IDENTIFYING AND OVERCOMING BARRIERS TO ADVANCE CARE PLANNING WEBINAR SUMMARY

Coalition to Transform Advanced Care (C-TAC) webinar
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Presenters

- Theresa Schmidt, Discern Health; Director
- Diana Franchitto, Hope Health; President & CEO
- Allan Zuckoff, Vital Decisions; Vice President, Clinical Program Development

Purpose

Industry experts discuss the latest research on best practices and regional variation in strategies for addressing the barriers to communicating and documenting care wishes and associated delivery of care.

Evidence-Based Best Practices for Improving Advance Care Planning

Presenter: Theresa Schmidt

What Is Advance Care Planning?

- Advance Care Planning (ACP) involves understanding the values, goals, and preferences of individuals and helping to ensure that their wishes are honored by health care providers if they cannot speak for themselves.
- ACP discussions can involve the completion of an Advance Directive or Physician Orders for Life-Sustaining Treatment (POLST) form.

The ACT Index and Advance Care Planning Measure

- Discern Health partnered with C-TAC to improve evidence-based actions to improve performance on Advanced Care Transformation (ACT) Index^{SM} measures.
- The goal of the project was to identify evidence-based actions that improve performance on rates of ACP, a 2019 C-TAC ACT Index measure.
- Analysis of this measure will allow us to compare states to one another and track changes over time.
- The ACP index measure measures the percentage of Medicare fee-for-service beneficiaries who have a claim with one or more of the ACP current procedural terminology (CPT) codes (99497, 99498).
- The national average in 2017 was 2.12%; Hawaii was the highest-performing state at 6.50% and North Dakota was the lowest-performing state at 0.25%.

Literature Review

- 100 drivers of ACP were identified in seven categories:
  - Patient Education and Resources

- Communication and Accessibility
- Provider Education and Tools
- Quality Improvement and Accountability
- Technology and Infrastructure
- Coalition Building and Community Outreach
- State Policies and Regulations

Data Analysis

- Discern performed a regression analysis and found five state-level drivers of ACP:
  - Provider resources
  - Medicare Advantage penetration
  - Medicare Advantage plan quality
  - Primary care access
  - Delivery of person- and family-centered care

Interviews with Key Informants

- Discern conducted interviews with eight stakeholders in two states — Hawaii (highest rates of ACP) and Louisiana (poorer than expected performance on ACP measure).
- Best practices identified:
  - Patient education and resources should be culturally tailored.
  - Provider education should begin early and be ongoing.
  - Change management principles should be applied.
  - Payers should cover ACP services and health plans should offer incentives to have ACP conversations.
  - Coalition building and community outreach are key.
- Barriers identified:
  - Culture and politics: Discomfort with end-of-life issues, fear of policies not considered "protective of life"
  - Data and infrastructure: Lack of coordination between organizations, poor electronic health record (EHR) integration
  - Timing: ACP conversations are not long enough, ACP conversations are happening when patients are in crisis
  - Difficulty in succession planning

Complex Care Conversations: Primary Palliative Care Training for Community Clinicians

Presenter: Diana Franchitto

Workshop Overview

- The project goal was to ensure that patients and families who are facing complex care decisions and end-of-life choices have the information and understanding they need to make informed decisions regarding their treatment plans.
- Known barriers include:
  - Lack of palliative care providers; there is a need to bring palliative care education to the primary care environment
  - Length-of-stay challenges
  - Current community education/training system not working
- The project received $250,000 in grant funding from a combination of public and private payers (Medicare and Blue Cross Blue Shield).
- The curriculum included materials from the Center for Outcomes Research and Education (CORE) program in Oregon.
- HopeHealth faculty served as faculty for the program. All these providers are board certified in hospice and palliative care.
- The workshops contained 10–25 participants, held over 8 hours.
- The workshops were interactive; there were no PowerPoint presentations.
- The workshops built on clinicians' existing skills and experience.

