



Webinar Transcript

DIGITAL ADVANCE CARE PLANNING

TRENDS, OPPORTUNITIES, AND MOVING INTO THE FUTURE

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DIGITAL ADVANCE CARE PLANNING: TRENDS, OPPORTUNITIES, AND MOVING INTO THE FUTURE

JENNIFER BOCCHIERI: Welcome, everyone. *Five Wishes* is pleased to present today's Practice Community webinar, *Digital Advance Care Planning: Trends, Opportunities, and Moving into the Future*. My name is Jennifer, and it's my pleasure to introduce today's webinar. We are recording the call, and we did mute all participant audio. This presentation will last up to 60 minutes, and you are encouraged to ask questions throughout. Simply click on the Q&A button at the bottom of your screen. A separate box will open, where you can then type in your questions.

It's now my pleasure to welcome Joanne Eason, President of Five Wishes. Hi, Joanne.

JOANNE EASON: Hi Jennifer, and thank you so much. And thank you all for joining us today for our 12th *Five Wishes* Practice Community. Our goal with the Practice Community is to assist all of you who do the work of advance care planning every day to have truly meaningful and effective conversations with the people that you serve. We do that through our program resources of course, but also through highlighting innovations, best practices, and some of the preeminent thought leaders in our industry.

When *Five Wishes* was developed 25 years ago, it was designed to make discussing and documenting health care wishes easier for people. As technologies changed, so too have changed the options that individuals

and providers have in accessing these documents and conversations.

And you know, Covid has certainly pushed our industry to the forefront regarding how important advance care planning is to folks, and brought to light some of the issues about ease of accessing this information when it's needed most.

So you know, our friends in the tech space have made great strides in making care decision documentation and discussions easier for individuals and providers. That's why we wanted to share with you what's going on and what's coming to the forefront of ACP tech by hosting some of our preeminent leaders within the industry and our friends and partners.

So, we are so grateful to them for joining us today, and I hope that you enjoy the program.

So, I'd like to also now introduce Kathleen Taylor, who will facilitate today's program. Kathleen serves as the *Five Wishes* Healthcare Program Director, and has extensive experience in hospice and palliative care-focused advance care planning, patient care, as well as program design. Kathleen, thank you for facilitating today's discussion.

KATHLEEN TAYLOR: Thanks Joanne. And thanks Jennifer, and thank you everybody who's on the call. I'm going to get right into it and introduce our expert conversation panelists for the day, so if all of you can turn

your video on, we will be able to look at your faces as I introduce you each.

Maria Moen

Maria is Senior Vice President, Innovation and External Affairs of ADVault, a digital advance care planning solution suite, enabling consumers and providers to create, upload and manage advance care plans. Maria has over 25 years experience in long term post-acute care leadership, and has served on numerous boards and workgroups focused on innovation in advance care planning. She has been recognized as an interoperability hero by DirectTrust, a nonprofit healthcare industry alliance supporting secure, identity-verified electronic exchanges of PHI (Protected Health Information), and she currently leads the Health Level Seven project, creating implementation guides for data exchange and access [to] advance directives and portable medical orders, using Fast Healthcare Interoperability Resources.

You can learn more about Maria and ADVault at advaultinc.com.

Ryan Van Wert, MD

Ryan is co-founder and Chief Executive Officer of Vynca Health, a serious illness management company that leverages technology, analytics and physician-led palliative care teams, helping healthcare organizations to manage their most vulnerable populations in their homes. In addition to his role at Vynca, Ryan is a part-time clinical assistant professor at Stanford University, where he maintains a small clinical practice.

You can learn more about Ryan and Vynca Health at vyncahealth.com

Arul Thangavel, MD

Arul is Chief Executive Officer of WiserCare, a personalized decision-making platform that combines patient preferences and goals with key clinical information to support and automate smarter choices in less time. Arul is a practicing internal medicine physician with extensive research, quality improvement, and clinical experience. He has been an assistant professor of medicine at Georgetown, a Foreign Affairs Officer at the U.S. Department of State, author of multiple peer-reviewed publications, book chapters, and newspaper articles.

You can learn more about Arul and WiserCare at wisercare.com.

Joanne Eason, MA

Joanne is the President of *Five Wishes*. Since 2014, she has strategically focused the Five Wishes program on creating unique new tools and resources, and building scalable programs to meet unique and specific advance care planning needs within organizations and communities. With more than 30 years of experience in healthcare and insurance communications, marketing, and relationship development, Joanne leads the program with a special emphasis on partner relations and collaboration, as well as insight into organizational decision-making.

Kathleen Taylor, MA, LMHC

Kathleen serves as the *Five Wishes* Healthcare Programs Director. She has nearly 30 years of healthcare experience with specific focus in advance care planning, palliative care, and end-of-life care. In her roles as a hospice

clinician, program director, clinical trainer, and community engagement professional, she has fostered clear communication within families, care teams, and communities. Kathleen is a Florida Licensed Mental Health Counselor and Qualified Clinical Supervisor, and a Certified EQ-i 2 Emotional Intelligence coach.

