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A strategic business unit of MiHIN

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# Does Advance Care Planning Impact Patient Care?

Well... yes and no.

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# Advance Care Documents: Current State

Percent of Americans with AD's

38.2 percent of **people with** a chronic illness had advanced **directives** compared to 32.7 percent of healthy **people**, a difference that wasn't statistically meaningful.

(Healthcare & Pharma, July 2017)

Most **people** nearing the end of life are not physically, mentally, or cognitively **able to make their own** decisions about care. Approximately 40 percent of adult **medical** inpatients, 44-69 percent of nursing home residents, and 70 percent of older adults facing treatment **decisions** are incapable of make those **decisions** themselves. (American Bar Association, 2015)



**Failure to comprehend a diagnosis, prognosis, or treatment occurs in 35%-50% of family members (Azouley *et al.*, 2000).**

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# Does the Existence of an Advance Directive Improve Quality of Care?

- A 2018 review of 80 systemic reviews (including 1,600 original articles) found no evidence that ACP was associated with influencing medical decision making at the end of life, enhancing the likelihood of goal concordant care, or improving patients' or families' perception of the quality of care they received.
- A 2020 review that included 62 recent high-quality articles also demonstrated no link between ACP and occurrence of goal-concordant care or patient quality of life and could not identify meaningful differences in health care use.

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# Possible Reasons for Lack of Influence



According to a report by the [United States Agency for Healthcare Research and Quality](#), between 65% and 76% of the physicians whose patients had an AD were not aware that it existed.

(NHHD, 2003)

Research shows that, even when one has made one's wishes known through the legal document known as an Advance Medical Directive, doctors and family members frequently disregard it.

(Office of the Assistant Secretary for Planning and Evaluation, U.S., 2008; Burkle, *et al.* 2012).

A study conducted by Duke University Hospital showed that, among patients for whom withdrawal or withholding of care was considered, there was a conflict between the family and the provider 78% of the time (Breen *et al.*, 2001).



## Physicians and ACP: A Provider Survey N=151

- Over 90% of the physicians thought that conversation or discussion with patients over their potential future medical needs was vital and that ACP involved more than merely creating an AD.
- 66.23% of the physicians surveyed indicated an above-average understanding of their role in the ACP process
- **When asked as to whether they consistently sought and reviewed existing patient ADs so that they could present a plan of care that is consistent with their patients' goals of care and desires for treatment, physicians indicated they did so only 47% of the time**
- **57% of those surveyed stated that it was not easy to access the AD in the EMR**
- About training, 68% of those surveyed mentioned that they would like training to help them grow in their competencies in terms of ACP and critical conversations. Of them, 70% were highly motivated to attend such training.

# Advance Care Documents and Advance Care Planning

## ADVANCE DIRECTIVES

- \_\_\_\_\_ DO NOT RESUSCITATE
- \_\_\_\_\_ DURABLE POWER OF ATTORNEY FOR HEALTHCARE
- \_\_\_\_\_ LIVING WILL
- \_\_\_\_\_ HEALTHCARE PROXY

**It's NOT  
either or, it's  
Both AND**

**We don't just create static documents; we prepare people and their advocates to make medical decisions regardless of medical situation.**

**It's not just about the documents, but the people they represent**



**Static**

**Fluid**

# Barriers to Effectiveness of AD's

- A recent nation-wide survey indicated one in four physicians said there was no place in their electronic health record (EHR) indicating if a patient had an advance care plan.
- Of those who were able to find presence or absence of an advance care plan in the EHR, only half said they could access the plan's contents.
- Although EHR vendors have recently begun efforts to improve their ACP functionalities, opportunities for standardization and improvement remain.
- Valuable ACP information (such as documentation of a patient's goals and wishes) is often scattered across the health record, requiring both time and effort to search for information that is needed to direct care optimally in an emergency to meet patient goals.



# Barriers continued

- In some health systems, even the inpatient and outpatient facilities of the same system use different EHRs, thus limiting access to this key information from clinician to clinician.
- Furthermore, in the absence of nationwide interoperability, information that is recorded clearly in one EHR might be completely inaccessible in the next setting where a patient is transferred or seeks care.
- With at least one recent study demonstrating an increase in the proportion of patients who die in a hospital outside the healthcare system that has previously delivered their care, this is a significant barrier.
- Lack of standardization. To date, there are no standards that support inclusion of key components of ACP or to ensure that these data are consistently recorded and easily accessible.

Advance Care Planning Documentation in Electronic Health Records:  
Current Challenges and Recommendations for Change, Journal of Palliative  
Medicine Vol. 21, No. 4

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# Factors that Affect Effective ACP

- How we define ACP
- Patients' preferences for care are not static
  - Age
  - Physical and cognitive function
  - Culture
  - Family
  - Clinical advice
  - Financial resources
  - Caregiver burden



# Continued

- Ill prepared surrogates
- Workflow processes around ACP/Advance Directives
  - Quality and frequency of the “conversation”
  - Engagement with Advocate
  - Review with Provider



# How MiHIN and Making Choices Michigan are supporting ACP in new ways

- ACP Facilitation –
  - Acuity Specific ACP Clinician Training
  - Design and Implementation
- Care Convene –
  - clinician-centered design empowers care teams to better coordinate safe effective Advance Care Planning with patients
- ADVault -
  - Provides statewide repository for ACD's to include Mi-POST. The Honoring Patient Choices Service work focuses on the design, development, and implementation of application programmable interfaces (API) to the MiHIN Statewide Advance Directive and eConsent repositories that enables healthcare providers including: hospitals, post-acute facilities, ambulatory practices, substance use disorder facilities, care managers, and those with active care relationships with patients to be notified or made aware of specific care needs and preferences for their patients



# Continued

- ACRS
  - Provides a framework for patient data integration, unification, analytics and sharing.
- Mi-Gateway –
  - Provides visibility of the existence of an ACD document



# Questions ???????





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# Thank you!

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