Workshop Objectives

- Increase non-palliative-care clinician comfort with complex care discussions
- Increase clinician (personal and professional) satisfaction in caring for patients with serious advanced illness and their families
- Increase the number of *effective* ACP conversations

Workshop Content

- Defining the role of the clinician in complex care discussions
- Structure for a good conversation on goals of care
- Capacity and surrogate decision-making
- Prognostication
- Role-playing experiencing a serious illness

Workshop Results

- Since January 2017, 894 providers/clinicians have been trained.
- 31% of those trained are physicians, nurse practitioners, or physician assistants.
- After the workshop, 93% of attendees indicated they were somewhat or very skilled with the 11 aspects of a complex care conversation.
- There was improved clinician satisfaction three months after the workshop.
- A number of clinicians outside of the pilot in Rhode Island wanted to participate.
- There is now a common language for HopeHealth palliative care teams.

Barriers to Improvement

- Time.
- Opening Pandora's box: Providers are concerned that if they begin an ACP conversation, they may begin a long and upsetting conversation.
- An "opt-out" world.
- Transaction: ACP conversations are often interpreted as what providers *aren't* going to do for patients, this needs to be reimagined as a conversation about what a provider *is* going to do.
- Can you capture how they live? It is important to respect patients' lifestyle desires, as much as is possible, in their final months.
- Brink of death: ACP conversations are often happening too late, providers don't want their patients to think they're giving up.

Facilitating Advance Care Planning Conversations: Challenges and Solutions

Presenter: Allan Zuckoff

Challenges of ACP

- For physicians:
  - Fear of upsetting patients
  - Concern about undermining hope or reducing patients' willingness for further treatment
  - Equating death with failure
  - Poor timing: ACP discussions happening within one month of a patient's death or during times of medical crisis
  - Lack of training and skills
- For patients and families:
  - These conversations are sad and frightening and can feel like a betrayal.
  - They may have a limited understanding of their options.
  - They may feel as though the conversations won't be effective.
  - These types of conversations are not often in a family's repertoire.

Motivational Interviewing Process

- Trained specialists can increase patient and family readiness for these discussions and help guide them through the ACP process.
- These specialists use motivational interviewing to enhance readiness for ACP discussions. Motivational interviewing is:
  - Empirically supported for improving engagement and outcomes in health behavior change
  - Effective via telephone
  - A good fit for the end of life
- Ambivalence about ACP can sound like:
  - "I know having a living will is a good idea. But I started to look at the questions, and they're so overwhelming."
  - "I realize my condition is serious, but thinking positive is keeping me going right now."

- Motivational interviewing can help overcome this ambivalence and enhance readiness for ACP; it allows the specialist to react to each person's specific situation and modify the counseling to fit their needs.

Q&A

What is the ACT Index?

- It was developed by C-TAC.
- It offers a single composite measure for each state (made up of 37 component measures).
- It was designed to allow C-TAC and others to track progress in advanced illness care over time.
- More information is available on the CTAC website.

What about ACP services that aren't billed through CPT codes?

- It is an imperfect measure of ACP services. We're not going to capture everything.
  - Conversations may happen among people who cannot bill for the service or who do not know these codes are available.
- The measure serves as a bellwether and shows opportunities for improvement.
- ACP conversations less than 16 minutes can't be billed using CPT codes, but can be billed under evaluation and management (E/M) codes.

Has there been any discussion about moving training on ACP to formal medical education?

- Yes, there are examples of integrating end-of-life training into curriculum.
- There should also be training available for social workers, nurses, and care liaisons, as ACP conversations are not always led by physicians.
- Sixty percent of participants in Complex Care Conversations workshops were not physicians.

Are people skeptical of the telephonic motivational interviewing process?

- The founders of the company began at the bedside and moved their services to the phone to prove their hypothesis that they could reach more people.
- There is a large body of research around motivational interviewing and other psychosocial interventions that have been shown to be effective over the phone.
- It is possible to create intimacy over the phone — some people open up more in this process.

How is this service paid for? How does the process work?

- The company partners with health plans to provide services for their beneficiaries at no additional cost to the patient.
- Health plans are willing partners, as this service improves member satisfaction.
  - Advance directive completion is often a quality measure for these plans.
  - When people have the opportunity to think through their end-of-life options, they often don't choose as much of the care that would be expensive or cost-inefficient.
- The health plan provides a list of beneficiaries who may need their services, and the company sends those beneficiaries a letter and calls them to begin the process.