Workgroup: ACP/End of Life Date: June 16, 2016

Issue Statement:
Advance care planning is not merely the completion of a healthcare directive of living will. It is a thoughtful, deliberate, ongoing process to engage patients in discussions with loved ones about their personal values and desires for future health care treatment decisions. The result of these conversations is typically the completion of a health care directive.

Describe the issue using public health data, peer reviewed research, or other evidence:

In prospective studies and randomized trials, ACP has significantly improved outcomes for patients, especially those patients with serious illnesses. The studies have found that advance care planning is associated with:

1. Higher rates of completion of advance directives (Detering KM, 2010), (Hammes BJ, 1998)
2. Increased likelihood that clinicians and families understood and comply with a patient's wishes (Detering KM, 2010), (Silveira MJ, 2010), (Hammes BJ, 1998), (Wright AA, 2008)
3. A reduction in hospitalization at the end of life (Teno JM, 2007), (Molloy DW, 2000)
4. The receipt of less intensive treatments at the end of life (Teno JM, 2007)
5. Increased utilization of hospice services (Teno JM, 2007)
6. Increased likelihood that a patient will die in their preferred place (Molloy DW, 2000)
7. Regardless of the clinical scenario, ACP should be proactive, appropriately timed, and integrated into routine care. In addition, ACO should be revisited every time a person's medical condition changes (Messinger-Rappart BJ, 2009), (Hickman SE, 2005).
8. Successful ACP programs not only ensure that doctors, patients and families talk about future care but also that the content of those conversations is documented in a fashion that travels with the patient as he or she moves across health care settings.
9. Minnesota has built a community-wide ACP program that has been operational since 2008 with many partners contributing to the same goal. (Wilson KS, 2014)
10. Other important clinical outcomes include a higher satisfaction with quality of care. (Detering KM, 2010), (Molloy DW, 2000) which is likely due to improved communication between patient, family, and the patient's clinicians resulting in shared decision-making; and better family preparation on what to expect during the dying process. (Detering KM, 2010), (Teno JM, 2007)
11. ACP results in a lower risk of stress, anxiety, and depression in surviving relatives of deceased persons (Detering KM, 2010), (Wright AA Z. B., 2008) likely because most patients and families welcome these discussions (Janssen DJ, 2012), (Davison SN, 2006).
12. Finally, there are emerging data showing ACP reduces cost of end-of-life care without increasing mortality. (Teno JM, 2007), (Zhang B, 2009)

What factors contribute to this issue? What racial, economic, geographic and other barriers contribute to this issue?

1. Racial - Multicultural groups generally have low rates of ACP (Johnstone MJ, 2009) and advance directive completion (Kwak J., 2005) with evidence that many advance directive documents as they currently exists are not culturally acceptable to them. (Hickman SE, 2005), (Bullock, 2011) , (Blackhall LJ, 1999)
2. Racial – Many non-English speaking Minnesotans do not trust Westernized medicine and there are clearly language barriers
3. Racial – Many non-English speaking Minnesotans do not have a primary care physician or a health care home so these types of discussions need to be community centric
4. Economic - Advance care planning is gaining national attention because as the Baby Boomers begin to retire many local, state and national leaders are concerned that our already stretched (and inefficient) healthcare system is in jeopardy of implosion.
5. Economic – Reimbursement for ACP is not adequate enough to make it "worth it" for clinicians to prioritize ACP over their other clinical tasks/conversations with their patients.
6. Geographic – Many Minnesotans either don't have a "medical home" or they jump from health care system to another so continuity of care is problematic.
7. Geographic – Rural locations have a more difficult time accessing ACP services and resources.
8. Other barriers – Most people avoid the conversation altogether.

What are the gaps in policy, systems and/or environmental services that give rise to this issue?

1. Policy - ACP is not required by the health care systems so it is not a priority conversation
2. Environmental -- ACP resources take time and money to embed in the community
3. System - The current electronic medical record systems to do talk to one another and different versions and vendors are present throughout the continuum of care which makes the findability of the ACP materials problematic
4. Environmental - We have a death denying culture
5. System and Environmental - Confusion about language - living will, healthcare directive, POLST, estate planning, hospice versus palliative care versus ACP.
6. System and Environmental - Cultural differences
7. Environmental - Lack of awareness of why ACP is important.

POLICY, SYSTEMS, and/or ENVIRONMENTAL (PSE) CHANGE: What are the policy, systems and/or environmental change opportunities to address this issue?

1. System - Collaborate with the medical school, nursing school, social work school and others to embed ACP into the curriculum.
2. System - Empower practicing physicians and other providers with tools and resources to begin the conversation early and continue those conversations as the patient ages and medical conditions present themselves.
3. System - Collaborate with EMR vendors and/or healthcare systems to develop best practices for housing and retrieving ACP materials in the electronic medical record

4. Policy - Partner with insurance companies to work on reimbursement that covers costs.
5. Environmental - Build a large scaled community awareness campaign.
6. System - Obtain continued commitment from health care systems to work collaboratively.
7. Policy - Work to mandate that advance care planning services are offered to all Minnesotans.

What strategies would you recommend to achieve PSE change?

1. Promote the use of ACP resources for all cancer patients near the time of diagnosis or early in treatment.
2. Educate health professionals about tools and resources available to them to have meaningful conversations with patients and families.
3. Expand culturally sensitive conversations about ACP.
4. Create and share best practices with clinics, hospitals, long term care facilities and others that address storage and retrieval of ACP plans in the EMRs so plans are more readily accessible.
5. Convene statewide partners to work collaboratively on consistent messaging and resources for Minnesotans coming from all sectors of the state.

HEALTH EQUITY: Which strategies promote health equity? Describe how they promote health equity.

1. Convening multicultural communities in this discussion works to break down the barriers associated with cultural differences, language, socio-economic factors.
2. Educating healthcare professionals about resources and best practices for engaging multicultural communities can lead to reducing health disparities and health inequities.

ALIGNMENT: Who are the partners already working on those strategies? What agencies and organizations should work together to address those conditions, gaps?

1. Honoring Choices Minnesota
2. Minnesota Network of Hospice and Palliative Care
3. Senior Linkage Line
4. Stratis Health
5. Minnesota Hospital Association
6. All hospital systems in Minnesota
7. All insurance companies in Minnesota
8. MN Business Partnership
9. MN Health Action Group
10. Institute for Clinical Systems Improvement
11. Metro Area Agency on Aging

12. MN Council of Health Plans (?)
13. American Cancer Society
14. MN Cancer Alliance
15. AARP

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