Use Case Summary

Use Case Name:	Advance Care Document
Sponsor:	None
Date:	March 5, 2020

Executive Summary

This brief section highlights the purpose for the use case and its value. The executive summary gives a description of the use case's importance while highlighting expected positive impact.

Honoring a person's wishes assures that a treatment plan matches the person's values, beliefs, and preferences for care. The related conversations help people discuss, decide, and document their preferences for future healthcare and/or complex treatment needs. It also decreases Patient Advocate stress when difficult decisions must be made or when complex care is needed.[1]

Frequently these various types of treatment plans are often stored in a patient or family's home, a glove box or within their provider's Electronic Medical Record (EMR). However, people are mobile and cannot guarantee they will have an available paper copy or that the electronic version will be in the treating provider's EMR. Therefore, these documents need to be electronically stored where they are easily accessible and retrieved when needed by those providing care to the patient at any point of care.

Purpose of Use Case: The Advance Care Document (ACD) use case supports the electronic storage and retrieval of ACDs from any organization participating in the ACD use case.

Overview

This overview goes into more details about the use case.

Advance Care Planning (ACP) is a process that supports adults at any age or stage of health.[2] The goal of ACP is to help ensure that people receive medical and mental health care that is consistent with their values, goals, and preferences.[3]

The focus of ACP is to build the foundation for a lifetime of conversations that ensure a person's preferences for healthcare are known. These conversations should culminate in

the creation of ACD. There are generally three Life Stages to ACP for those that are 18 years or older:[4]

1. Those who are healthy (including stable chronic illness)
2. Those who are managing serious illness
3. Those who are preparing for end of life

A patient's ACD must be readily accessible. ACD retrieval can be very difficult when the documents are inconsistently housed within the EMR. Therefore, standardized location is necessary to ensure quick retrieval of needed information.[5] ACDs must be stored in such a way that ensures easy access and quick retrieval to help with clinical decision support by participating medical personnel within the healthcare continuum.

Types of ACDs submitted and retrieved may include but are not limited to**:**

- Certificate of Disability
- Code Status/Orders with or without Organ Donation
- Designation of Patient Advocate with or without "No Blood" clause
- Do Not Resuscitate
- Durable Power of Attorney for Healthcare
- Guardianship
- Living Will – Treatment Preferences
- Mental Health Power of Attorney
- Michigan Physician Orders for Scope of Treatment (MI-POST)
- Military Advance Care Directive
- Physician Orders for Life-Sustaining Treatment (POLST)
- Post Death Request
- Resignations and Revoked Documents
- Statement Of Incapacity
- Statement of Treatment Preferences (SOTP)
- Termination of Guardianship

Types of organizations that may contribute ACDs may include but are not limited to:

- Attorney
- Community Organization
- Health Information Exchange
- Home Health
- Hospice
- Hospital
- Long Term Care
- Outpatient Clinic
- Provider Organization
- Senior Living Center

Submission of ACDs may include but are not limited to:

- Web Portal
- EMR Interface

Persona Story

To explain this use case, this section follows a persona example from start to finish.

David Tomas Silva

When David Tomas Silva was diagnosed with prostate cancer, he was not surprised. His grandfather and two of his uncles also suffered from it. He stayed by their sides, watching through each step of their healthcare journey, experiencing with them their fluctuations in health. David always hoped that he would not get it, but in his heart he always felt it was inevitable. The only shock was that it happened so soon.

David is a busy man, so when he developed mild urinary tract infection-like symptoms he put off seeing his primary care physician for a few weeks. He is only 48, so he was not expecting it to be cancer so soon. Luckily the cancer was still diagnosed early, making successful treatment more possible.

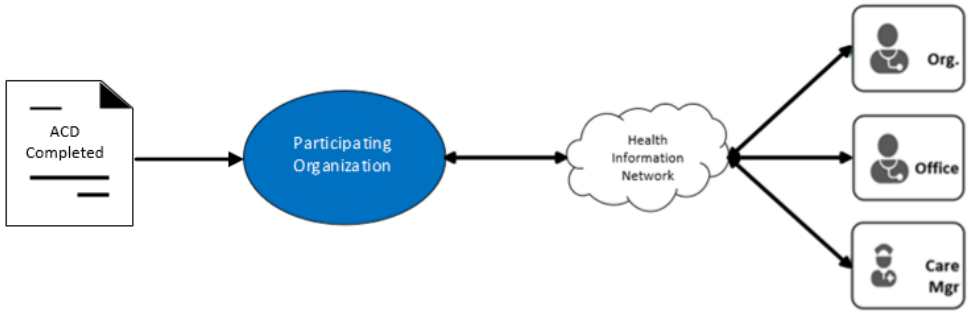
Since the diagnosis, David has been focused on winning living well during cancer treatment. He is aggressively watching his health, seeing his doctors regularly, and accepting any opportunities for curative treatment. David knew that he needed to make sure that medical providers would follow his wishes. He also wanted to be sure his wife/Patient Advocate would not have to make uninformed decisions about his care if he was unable to speak for himself.

