



# ADVANCE CARE PLANNING

## WHAT IS ADVANCE CARE PLANNING?

Advance Care Planning (ACP) is a structured discussion with a patient and/or his or her representative about the patient's health care choices that results in the documentation of the patient's end-of-life instructions. This includes a process that makes the documentation available to all who will participate in the patient's treatment.

## WHY DO WE NEED ADVANCE CARE PLANNING?

Research indicates most patients have NOT participated in advance care planning, yet many are willing to discuss end-of-life care.

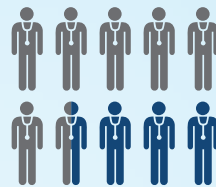
**Studies also show that 30 percent of medical expenditures occur in the last 30 days of life.**

Lubitz, J., and R. Prihoda. 1984. The Use and Costs of Medicare Services in the Last Two Years of Life. Health Care Financing Review 5:117

## PATIENT PREFERENCES FOR CARE AT THE END OF LIFE ARE OFTEN NOT DOCUMENTED. (Source: AHRQ, 2003)



**LESS THAN 50%** of the severely or terminally ill patients studied had an Advance Directive in their medical record.



**BETWEEN 65-75%** of physicians whose patients had an Advance Directive were not aware that it existed.



**ONLY 12%** of patients with Advance Directives had received input from their physicians in its development.



**MORE THAN 80%** of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness.

(Source: The Dartmouth Institute, 2010)

**Physicians are in the best position to discuss advance care planning with patients. Studies have shown increased patient satisfaction, less fear and anxiety about end-of-life care, and a stronger belief that their physicians were respectful of their wishes.**

This information provided by

**HAWAI'I HEALTH PARTNERS**

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Hawai'i Health Partners is an accountable care organization of independent physicians, employed Hawai'i Pacific Health physicians, and Hawai'i Pacific Health hospitals and clinics.

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# ADVANCE CARE PLANNING QUALITY MEASURES FOR HAWAI'I HEALTH PARTNERS:

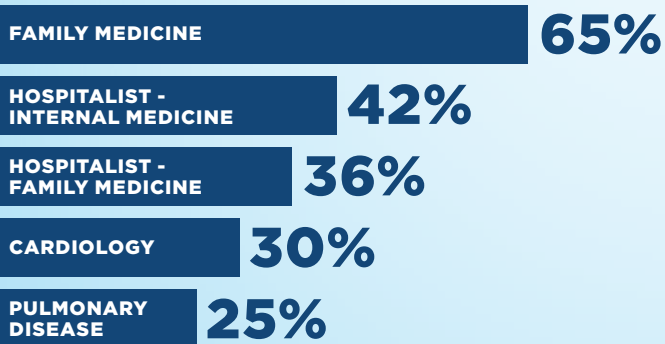
Physicians in primary care and certain specialties earn points in HHP's Quality Performance Program for performance on these four measures.

(See the HHP Program Guide for Physicians for additional details.)

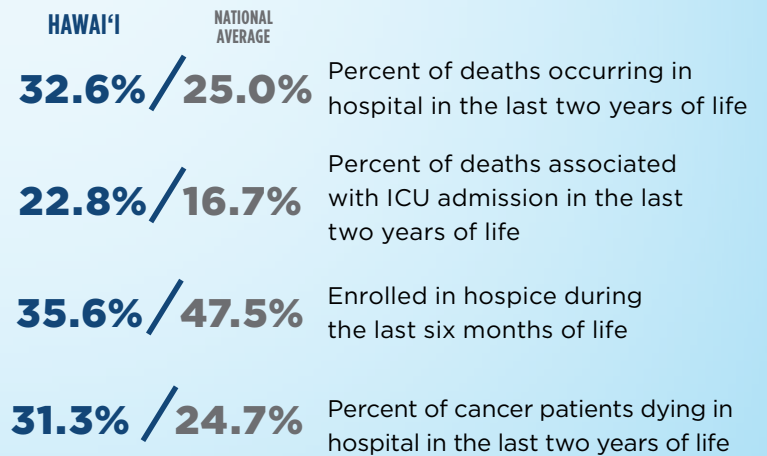
- 1. ADVANCE CARE PLANNING FOR ADULT PRIMARY CARE** - Percentage of commercial patients 75 years of age and older at the end of the measurement period who had an advance care plan and/or advance care planning discussion with their PCP documented during the measurement period. (HMSA P4Q Measure Description)
- 2. ADVANCE CARE PLANNING FOR LAST STAGES PATIENTS WITHIN 30 DAYS POST DISCHARGE** - Percentage of last stages patients who have had an ACP document recorded in Epic. ACP "Last Stages Population" includes patients who have an expected life span of approximately 12 months or less who might benefit from ACP such as:
  - a. Patients who have limited resuscitative orders - partial or DNR code orders and will be discharged from the hospital
  - b. Patients who are being discharged to hospice
  - c. Patients who are ≥ 90 years old
  - d. Patients who are ≥ 80 years old and readmitted twice within the past six months
- 3. HONORING POLSTS AT THE HOSPITALS** - Percentage of patients whose physician reviewed their POLST at an HPH hospital within 12 hours of patient arrival.
- 4. ADVANCE CARE PLANNING IN THE AMBULATORY SETTING** - Five POLSTs or Advance Care Directives recorded in Epic. Physicians in primary care and certain specialties can earn points by submitting ACP documents on behalf of HHP patients to Medical Records by December 31, 2014.

## MEANINGFUL ADVANCE CARE PLANNING

% Last Stages Encounters Receiving Meaningful ACP by Specialty (January - July 2014) \*HHP Physicians Only



## THE DARTMOUTH ATLAS OF HEALTH CARE MEDICARE PATIENTS - 2010 DATA



IN 2014, THERE HAVE BEEN **755** occurrences where care was changed to honor a patient's choice as a result of a POLST.