

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

National Academy of Medicine

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Communication & Advance Care Planning

NOTES—BREAKOUT SESSION 1

Barriers		
<ul style="list-style-type: none"> • Mismatch of billing and coding • Incentive structure of CMS model (e.g. time, add-on for regular visit) • POLST model done state-by-state • Permissions associated with who can sign a POLST paradigm form • Portability and interoperability • Public misunderstanding and lack of awareness of advanced care planning • Discord between completing POLST and receiving care that has been documented • Implementation and operationalization of advanced care planning within heterogeneous systems • Measurability of outcomes and integration for improved quality control • Buy-in of staff from physicians to administrative, education, and training • Provider burnout • Transfer of information in advanced care planning • Physical/sensory ability to hear and see relevant information for decision making and engaging people where they are • Not having an advocate, which may or may not be the primary caregiver • Communication between primary care and specialists 		
Solutions/Opportunities		
<ul style="list-style-type: none"> • Information and data, including from the California Health Foundation, about paying for conversations • National registry of advanced directives • Web-based application to level the playing field versus EMR • Rules about transfer of end-of-care information being discussed on the Hill • Public awareness campaigns (to pressure systems and drive people-focused solutions) • Education of physicians, team-based care, and patients • “Allergy analogy” and registries such as vaccinations, organ donations • Training on palliative care through California Health Foundation • Synchronization across providers and inter-professional teams (e.g. physical therapists, translators, dieticians, interpreters, occupational therapists, social workers, caregiver, pharmacist, chaplain, nursing assistants) • Normalizing conversations about end-of-life care earlier on • My Gift of Grace game 		
Other		
<ul style="list-style-type: none"> • Interoperability and evidence of “goals of care” conversations • Carrot or stick approach 		
Top Priority Action Items (limit to 3-5)		Actor(s)
1	Normalizing the conversation, with early introduction of these discussions	Everybody!
2	Inclusivity beyond the nuclear team to therapists, family	Health systems, families, professional

	caregivers, etc.	societies, health care not-for profits, caregiver organizations, payers
3	Systems-level advance care planning	IT vendors, regional health information organizations, vendors, EMS, community
4	Sharing information and education for shared decision making?	IT
5	Research and data-driven outcomes	