Therefore David had an Advance Care Planning session with an ACP Facilitator. In a short time, David was able to document has wishes, identify his Patient Advocate and have his Power of Attorney for Healthcare/Advance Care Document uploaded into a Longitudinal Record by his PCP. It was reassuring to David to know that if he traveled outside of his network of providers, that other medical personnel would be able view his medical information and easily retrieve his ACD to honor his wishes.

David's doctor also utilizes the state's health information network to report David's information and updates on his status, and to coordinate with other members of David's care team. Together, they feel they can effectively treat his cancer, honor David's treatment wishes and return David to the life he was living before.

Diagram

This diagram shows the information flow for this use case.



1. ACD Completed
2. Participating Organization submits ACD to HIN
3. HIN stores ACD in appropriate data lake(s)
4. Medical personnel retrieves ACD for clinical decision support

Regulation

This section describes whether this use case is being developed in response to a federal regulation, state legislation or state level administrative rule or directive.

Legislation/Administrative Rule/Directive:

☒ Yes - Supports the PSDA and Michigan Estates and Protected Individuals Code
☐ No
☐ Unknown

Section 936. **Patient Protection and Affordable Care Act (PPACA**) on shared decision *making requires collaborative processes between patients, caregivers or authorized representatives, and clinicians* that engages the patient, caregiver or authorized representative in decision-making, provides patients, caregivers or authorized representatives with *information about trade-offs among treatment options*, and facilitates the incorporation of patient preferences and values into the medical plan. *ACP is by definition a shared decision making process*.

Medicare requires plans to *support the **Patient Self-Determination Act (PSDA)** through case management assessment* of advanced directive completions, provision to physician, and education as necessary.

Michigan Estates and Protected Individuals Code. Michigan compiled laws §§ 700.5506-700.5520. (1998).

Meaningful Use:

☐ Yes
☒ No
☐ Unknown

Cost and Revenue

This section provides an estimate of the investment of time and money needed or currently secured for this use case.

Costs

The project financially covers the following components:

- Development and maintenance of the implementation and user guide
- Development and deployment of a PCD Submission application at MiHIN
- Technical development and maintenance at MiHIN
- Partnering with certified electronic health record (EHR) systems to identify message content and send standard message types (excludes any EHR vendor costs)
- Participant development and implementation to onboard for this use case

Revenue

The following indirect revenue is projected for this use case:

- Increased value-add to the Longitudinal Record
- Alignment with Value Based Programs' reimbursement strategy

Implementation Challenges

This section describes the challenges that may be faced to implement this use case.

Implementation challenges associated with this use case include:

- Conformance to standards and the consistency of ACDs submitted by TDSOs
- Omission of data elements for varying reasons even with data fields being populated as required by this use case's implementation guide and the correct event types being sent through the source system (TDSOs)

- Incomplete or inconsistent demographic information contained in the HL7 Interface message which could affect accurate patient matching

Organizations participating in the use case also onboard to any of the following use cases: Active Care Relationship Service, Health Directory, Longitudinal Record, eConsent and Common Key Service.

Healthcare stakeholder's ACD submissions via an electronic health record (EHR), electronic medical record (EMR) may require information technology architecture enhancements and upgrades to transmit standard incoming HL7 messages.

Vendor Community Preparedness

This section addresses the vendor community preparedness to readily participate in the implementation of this use case.

None

Support Information

This section provides known information on this support for this use case.

Political Support:

☐ Governor
☒ Michigan Legislature
☐ Health Information Technology Commission
☐ Michigan Department of Health and Human Services or other State of Michigan department
☐ CMS/ONC
☐ CDC
☒ MiHIN Board

Other:

Concerns/Oppositions:

None

Sponsor(s) of Use Case

This section lists the sponsor(s) of the use case

None

Metrics of Use Case

This section defines the target metrics identified to track the success of the use case.

- The number of successful uploaded ACDs and Clinical Documents
- The number of active ACD submitters and organizations

Other Information

This section is provided to give the sponsor(s) an opportunity to address any additional information with regard to this use case that may be pertinent to assessing its potential impact.

[1]Wright, A. A., Zhang, B., Ray, A., Mack, J. W., Trice, E., Balboni, T., ... Prigerson, H. G. (2008, October 8). Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA, 300, 1665-1673. doi:10.1001/jama.300.14.1665
[2]Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage 2017; 53:821.
[3] Ibid.
[4] Messinger-Rapport BJ, Baum EE, Smith ML. Advance care planning: Beyond the living will. Cleve Clin J Med 2009; 76:276.
[5] Wilson CJ, Newman J, Tapper S, et al. Multiple locations of advance care planning documentation in an electronic health record: are they easy to find? J Palliat Med. 2013 Sep;16(9):1089–94. DOI: http://dx.doi.org/10.1089/jpm.2012.0472.