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

National Academy of Medicine
May 23, 2016

Communication & Advance Care Planning

NOTES—BREAKOUT SESSION 2

<table>
<tr><td colspan="2">Barriers</td></tr>
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Physical/sensory ability of patients to speak for themselves and timeliness of the conversation
Reluctance to have discussion around advanced disease planning, end-of-life, palliative care earlier
Voicelessness, both physically and the ability to be a self-advocate
Physician comfort and self-awareness with initiating conversations
Workflow and documentation
Fragmentation of care
Lack of ownership
Compensation, both inpatient and outpatient
Language to explain, perhaps easier for an oncologist than an organ-based or frailty issue
Accessibility of communication and family members’ filtered interpretation of communication
Educational materials for advance care planning and interpreters
Mismatch of expectations for those with disabilities and those without disabilities
Changing values, beliefs, and goals throughout the spectrum of life
Who raises the conversation
Hierarchy within hospital systems
Right to treatment legislation
Ownership and clarity about whose responsibility
Workflow and accountability
Accountability for systems change
Fragmentation of CPR
Graduate medical education about end-of-life conversations
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<tr><td colspan="2">Solutions/Opportunities</td></tr>
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Gunderson Lutheran’s Respecting Choices Advance Care Planning training for physicians led to a 95% compliance rate in one case
CPT advance care planning codes include conversations not just with patient but also caregiver
Normalizing the conversation throughout the lifecycle
Strategies from other sectors such as organ donation sticker on driver’s license being relevant to advance directive
Health care proxy early (e.g. 18-25) with different milestones at different ages like what is done with immunizations
Evidence that the best systems start earlier
Community education and physician recommendation
Models of change that are not only physician-centric
Well-informed, process-driven, shared decision making
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<tr><td>Top Priority Action Items (limit to 3-5)</td><td>Actor(s)</td></tr>
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1	Prioritize interdisciplinary education for practicing clinicians and those in graduate medical, nursing, social work to include all disciplines	Health professional associations and organizations, governments
2	Work flow for advance care planning in all settings with accountability for who is going to do it incorporating quality metrics, data, and structure and process outcomes	Health systems, practices, plans, payers
3	Accountability from CEOs to ACOs	
4	Documenting and accessibility of the conversation and the documents (advance directives, medical orders)	Health systems, regional RHIOs
5	Normalizing the conversation	Clinicians, patients, community, faith-based organizations, diverse populations