**ADVANCE CARE PLANNING**

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| **Project Title** | Advance Care Planning |

**Rationale for the Project**

Advance Care Planning (ACP) is the process of people reflecting on their wishes, values and goals for end of life care, designating a person to speak for them when they cannot, documenting their choices in an Advance Directive, and sharing them with medical providers and loved ones.

There is an enormous gap between the perceived value of Advance Care Planning and actually doing it. For example, 90% of people say that talking with their loved ones about end-of-life care is important, but only 27% have actually done so (The Conversation Project National Survey 2013). 80% of people say it's important to put their wishes in writing, but only 23% have completed this process (California Healthcare Foundation 2012). This gap strongly suggests an unmet need: awareness, tools, and support to help people navigate the advance care planning process and complete advance directive documents.

Medicare spends nearly 30% of its budget on beneficiaries in their final year of life. About half of Medicare dollars are spent on patients who die within two months, and an estimated 13% of national health care spending is devoted to care of individuals in their last year of life (Aldridge, Kelley 2015). These expenditures are not always for care that the patient and/or family desire, a discrepancy that could be alleviated by having completed advance directives.

*Supporting research (evidence-based and promising practices) for the value of the proposed project.*[i]
This project would be based on Respecting Choices®, an internationally recognized, evidence-based model of advance care planning based in La Crosse, WI. In 2014, about twenty years after starting Respecting Choices® in La Crosse, 96% of adults who died in area hospitals had a completed advance directive on file. Respecting Choices® has demonstrated that the model improves patient care, improves population health and controls the per capita cost of care (http://www.gundersenhealth.org/respecting-choices/news-media-and-research/why-implement-RC).

In 2012, the Whatcom Alliance for Health Advancement (WAHA) implemented a community-based ACP project based on the Respecting Choices® model. This ongoing project includes training Respecting Choices® facilitators; developing, producing ACP Kits; and educating health care professionals. In 2015, 70 ACP community workshops were attended by over 850 people, and 145 people received one-on-one sessions with certified Respecting Choices® facilitators. Over 2,500 advance directives were scanned into the electronic medical record system at our local hospital, making them easily accessible to medical providers when needed. Much of the staffing for this program is provided by volunteers, who donated nearly 500 hours in 2015.

*Relationship to federal objective for Medicaid, and particularly how this project benefits Medicaid beneficiaries.*
This project aligns with the federal Medicaid objective of **increasing the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks**. Medicaid beneficiaries, like all adults, should have advance directives. Due to limited income and other barriers, this population may be less likely to receive assistance with ACP via other channels such as a lawyer or estate planner, making a community-based program such as WAHA's especially important.

**Project Description**

*Which Medicaid Transformation Goals*[ii] *are supported by this project/intervention? Check box(es)*

- **X** Reduce avoidable use of intensive services
- ☐ Improve population health, focused on prevention
- ☐ Accelerate transition to value-based payment

**X** Ensure Medicaid per-capita growth is below national trends

*Which Transformation Project Domain(s) are involved? Check box(es)*

☐ Health Systems Capacity Building
**X** Care Delivery Redesign
☐ Population Health Improvement – prevention activities

*Region(s) and sub-population(s) impacted by the project.*
This project could be at a local, regional, or statewide level based on ACHs' interest and capacity. The target population would be individuals nearing end of life and/or those with chronic conditions or functional limitations.

*Relationship to Washington's Medicaid Transformation goals.*
This project would help achieve the goal to reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional Long Term Services and Support (LTSS), and jails.

*Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*
The near-term goal is to increase the number of people who complete the advance care planning process, including completing an Advance Directive document. The longer-term -- and arguably most important-- goal is that the wishes documented in advance directives are consistently honored at end of life.

*To accomplish this goal*:
A) Train ACH networks about the importance of ACP and effective strategies for engaging individuals to learn about ACP resources; B) Provide printed ACP Kits modeled after the WAHA Kit, which includes a "road map" of the ACP process, values clarification workbook, roles and responsibilities of health care agents, and an advance directive form; and C) Develop online ACP resources and place on partner websites; and D) Train Respecting Choices® Facilitators on the ACP process and the resources (print, online, community workshops and trained facilitators) that are available in their communities.