KATHLEEN TAYLOR: Thank you all again for being with us today, and for helping us walk through the topic of digital advance care planning.

And to start us off, I just want to acknowledge what I think everybody who's on the webinar today knows: Before the pandemic, we already felt the move to digital health beginning. Providers were required to use electronic medical records, and healthcare consumers — or patients — were starting to interact with portals, with kiosks, apps, electronic forms. And then the pandemic came, and digital technology became a necessity to provide care, rather than something that we were phasing in through all these programs that...we were getting to all these different percentages of use and then all of a sudden it was like: Look, if you want to do care, you have to be using digital solutions. And even people who said they would never embrace it were conducting virtual visits and filling out electronic healthcare forms.

So now, conducting advance care planning visits over virtual and digital channels is much more common. So what I want to lead off with today is: Given how all of that has recently happened, where are we today? What do you think is the state of the union of digital advance care planning, and where do you see this heading in the next — I'm not going to be a five-year-out person

anymore — let's say one to three years — where do you see us now, and where do you see us going? And anyone can start this off who'd like to.

ARUL THANGAVEL: Kathleen, I can start off with some thoughts. So, I think you summarized it really well. The pandemic allowed us to take the conversation, which is critically important in advance care planning, and move it into a digital sphere, which is again super important, so it doesn't need to be in the four clinic walls, it can now be digitized. And while that conversation can now be digitized, there are still some barriers that we see around the other components of advance care planning that are necessary to really drive some of the process.

So for example, systems sometimes track their document completion rates. And while documents are necessary, they're not sufficient to drive advance care planning program success. Documents are still a key measurable statistic.

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And there, some things, like witnessing, for example, have different legal frameworks state by state. So in Illinois, you have remote asynchronous witnessing available, which makes witnessing super simple. But even next door in Indiana the witnessing requirements are quite different. They can be remote, but they need to be synchronous, which means you have to get everybody on a Zoom call like this in order to get your advance care plan straightened out.

So there are definitely some barriers to document completion...but there are fewer barriers to digitizing the conversation and bringing that conversation into more of a digital age.

MARIA MOEN: And Kathleen, looking at it from the standards perspective that I hold, and all of these years in healthcare, you know our healthcare records are becoming increasingly digitized. And as patients move through the healthcare ecosystem, their electronic health data has to be available and discoverable and understandable further to support automated clinical decision support and some of the other machine-base processing that are becoming the norm in today's healthcare settings. And the data has to be structured and standardized. So, what we see as growth and the availability of new health data, along with this progressing app economy, right, everybody's got their phone, they've got their apps. And it creates a need for clinicians and consumers to share the data in a lightweight real time fashion using these modern internet technologies and standards.

I think there's an expectation on the part of the patients — we've all been a patient at one time or another — and on the part of providers, there is an expectation that

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RYAN VAN WERT: I would agree. I think the biggest tailwind we have is that I think there has just been a general progression in terms of how healthcare standards are being developed around interoperability, and the fact that it is just a standard of care now that we're using digital tools as simple as an electronic health record or any of the other ways that we can digitally engage and provide excellent health care and engage individuals in their own health care, is the biggest tailwind that advance care planning has. Advance care planning happens to be operationally complex. We're all aware of the nature of the conversation, and ways that we need to ensure that there's a standard process for high-quality dialogue, a standard way of sharing this information, and so on. But it really is part of the larger trend of healthcare, I think it's the job of everyone on this webinar, everyone participating, to be a part of making sure that something like advance care planning is

incorporated into those tailwinds in the best possible way.

KATHLEEN TAYLOR: I think that's well-said by all of you. And also I think you just provided a beautiful outline for everything I think we can talk about for the next hour or so, thank you so much for that!

One of the things that's coming next, and you talked about, is this just being really institutionalized into some of the care models — speaking of those care models, I want to carve out a little time to talk about value-based care models specifically, because we know that that's coming, and one of the things all of us in health care can see is a more complete changeover to value-base care programs and models, which — just so everyone's on the same page listening — incentivize providers for providing high quality and high value, as opposed to low value care, and they're designed to support the Triple Aim. So that's better care quality and experience for individuals, that's improving the health of populations, that's reducing the cost of health care per capita.

So, these models test out different ways, largely of providing those things, of delivering care, and paying for care, hoping again to increase those things that we want to increase. One of the things I'm excited about, and I really want everyone to pay attention to this so we can get it right, is

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"...getting it right is not just memorializing the results of a conversation on a document that is trapped inside your walled garden of an electronic medical record — but it is liberating that data so that it is available when seconds count and minutes matter. And the study reveals that when it's done right, you can save an average of \$9,500 per person in the last year of life. The multipliers on that are staggering."

that advance care planning is named as a requirement for a lot of these value-based payment models that are coming out, and I think will continue to be, for the ones that we are about to see emerge, because I think they're going to do the test runs of these and we're going to see that it works.

So, how can we help the people listening today to think about digital advance care planning as a way to meet the requirements for participation in these new models, so the requirements don't frighten them but they feel like they can walk into that prepared? And again, anyone who's burning can go ahead and start with this.

