)

Most promising opportunities/solutions identified by both groups

- Create a national, advance directive registry and consider a national POLST paradigm registry (learn from other registries—organ donation, immunization, etc.)
- Move the conversation upstream to normalize earlier
- Leverage the new CPT codes for advance care planning as a carrot for professional training

Top 3-5 priority action items and actors identified by both groups

Top Priority Action Items		Actor(s)
1	Normalizing the conversation and moving it upstream with early introduction of these discussions	Clinical and community organizations—everyone!
2	Portability and interoperability	IT vendors, regional health information organizations, POLST paradigm coalitions
3	Accountability for the advance care planning workflow in all clinical settings	Administration, system, physician, and clinician leaders
4	Research and data-driven structure and process outcome	National quality organizations

	measures that are patient-centered and family-oriented	
5	Shared decision making that is well-informed and ensures patient, family, and caregivers understand health status, prognosis, values, beliefs, and goals for care	