*Links to complementary transformation initiatives - those funded through other local, state or federal authorities and/or Medicaid Transformation initiatives # 2 and 3.*
*This project has the ability to connect with the following initiatives:*

- Medicaid Transformation Initiative #2: Provide outreach and ACP services to individuals who are either pre-Medicaid or already Medicaid eligible for health care and/or Long Term Care Services and Supports and their family caregivers.
- Bree Collaborative: End of Life Care Report and Recommendations, November, 2014, contains recommendations about increasing awareness of advance care planning.
- Joint Legislative Executive Committee on Aging and Disability Issues, Final Report December 2014, includes recommendations on system changes related to end of life care planning.

*Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.*
Potential partners may include the WA State Medical Association and WA State Hospital Association's program *Respecting Choices Pacific Northwest*, along with regional end of life collaborations and local health care systems engaged in ACP activities. Partners outside the health care sector may include social services and faith communities.

**Core Investment Components**

*Proposed activities and cost estimates ("order of magnitude") for the project.*

- Print materials: $20,000 per year for ACP kits. This would pay for 4,000 kits at $5 per kit, using the WAHA Kit as the prototype.
- Respecting Choices® Facilitator training: $5,025, $335 per person for 15 people. Training would be on-line and in person, and include understanding the process of ACP and where additional resources and assistance are available. Note that the facilitation model for the program is volunteer-based, meaning the only cost is the upfront training and reimbursement for mileage for volunteers
- Master training and certification in Respecting Choices: $5,000
- Program Lead – to oversee and coordinate volunteers - 0.5 FTE - $28,000

*Best estimate (or ballpark if unknown) for:*
*How many people you expect to serve, on a monthly or annual basis, when fully implemented.*
In Whatcom County, 4000 Medicaid-enrolled individuals or their family caregivers would receive information about ACP, or about 7.5% of the Medicaid-enrolled population. It is projected that five to ten percent of individuals who receive ACP information would seek one-one-one sessions with a Respecting Choices® Facilitator and complete advance directives, translating to 200-400 completed advance directives each year in Whatcom County for Medicaid beneficiaries. If scaled up to the entire North Sound ACH, this would translate to approximately 20,265 people served and 1000-2000 newly completed and filed advance directives.

*How much you expect the program to cost per person served, on a monthly or annual basis.*
Note that the program is population-based and also serves the non-Medicaid population. The annual budget of running the program for a community the size of Whatcom County is $58,025 per year, with an estimated 30% of the budget allocated to serving the Medicaid population. Using the assumptions from above, this translates to an average per-unit cost of an advance directive of $44-$87. Expenses include print costs for ACP kits, training facilitators, reimbursing for mileage, and personnel for administering the program. Program expenses are low because this is a volunteer-based program, with only one part-time program lead. If the program was scaled to the entire North Sound ACH region, we anticipate substantial economies of scale leading to a reduced per-unit cost of each completed advance directive.

*The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
At the Respecting Choices® model hospital, Gundersen Lutheran, the average cost of care in the last two years of life is about $18,000 per person, compared to the national average of nearly $26,000 per person. Advance directives greatly increase the chance that people receive the care they want, which often avoids unwanted excessive or intensive care – thereby lowering health care costs.

*How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
Awareness training, preparation of ACP kits, and certification of Respecting Choices Facilitators could take place within a 6-month period. However, a significant increase in advance directives doesn't happen quickly, so ongoing efforts are needed to have a meaningful and enduring impact.

**Project Metrics**

While the Washington State Common Measure Set on Health Care Quality and Cost does not include any measures specific to advance care planning or end of life care, such measures could easily be included in several key sections. Most notable are Ensuring Appropriate Care: Avoiding Overuse; Effective Hospital-Based Care; and Cost of Care.

Key process measures may include:

- The number of Medicaid members/providers who participate in ACP awareness training.

- The number of individuals who receive ACP Kits and/or introduction to similar materials online.
- The number of individuals trained in the Respecting Choices® First Steps program and certified as Facilitators.
- The number of individuals who meet with an ACP Facilitator for ACP discussion and completion of materials.
- The number of advance directives filed with health care providers/systems.
- The proportion of the population with a completed advance care directive.