MARIA MOEN: I think there's a study out there that is recently published that talks about when you get ACP right — and getting it right is not just memorializing the results of a conversation on a document that is trapped inside your walled garden of an electronic medical record — but it is liberating that data so that it is available when seconds count and minutes matter. And the study reveals that when it's done

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right, you can save an average of \$9,500 per person in the last year of life. The multipliers on that are staggering.

So how do you know you are creating those cost savings if you are a group of providers who have created an ACO, you know, you're measuring above the line, you're measuring below the line? But really triangulating the impact of ACP upon that high-cost end-of-life, it is realized through that high-quality ACP. When the cost curve is dropped and those end-of-life documents are available, nobody wants to pay for unwanted, futile overtreatment, but they do want to honor the wishes of the individual.

So I go back to accessibility — not just storing it, but making it available. And then the willingness of the care team community to refer those documents to inform care, to walk away from some of the cookie-cut mechanisms that exist in all of our EMRs, and to really embrace with an open spirit the insertion of patient-centered goals and intervention preferences so as to inform that care.

That's sort of my two cents worth. If you're doing what people don't want, then your quality is going to be decreased, your costs are going to increase. If you are goal-concordant in your care delivery, everything

becomes meaningful, profitable, and of high quality.

KATHLEEN TAYLOR: I love that. Do you happen to have an inkling as to who conducted that study, in case people look that up?

MARIA MOEN: I do, and Kathleen I'd be happy to share that link with you at the conclusion of this webinar so you can post it with the materials, it would be my pleasure.

KATHLEEN TAYLOR: We'll do that, thank you.

ARUL THANGAVEL: Kathleen [and] Maria, I totally agree, that study is very fascinating, and actually replicates data from the past showing about a \$10,000 benefit when high-quality advance care planning is done in that last year of life. That was done in an ACO setting. But I think the really interesting wrinkle here is that that intervention focused on *high-quality conversations* — that was the intervention, right? That advance care plan was delivered to a primary care doctor who was part of a primary care-based ACO, but variably transmitted if at all to hospital systems and specialists.

So what that tells me is that if you can do ACP conversations in a high-quality way,

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you can start to achieve this benefit of goal-concordant care. Now, interoperability is critically important and can actually help take that kernel of benefit and transmit it to others. But it's still that conversation aligning patients, family members, and primary care teams on what goal-concordant care means for an individual. That's what really moves the needle.

And the other really interesting part here is that in the study that this study replicated, a study out of OSF where they took their ACO patients and put them through a high-quality ACP process, they found a reduction in cost in the last year of life, primarily due to reduced ER visits and hospitalizations in that last year of life — not due to the decrease in ICU days in that last month of life, which we all as clinicians kind of go to as the kind of standard in our mind where costs might be reduced.

So what that actually means is that ACP started early in a phased way, maybe even when you're healthy, can start to lead to capturing that benefit of ACP in the last year of life.

So to your original question, how do you start to build digital ACP programs to support value-based care: You gotta start early, with healthy members, healthy populations, you have to start where the incentives are aligned, like in an ACO or in a primary-care-first model, or perhaps if you are a pay-vider and in a plan context with VBID, but ultimately it's that conversation that you gotta focus on, and especially getting that conversation done in the right way at the right time with the right resource. You can't expend your valuable physician resources that are becoming increasingly scarce for helping individuals who need advance care planning done in some basic

way. You have to be able to support that digitally, and then in a stairstepped way engage all the rest of the members of your care team to ultimately getting that benefit for advance care planning in the last year of life.

RYAN VAN WERT: I think one of the things to emphasize is that when these measures are top of mind as part of a value-based model, that there is a big opportunity around measurement and reporting and iteration. And we know that this is — especially if you're talking about a large health system, you know, an ACO where you're dealing with multiple different practices typically that are coming into that ACO — that it's complicated to get this done right. And I think one of the nice things that a digital process can do is, first of all, help with that standardization, help with giving

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But I think more importantly, it allows you to see where there are pockets that are succeeding and where there are pockets that are not succeeding, and to go to those pockets that are succeeding and say, "What are you doing that's making this work in your clinic, and how can we take those best practices and learnings and apply them more broadly?"

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But I think more importantly, it allows you to see where there are pockets that are succeeding and where there are pockets that are not succeeding, and to go to those pockets that are succeeding and say, “What are you doing that’s making this work in your clinic, and how can we take those best practices and learnings and apply them more broadly?” And where they’re not working, to go in and, again, just understand what the needs, the gaps, the barriers are. And regardless of what system you’re using, these are reports that you can generate relatively easily to support that continuous quality improvement work as you’re attempting to scale a program across an organization.

MARIA MOEN: Ryan, I think that was really, really well stated. You know, one of the observations that we’ve looked at and — when we do interoperability standards we’ve typically got CMS or NQF at our shoulder wanting to measure. And so depending on the kind of organization you are, if you’re a value-based payment organization, then you’re driven towards that quality and lowering those costs because you’ve done things the right way. So maybe time isn’t as important to you as the end result.

