



**MCA Cancer Plan Revision Meeting Summary
Advance Care Planning/Hospice Workgroup**

2 – 3:30 p.m., May 23, 2015

Participants: Susan Marschalk, MN Network of Hospice and Palliative Care, and Sue Schettle, Twin Cities Medical Society, co-chairs; Catherine Graeve, Allina; Holly Guerrero, American Cancer Society; Shari Hahn, Sanford Health; Heather Hirsch, legacy representative; Belle Matheson, Hennepin County Medical Center; Janelle Shearer, Stratis Health

MDH Staff Liaison: Jeanne Steele

Location: Twin Cities Medical Society and by TCMS conference line

Agenda Topic	Key Points Raised	Next Steps/Points of Agreement
Introductions & Welcome	Participants introduced themselves and explained what they do and why they're interested in advance care planning and end-of-life issues.	NA
Advance Care Planning – Obj. 20 <i>To increase the use of advance care planning</i>	<p>A lot has happened since 2011 when current plan was created, but a lot more needs to be done.</p> <p>Challenges:</p> <ul style="list-style-type: none"> • In some cases, physicians are reluctant to talk about ACP because they think patients are in denial about the seriousness of their illness, but patients diagnosed with a serious illness want their doctor to talk with them about hospice; • Most physicians and providers are not adequately trained/not comfortable talking about end-of-life choices; • Some providers and caregivers see hospice as “giving up” on a patient. . . a failure; 	<p>MNHPC is planning to survey its members. Doing it sooner than planned might help identify some new ways of “doing this work.”</p> <p>Need to:</p> <p>“Re-imagine” the physician/patient relationship.</p> <p>“Back-up” the conversation and help people accept death as part of life, that we really are all going to die. What</p>

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	<ul style="list-style-type: none"> • Can be really overwhelming for the patient; • Not enough time to have those conversations; more people need to be involved and earlier – not when a person has a serious illness; • Right people are not always involved, i.e., social workers often don't have the medical background (or the time) to address specific issues that can arise • It's not just the patient who needs to understand what hospice/end-of-life choices are; family and caregivers need to be educated <p>Barriers:</p> <ul style="list-style-type: none"> • Medical and nursing curricula do not allow enough time/emphasis on ACP; • Interoperability of electronic medical record systems is outside of our sphere of influence/controlled by EMR vendors; • Training needs and opportunities vary by setting, e.g., needs of nursing staff at long term care facilities differ from those of intensive care unit staff • Payment for conversation about ACP not sufficient <p>Related issues:</p> <ul style="list-style-type: none"> • Need a structured/standardized approach that ensures conversations take place and are documented – not necessarily “same” approach • Need strategies that not only promote <i>documentation</i> of an advance care plan, but also <i>understanding</i> of what choices mean • Ideal = standardized prompt, documentation, filing system that affords as needed access, process for updating/maintaining a “living” ACP • ACP should be promoted for everyone, but cancer patients have specific needs that should be addressed • Minnesota has a lot of resources for ACP. We have a great opportunity to expand the reach by working collaboratively. 	<p>does it mean to be mortal? – not an option but inevitable.</p> <p>Build awareness AND understanding about ACP and end-of-life issues.</p> <p>Work to incorporate more exposure to end-of-life skills in medical school curriculum.</p> <p>ACTION:</p> <p>Recommend that Obj. 20 be retained as written.</p> <p>Possible strategy language:</p> <p>Promote the use of advance care planning resources for all cancer patients near the time of diagnosis or early in treatment.</p> <p>Build consumer awareness and understanding of advance care planning tools and resources in communities statewide.</p> <p>Expand culturally sensitive conversations about advance care planning.</p> <p>Share best practices with clinics, hospitals, longterm care facilities and hospice providers that address storage and retrieval of ACP plans in the EMR so plans are more readily accessible when needed.</p>
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<p>Hospice and Palliative Care – Obj. 21 – <i>Improve availability of palliative care services.</i> Obj. 22 – <i>Increase utilization of hospice care.</i> Obj. 23 – <i>Increase number of hospice care providers who accept pediatric patients.</i></p>	<p>Many of the issues raised during the discussion of ACP pertain to palliative care and hospice.</p> <p>Challenges:</p> <ul style="list-style-type: none"> • Hospice orientation (training) for long-term care facility personnel is not “online.” Rather, it’s in print. This creates a problem in terms of consistency in the training of staff. • Achieving health equity is a ‘forever’ project. It means approaching the community with humility and listening. • The general public still perceive that using hospice means “giving up.” Myths about hospice continue to be generated, and the public responds by not utilizing hospice earlier. Communication and messaging needs to change. 	<p>Obj 21: Retain; Recommended strategies:</p> <p>Get professional organizations to fund palliative care education and possibly provide some type of certification.</p> <p>Conduct a pilot in 3 or 4 places around the state to???</p> <p>Promote use of nationally recognized programs to train health care personnel in palliative care. Don’t create new ones.</p> <p>Grow current programs; create new programs.</p> <p>Obj. 22 -- Use media to let people know what hospice really is, e.g., story on KARE 11.</p> <p>Work with Hospice and Palliative Nurses Association to help MN nurses achieve national certification.</p>

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		<p>Educate family members, not just patient, about what hospice really is.</p> <p>Use stories and oral traditions to explain how hospice works over time.</p> <p>Obj. 23 – Susan to reach out to Jody Chrastek, pediatric advanced complex care team coordinator, Fairview Home Care and Hospice, for input – to see what’s missing.</p>
Next Steps	<p>Sue – Takes lead on ACP, drafting and circulating deliverable form for review at next meeting. Shari, Heather and Holly will assist.</p> <p>Susan – Takes lead on Palliative Care, drafting and circulating deliverable form for review at next meeting. Belle will assist.</p> <p>Susan – Takes lead on hospice, drafting and circulating deliverable form for review at next meeting. Janelle, Catherine and Heather will assist.</p> <p>Jeanne – Will assist all subgroups upon request.</p>	

Next meeting: June 16, 2:30 – 4 p.m., Twin Cities Medical Society

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