

**End-of-Life Care**

**Rank: 5 (medium provider adoption)**

**Survey Responses- Hospitals: 12**

**Medical Groups: 10**

**Health Plans: 7**

Adopted November 2014 | 25 months from adoption to survey

Read the Report and Recommendations here: [www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf](http://www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf)

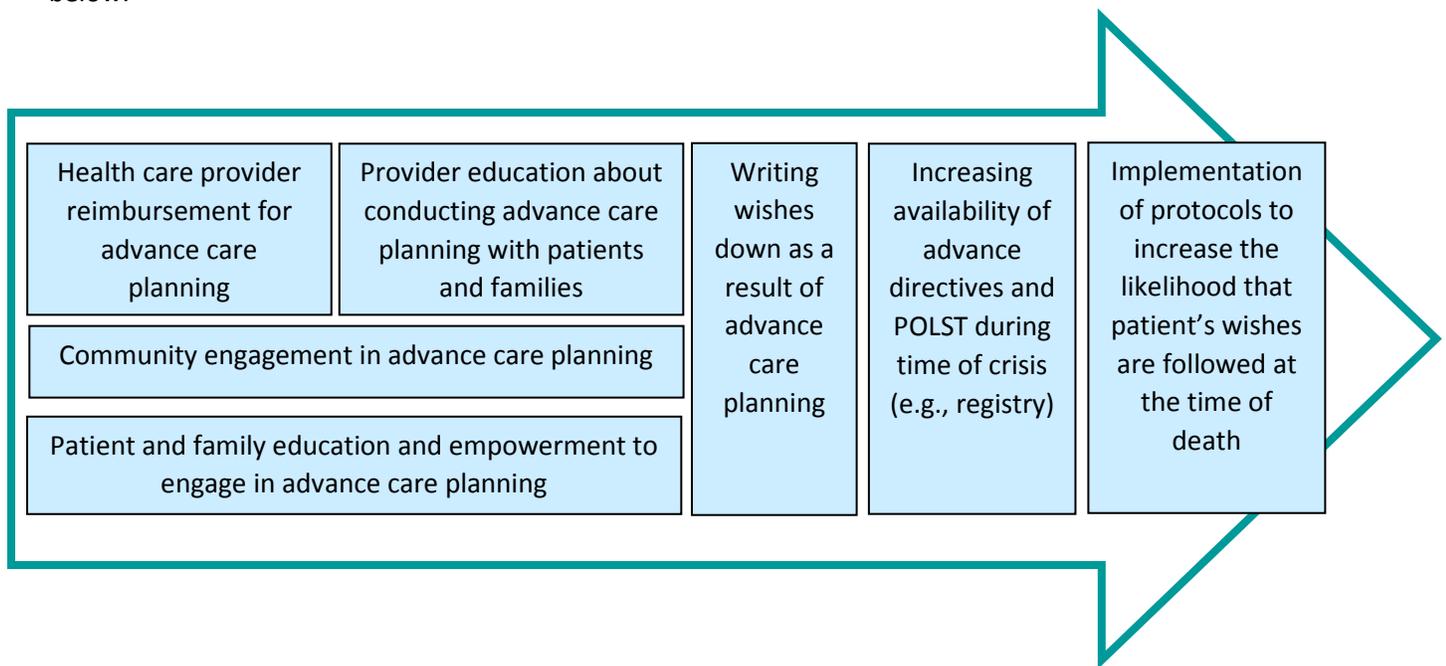
**Roadmap to Implementation**

Current State	Transition Activities	Ideal State and Sustainability
<b>Hospitals, Clinics, and Individual Clinicians</b>		
<ul style="list-style-type: none"> <li>• Patients do not receive the care that they want at the end of life</li> <li>• Physicians and staff are not trained on how to have a conversation about advanced care planning, how to help the patient draft an advance directive, or document patient goals of care in the medical record</li> <li>• Advance care planning conversations are not reimbursed</li> <li>• Advance directives are not completed</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic or hospital participates in a training program such as <i>Honoring Choices: Pacific Northwest</i></li> <li>• Staff are trained to discuss advanced care planning</li> <li>• Referral relationships and communication are established with hospice and other community care providers</li> <li>• Training for appropriate billing codes for advanced care is conducted</li> </ul>	<ul style="list-style-type: none"> <li>• Patients receive care at the end of life that aligns with their goals and values, including hospice care</li> <li>• Patients are given the opportunity to discuss their advance care plans with their clinician</li> <li>• Physicians are comfortable discussing advance care planning</li> <li>• Specific billing codes are used for advanced care planning</li> <li>• Family members and friends, at the patient’s request, are included in the advance care planning conversation</li> <li>• Advanced directives and Physician Orders for Life Sustaining Treatment (POLST) are documented and available when needed</li> <li>• Appropriate hospice and other end-of-life care is promoted and referred</li> <li>• A quality improvement program tracks adherence to patient goals of care and outcomes</li> </ul>
<b>Health Plans</b>		
		Counseling regarding advanced directives and end-of-life planning is reimbursed