And when you’ve got the “right” right — if you can measure it, you can manage it. When you have a particular resource... You know, let’s look at some of this exciting legislation about social workers being able to bill for services. They have an innate ability to tease the essence of an individual out of them in a very painless, frictionless way. If it takes them twice as long to get to the desired end result than it does a PA or an

MP — I’m not saying it does, I’m just saying “if” — then you have to look at who you are as an organization. If you’re a fee-for-service organization, speed may be of the essence. And we’re certainly going to get to the right end result with tremendous training programs like *Five Wishes*, you know, *Respecting Choices*, *Honoring Choices* at a community level, all of the organizations that are just part of the rising tide.

But I think you’re spot on. If you’re value based, maybe it’s a better end result for your organization to spend a little more time, to increase that engagement, that feeling of satisfaction. So you’re right, the metrics are where it’s at, and no two metrics work the same across multiple verticals. So I think you’re just spot on with that observation.

KATHLEEN TAYLOR: This conversation is — I’m thinking of so many actual examples of conversations that we’ve had recently about measures, and I want to take it up a little bit into a helicopter, just so that I can actually help the people that I’m thinking of, and the people like them. Most clinicians and clinical leaders understand the value of advance care planning. They’ve experienced it and they’ll tell you stories about how meaningful it is and has been with actual patients. But determining the return on investment — and somebody just asked a question about ROI — determining the return on investment for the time, the education, the tools and the resources that empower clinicians to have high-quality advance care planning conversations — and you mentioned that Arul, and I want to come back to that in a little bit — but to empower our clinicians to have high-quality conversations requires leaders to identify meaningful measures.

There’s a lot of — that’s something that has been a decades-long challenge for people

around advance care planning. There's a lot of measures of documents completed, we got excited when people would start to measure conversations rather than documents, but still, this is very low hanging fruit. And I think it becomes overwhelming for people to think through "How do I just make a case for investing in one of these solutions, or investing in some *Five Wishes* resources or something?" They get overwhelmed.

So without producing a crosswalk for what kind of organization are you, what are some tips that we can give people about thinking through the things that you can measure to get to the point of introducing some digital advance care planning solutions?

RYAN VAN WERT: I think it really comes down to understanding what the organization's priorities are, and then figuring out how advance care planning can support success in those models. I think we have to take off our clinician hats for a moment and put on the hat of somebody that has got organizational responsibility, who is accountable for delivering on either strategic priorities or priorities that are related to success in a value-based model or otherwise, and understand what they are. And when we think about that, I think about it in a few different buckets: you know, the

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measure itself, if it's a model in which that measure is being counted, and then look at it in some of the other ways that I think we all understand and we've spoken about here around the benefits of advance care planning, whether it's around a patient or member satisfaction impact, whether it's around a healthcare utilization avoidance impact, or otherwise.

And I think the challenge that people get into is around attribution, which is to say that, well, how do we know that advance care planning actually had an impact on this, and it wasn't...this program or that program, or this intervention. And that is a complicated question to answer, but I do think that there are some ways that these are knowable facts. I mean, we've done some work with some of our partners where we've tried to control for as many of those things as we can, and really come down to look at, well, what was the impact on, say, the hospitalizations in the last 30 or 60 days of life when we control for as many of the factors in the group that had an advance care planning process done versus the group that did not have an advance care planning process done.

And I think we've all shared examples even today of — we know the process works. So I think you can build a business case around saying there is enough data to show that there is an impact, but it really comes down to understanding what those strategic priorities are and using the data to support them.

ARUL THANGAVEL: Ryan, we do something similar. So in our approach we help educate our customers as to how to best present the benefits of advance care planning up the chain in their leadership. So that's critically important. But then the question quickly

comes to, “How do I actually get this done? How do I stand up an ACP program in a cost-effective, scalable way?” And that’s where a multi-pronged approach we found to be effective. So engaging patients in self-service advance care planning, in addition to facilitated conversations, and even, where needed, outsourced conversations. All three of these can be factors that can help you drive towards the type of numbers you need in order to demonstrate the value — the return on investment — that you need to to the stakeholders.

One thing that is interesting there, that we find to be a pretty compelling statement in this day and age, where Covid subsidies are coming off the health systems, and we’re all going to be living in this revenue-hungry environment as a health system. The idea that an ACP system, or an ACP program, can be more efficient and effective while leveraging a digital platform is really impactful for a healthcare system.

So for the cost of an FTE you get 30% or 40% increase in efficiency and productivity of your existing ACP workforce. That functions really well for a system that already is concentrated on advance care planning and wants to maintain or scale their program in an era of financial austerity.

On the other hand, finding really cost-effective ways for organizations to do advance care planning without necessarily outlying any of their own resources has been something that we’ve been really strongly focused on.

So kind of meeting your customer where they are in supporting either building an ACP program or making an existing ACP program more efficient has been our approach.

MARIA MOEN: And I think ROI — there’s two ways of looking at ROI. There’s hard ROI, which your CFO would like very much if you would deliver that to them, please. And then there’s the soft ROI, which is harder to measure and nonetheless it can be tangible. When you’ve got an organization that is fully engaged in the conversation, in the process, they want to know about you. They want to deliver goal-concordant care. And it is clear in their approach. You know, if you’re a hospice organization, there are eight CAHPS measures, and six out of the eight have to do with how well you engaged that individual according to the family or the people that are their village.

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You look at skilled nursing facilities, their all about readmission penalties, and so they want to have those hospital transfer partners, and so what's the ROI? If you can quantify even a 2.7% reduction in avoidable hospitalizations through advance care planning protocols, you can start to come into those figures.

The same thing works in home health. Home health is a referral-based type entity, and there's 22 to choose from in my geography right here — who am I going to go to? The ones that people said they delivered fabulous care, but what really matters is, they cared about me. And so to me, the ROI, again, veers away from the start-completion of the document to what you did with it once it was completed. Did I engage you? Did I make sure that those you who wanted me to share it with had a copy so they felt included in the journey? Did I liberate that document so that, you know, if I was transferred to a local hospital, they could say, whoa hold on...we've got selective treatment interventions, there's a medical history here that I can't get as quick as I can get the ACP information and so, you know, we need to step out of our standard protocols and we need to deliver that personalized care. EMS — was I able to stop EMS even though they were called and did they understand that comfort measures had to be rendered? Some of those soft ROI turns into increased census, turns into increased referral.

So to Ryan and Arul's point, you have to kind of know your audience when you're asked the question. But I think it's incumbent on us as service providers to understand those sectors of the industry that we serve, and make sure that those tools meet those unique needs of that sector.

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KATHLEEN TAYLOR: I think all of that resonates. There's a couple of things out of that that I want to flag and pull on. One is just, what are providers' perceived barriers to adopting digital advance care planning? I think we all hear different versions of them, but what are you hearing as the perceived barriers from the provider perspective? I want to talk about the patient perspective later, but let's start with the providers.

MARIA MOEN: It depends on whether you're talking about patient-authored documents, which — I'm personally very active in the patient advocacy world, and I'm Chairman of the Patient Empowerment Standards Committee — or whether you're talking about practitioner-authored, I think you have different barriers.

But it has been my experience that whether you're engaging with a patient who has already prepared their own documents and you're helping them to understand what it is that they've completed, or you're a provider who's introducing the concept and you're memorializing what they've done, that the person believes that there is an implied promise. That *I promise*, that if you will tear open your chest and you have these incredibly difficult scary conversations

with me, or if you will review what you documented at your kitchen table when everybody was asleep and you needed time to think, if you will review that with me, that these documents, these thoughts are going to be available to inform care.

And I think there are some barriers with broken promises. I think that we have trapped those documents and we've stored them and we've scanned them, or we've checked a box that says "Yeah, they have one — anyway, so how often are you cognitively intact and dizzy and all these other things..."

And I think that some of the barriers are in changing workflow. We're very very very good in healthcare at doing what we know works. And we do the things that we've always done because they're best practice, because they're high-quality standard, but I think that we have to look at workflow as a barrier sometimes. And we have to embrace innovation and looking at different ways of doing things. If you're asking the question now, are you taking two more steps to collect the document to make it available to talk about it during care conference, and to make sure that it's an intractable part of your care plan, or are you just kind of checking a box and going through the motions and [saying], "Yeah, they have one, and I can't find it, so let's just call 911"?

So I worry about broken promises as a barrier, and I think it's a big concern as a barrier.

ARUL THANGAVEL: My perspective is — going back to the question of what are the physician barriers — in my primary care practice, the biggest barrier is time. And it's time for two reasons. The first is that it requires a holistic look at a patient to really start to open the door to a high-quality advance care planning conversation. It's

relatively easy to look at their diabetes and see what needs to be escalated, or their hypertension, or their CKD. Those are little pearls that I can just work on. But to do advance care planning I need to kind of sweep aside all those things, consider them all in their aggregate, and then present them to the patient in a really comprehensive way. So that process takes at least one visit just to introduce the idea, and then multiple visits to walk through the ramifications of considering the entire clinical picture in its entirety.

Which gets back to time. You know, in my practice, we've had about a 30% primary care provider attrition rate, which I think is replicated across many, or much of the country. We're seeing this dearth of providers, while patients need even more services coming out of Covid.

So you know, I think anything can help that can decrease the amount of time and start to introduce the topic of advance care planning prior to that actual visit with a provider can really help open the door to generating high-quality conversations that ultimately can get you to the promise of goal-concordant care.

RYAN VAN WERT: Yeah, I agree. I think that a lot of these barriers are not technology-related, and technology is the way to solve a lot of them. And as Arul said, looking at some other ways that you can offload that — offload what is a very highly constructed clinical day to integrate advance care planning. I would say that some of the earlier conversations we had today around the signature requirements, witnessing requirements — all of those things have answers. They're all knowable, and I think all of us on this webinar today can support answers to those questions. And certainly

“...anything can help that can decrease the amount of time and start to introduce the topic of advance care planning prior to that actual visit with a provider can really help open the door to generating high-quality conversations that ultimately can get you to the promise of goal-concordant care.”