Read the full Roadmap here: [www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf](http://www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf)

## Background

The Bree Collaborative’s goals are that all Washingtonians be informed about end-of-life care options, that care preferences are communicated in actionable terms, and that care is aligned with patient goals and values and those of family members, at the patient’s request. The workgroup developed five focus areas corresponding to how an individual would ideally experience advance care planning for end-of-life including increasing: community awareness, advance care planning conversations, recording end-of-life care goals and wishes, accessibility of completed advance directives and POLST for health systems and providers, and the likelihood that patients’ goals and wishes are honored at the end of life. The workgroup created the following implementation model to better align end-of-life care with patient preference while taking into account how patients interact with the health care system, as shown in below:



The Washington State Hospital Association and Washington State Medical Association have developed a statewide strategy to spread advance care planning conversations and ensure that *“everyone will receive care that honors personal values and goals in the last chapters of life.”* Called Honoring Choices® Pacific Northwest, this initiative is using national best practices to transform culture through health care organization and community engagement. *“Statewide engagement includes large and small, urban and rural medical groups and hospitals. Participation is expanding to community groups. As of September 2016, there are 95 Facilitators in 23 organizations actively having advance care planning conversations. Additionally, Honoring Choices Pacific Northwest developed free state-wide patient engagement materials, including an advance directive, wallet card, informational sheets and education guides.”* Learn more here: [www.honoringchoicespnw.org](http://www.honoringchoicespnw.org)

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## Implementation Survey Results

Several hospitals and clinics in our assessment survey indicated they have begun active participation in *Honoring Choices: Pacific Northwest*<sup>®</sup>. Some provider organizations are participating in other advance care planning programs including *Five Wishes*; *Your Life, Your Choices*; and *The Conversation Project*.

Several internal pilot programs are mentioned in survey responses. One large medical group dedicated a four-hour medical staff meeting to educate physicians, with a nationally known physician expert speaking on the subject. Others offer patient classes on the subject. However, several said that community engagement has been difficult.

Bree Collaborative recommendations scoring lowest on the implementation survey for this topic include:

### *Hospitals and Medical Groups:*

- All patients over the age of 18 are encouraged to consider having a conversation about advance care planning with the content of those conversations appropriate to the patient's age, health status, literacy level, and readiness.
- A durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making, and includes a written personal statement that articulates the patient's values and goals regarding end-of-life care.
- Standardized protocols developed on how to transfer information contained in the advance directive or POLST to hospitals in your community such as through the advance directive/POLST registry, if in existence.

### *Health Plans:*

- Family and friend satisfaction with end-of-life care is measured by widespread use of an after-death survey tool similar to that used by hospice agencies.

## Next Steps

- **Reimbursement.** Health plans responding to our survey indicate they are educating providers on how to bill for advance care planning. However, responses from hospitals and medical groups indicate less progress in educating front-line caregivers on how to bill.
- **Measurement.** Billing data might be the most useful source of data to assess adoption and can be considered for further analysis. Although data collection and measurements may exist for local pilot efforts, more comprehensive state-wide measures would be beneficial.
- **Establish a state-wide, easily accessible registry.** An advance care planning document and POLST registry will help ensure that a patient's advance directive instructions are available to caregivers at the time they are needed.
- **Working with existing, accepted programs.** Financial support for *Honoring Choices: Pacific Northwest*<sup>®</sup> is provided by several hospitals, clinics, and health plans, along with associations and foundation contributions. These efforts should continue to be supported, and progress

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monitored. The program works to engage hospitals and medical groups across the state, and has already produced a growing cohort of trained facilitators able to lead advanced planning conversations with patients and their health care agent. In some cases, patient satisfaction with the program is measured and has shown to be very positive. These will build on the progress already described.

- Learn more: [www.honoringchoicespnw.org](http://www.honoringchoicespnw.org)
- Program Report: <http://www.wsha.org/articles/honoring-choices-progress-valuing-wishes/>