Five Wishes as well has done tremendous work in that regard.

So I don't think there are really barriers around the digital piece itself. It's more the other way around, how does this digital piece help us to really integrate this into our care processes.

KATHLEEN TAYLOR: I think that makes sense, and that takes us back a little bit to the piece about making the case for investing in solutions, and people struggling with that. And I want to — Maria, if you're o.k. starting us off with this one — I want to talk a little bit about care coordination and interoperability, because I think one of the things that often gets missed in people thinking about, “how do I make a case for investing in resources — digital advance care planning resources — or even having high-quality conversations?” when they get stuck there, it's often because they're thinking only of, like I was mentioning, that really low-hanging fruit, and what's not coming to mind are things that have to do with the ability to have insight into care coordination and to improve interoperability.

And again, just so all of us on the webinar are on the same page with that: Care

coordination ensures that all of the providers and specialists who are caring for a given patient — or John — have the same information and can communicate seamlessly with one another and they're therefore able to provide the right care in the right place at the right time. Interoperability makes that possible. That's the capacity for different information systems and platforms to access and exchange and integrate and use data in a coordinated and meaningful manner.

So first, does that sound right? And second, how can we help people think a little bit more forward into looking at that as some of the ROI on solutions like digital advance care planning, and just high-quality advance care planning conversations?

MARIA MOEN: Thanks, Kathleen. As you know, from some of the work that we did when we were getting to know each other before this webinar, I've spent a lot of time in the interoperability world. And prior to that, I have 25 years of working in the field for providers, helping providers install systems. And for a long time, I knew about interoperability, but it just wasn't top of mind, you know, and I'll just get what I get and I won't have a fit. And when somebody admits to my skilled nursing facility at 11:00 on a Friday night — because that's typically when they come — they're going to have a folder in their chest. And my nurse is going to flip through it quickly, and we're just going to go through and we're going to learn what we need to learn.

I think that, when you look at the opportunities that exist today, and — you know, FHIR — so, Fast Healthcare Interoperability Resources — it's been a push by the ONC. The ONC knows that when you can move information from System A to

System B, you are going to be enabled to a continuity of care delivery that is exactly what the health system wants to achieve. The physicians want to achieve it. Ryan wants it, Arul wants it. We all want it, you know, I want it for me.

So, interoperability is fast moving forward. There is a way of exchanging documents using CDA — and I'm not gonna throw a bunch of three-letter acronyms at you. And that's kind of a PDF summary of who you are as an individual. Well, there is a group with National POLST who just finished the standards work to enable — it's just coming on a ballot right now — to enable portable medical orders, the National POLST form, to move from System A to System B using this clinical document architecture. That's a huge move in the right direction.

I am working on the FHIR projects. We started with patient-authored data, so my advance directives, my personal advance care plan — of course *Five Wishes* was in the environmental scan, so you know, we have all of the data for digitizing that — and moving that with FHIR.

So what is FHIR, right? I was plenty ahead of people. You pick up your phone and you punch the LinkedIn button, and you see a LinkedIn page. That's made possible through an API. FHIR is a lightweight, streamlined, highly secure mechanism for moving data from Point A to Point B. All of that standards work is afoot, all of that work is coming. And so, there's a demand by the office of the National Coordinator that governs health IT, and says, "*You shall*, effective October 6th, stop with this funny information blocking. *You shall* make chart information available to your patients."

And sure, there are certain sectors that are affected by that mandate and certain sectors

that aren't, but when you're looking at ROI, isn't it true that the other referral and admission partners within your ecosystem, don't they want to see you as a high-value referral and transfer source? Will they send patients to you, whether they have been in the hospital and they're coming back for home health services, or they're coming back for skilled nursing or assisted living? Don't they want to work with the organizations that will provide them with the optimal amount of data to continue that continuity of care? Nobody wants to walk through a room full of broken glass with a bag over their head, which is what a lack of interoperability does. And we don't need sneakernet, we actually need interoperability. And I think that's emerging, Kathleen, and I think that it just provides a tremendous opportunity to change the face of health care as we know it. And I think patients — we deserve that, so I hope that answers your question.

KATHLEEN TAYLOR: I agree. Thank you. Anybody else with interoperability?

RYAN VAN WERT: We think a lot of interoperability as provider-to-provider, but I don't want it to be lost that there's interoperability between the individual and their surrogate decision-maker, and the rest of the individuals in their care circle. So I think about the advance care planning accessibility issue as almost that Swiss cheese model of failure, where there's no one silver bullet to solving this problem. It is all about putting in as many ways to prevent a discordant care event from happening.

And I think that a lot of us who are clinicians and who have worked in emergency rooms and ICUs know that that surrogate decision maker is often accessible and is often present. And the challenge is not so much

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that they are not there, the challenge is that they haven't been informed, they haven't been involved around the dialogues around the particular preferences of the individual. And so, it's not the silver bullet in itself, but it's an important aspect of interoperability, and another way that advance care planning can make sure that everyone that an individual wants to be in the loop is in the loop around sharing their care preferences.

KATHLEEN TAYLOR: Yeah, that makes sense. And I like that you brought it back home to — what is at the center of all this is patients and their people. And I want to go back to — you know, I put a little flag in my brain — when we talked about high-quality conversations, I want to go back there, because I think it's really important that we get to that on this webinar.

Let's — I think we can all of us agree that value-based care, whether that's with the capital VBC or just when we're talking about high-quality valuable care, can only happen when we understand a patient's goals and priorities, and that inviting some discussion about that and skillful eliciting and clarifying, and hopefully documenting a person's goals and priorities — that is the intervention of high-quality advance care planning. And hopefully that's the kind of patient-informed choices and shared decision-making that we want to be doing in all of healthcare. But that's really the intervention of advance care planning.

I think all of us are advocates for not just advance care planning — not the checkbox — but the high-quality conversations. And there's a question that came in about: Physicians can't really spend hours with patients, and how do we do high-quality conversations in a way where we can hand them off if we need to, or have them not take that much time? I just want to assert before I throw it all to you, it has not been my experience that a high-quality advance care planning conversation requires more time than a low-quality advance care planning conversation. And I say that as a person who has facilitated hundreds of them. That has not been my experience. My experience has been that it relies on the skill, the comfort level of the facilitator; it depends on you assessing someone's readiness to enter into that conversation. It doesn't have to take more time when it's done well and when we have tools and when we have skills to conduct the conversation.

So, I'm going to throw that all to you. How do we, first of all — specific to digital advance care planning — how can that help ensure high-quality conversations? And

second of all, just what do want to say about what those should include in them, and the time-barrier perception that I'm hoping we can just bust today?

ARUL THANGAVEL: Kathleen, I can start. So when we think about high-quality advance care planning, it all focuses on that conversation. And in order to get — I totally agree with you, a low-quality advance care planning conversation can take even more time than a high-quality advance care planning conversation because you're spending a lot of time defining terms, and the terms of engagement to the advance care planning conversation before even getting into the meat of the topic.

So I think the first step is to prepare patients and their surrogate decision makers and their non-decision making family members as to what advance care planning means and what it can mean for you. When then kind of begs the question of what digital advance care planning is, right?

“...a lot of the advance care planning work has been shifted to physicians primarily because physicians are the folks who can bill for advance care planning, right? ...the first thing you need to do to get to high-quality advance care planning that doesn't take up all of your provider's time is allow patients a way to really engage deeply and meaningfully in the process aside from clinicians, and really use clinicians as a resource.”

And we've talked a lot, for example on the interoperability side, when you have a POLST document, interoperability is key, right? An EMS provider needs to know whether or not to resuscitate somebody. But it's not necessarily — an EMS provider may not necessarily understand how to absorb a health care decision maker document along with a value statement that helps that health care decision maker make decisions.

So when we think about digital advance care planning and making it as valuable as possible, we've got to think about what the outputs are, and are those outputs really geared towards changing ongoing care, is it really at the end of life when those very intense treatment decisions are happening, or is it something else entirely?

And the other thing that I'd say, in terms of the time component, a lot of the advance care planning work has been shifted to physicians primarily because physicians are the folks who can bill for advance care planning, right? And so, as was mentioned earlier, we hope that social workers will be able to bill for this, we hope the incident-to rules will change, allowing other care team members to start to participate in this process, but the first thing you need to do to get to high-quality advance care planning that doesn't take up all of your provider's time is allow patients a way to really engage deeply and meaningfully in the process aside from clinicians, and really use clinicians as a resource that is almost like a referral resource.

I have a very specific question as to what this means: What does comfort care mean in the case of irreversible brain injury, what does that mean? And once you can utilize clinicians for that and not, you know, where

do I put the address on the form, that then ends up becoming a more scalable program.

You could also do very interesting things. Like for example, engage a patient in digital advance care planning around healthcare surrogate naming and value solicitation prior to an annual wellness visit, have a care coordinator start to do more advance care planning for the patient, actually bill incident-to the clinician if they're in the same physical space, and then ultimately hand the patient to the clinician with effectively a completed advance care planning process with perhaps one or two questions that that physician can answer.

So I think, you know, just to summarize, I think patient engagement, deep patient engagement, is critical and key, and the other component is utilizing the scarce resources that we have in the healthcare system as intelligently as we can to try to get to that goal.

MARIA MOEN: Yeah, and I think the time issue as well... When I look at some of the work that we're doing with some large EMR vendors in the standards space... You know, being able to take that discrete data and have that discrete data fire off clinical decision support in your EMR... Right, so I've got this document and it contains decisions. When the answer to a question can actually appear within the banner or deliver certain clinical alerts based on procedures and treatments that are about to be delivered, all of a sudden, you know, we've realized that it wasn't a process of how much time did it take to do all of this. It is, throughout the ecosystem, how much time did it really save as we got down the line?

And I think that's where, you know, technology solution providers like the three of us — that's where our greatest

opportunity lies. When you can literally extract those discrete data elements and I don't have to look up the address and look up all the other information off of their health care agent designee because it's in my EMR, I already know who their contacts are, and it floods into the document. That's time spent, that's an efficiency, that's a resource labor utilization that you've decreased. And then, when your EHR is able to flex and literally respond to the discrete data that is flooding into it, that's a time saver, that is a risk mitigation strategy.

So I think when you're talking to providers, you, again, step outside of where you are now, look at ways of reworking your workflow — not adding time, but working smart — and how does it impact you? And we talked about advance care planning being done downstream, how does it help you as a provider upstream? So I think that there are various ways you can measure efficiency.

KATHLEEN TAYLOR: That makes sense. Anything else on that before we move to something else?

The something else I want to get to real quick is patient engagement, because for us at *Five Wishes* it's one of the top questions that we get. We get it in particular with digital advance care planning, with people asking us how do we generate higher engagement of our patients with...the advance care planning is in the portal or somewhere else and they have...usually, you know, if we're putting a lot of enthusiasm behind it we could say 40% of their patients are interacting with the portal anyway. So we get the question a lot, "How do we engage our patients more?" I want y'all to answer the question. I also want to say you

don't do it just through pushing a digital version.

Arul, you hit on it in one of your comments a moment ago, patient education is a key to this. It's a key to high-quality conversations, first of all because you want patients and families prepared to ask you the right questions, and also prepared to understand, what is the thing you're sending me on the portal? It's difficult to get someone engaged with something when they don't understand before they receive it what that is. So that's my two cents, but I want all of you to pitch in and let's see what we can help people with about how we can better engage people, I think not just in digital advance care planning, but in advance care planning in general?

RYAN VAN WERT: You know, I think we can look at it in a few different ways, but the question we all have to ask ourselves is, what's going to make this the most important thing on this Tuesday for this person to do? So again, looking at that individual, what's important to them, how do you craft messaging that reflects that, that makes the individual want to engage? I think [that's] the most important thing. Because regardless if it's a clinician-initiated activity, whether it's a portal interaction, whether it's outbound messaging, digital or paper-based, that invites the individual to go through advance care planning, it's really about the "why." And there's a variety of different ways that that "why" can be articulated. It depends on populations, it depends on unique local healthcare circumstances and otherwise, but that messaging can be crafted, and you can measure it, and you can iterate on it, and you can improve that messaging and engagement.

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I think the second thing is, going back to a few of the themes of the conversation today, which is meeting the individual where they are. And some people are going to want to engage fully digitally, some people are going to need the "phone a friend" option, some people are going to need a direct outreach to them to engage, to be invited to engage into this directly.

There's a few different ways that some of our partners have done that, from using the highest level of analytics type frameworks to customize that outreach based on level of illness and other factors, or looking at how this could be more ingrained into clinical workflow so that, there's that pre-step in advance of an annual wellness visit or something like that as the case may be.

But I think that's the — that really is the most important message, is to really understand the "why," and understand that there's not going to be one solution for everybody, and it's all about understanding the individual you need to engage to be successful.

ARUL THANGAVEL: You're right, agree. I think that it's critical to develop messaging that's specific to develop messaging that's specific to individual patient cohorts, and that's been shown over and over again to be a critically important part of engagement. But I think the other — just zooming out — I think the really important thing to think about is that advance care planning will require multiple approaches to really cover the entire population.

So we've seen, for example in my organization Wisercare, we've seen incredible uptake for some patient cohorts in the self-completion route via the patient portal. That's great for digitally native individuals who are motivated to do advance care planning. But that needs to be paired with other methods of digital ACP engagement, and even non-digital ACP engagement.

So for example, we see incredible uptake when a provider endorses advance care planning as a process that needs to get done. In that case we have about 70% of individuals who actually go on to complete the digital process, and speak with their physician about advance care planning.

In tandem to that, there are other processes at the community based level that you could even employ to start to get advance care planning interest in a non-health system context to contribute to the health system itself. So I think that advance care planning — digital advance care planning — requires a multi-pronged approach to really get

to the right — to cover as much of the population as possible.

And along with that, you need a multi-level approach. So, not every individual is going to be ready to discuss CPR preferences at the initiation of advance care planning. Some folks might just be interested in discussing health care surrogacy and goals of care in severe brain injury. And this is where we work with our partner Respecting Choices in developing appropriate stepped materials for systems to deploy so they can meet their population where they are at the right time. This kind of goes along with the messaging, but it's about the content of what we deliver.

And finally, I'll just mention one really interesting implementation that we had, because it might be of interest to the folks on the call. We had a healthcare system that's deeply involved in advance care planning that wanted to use their co-workers as the base by which they were going to proselytize advance care planning throughout the organization. So they started off their advance care planning program by getting co-workers to do advance care planning and measured how much more likely those co-workers were to do advance care planning with patients — and they saw remarkable increases there.

So it's kind of this generation of a viral effect for advance care planning that I find very fascinating. So in addition to a multi-channel approach, some creative approaches that engage in communities and co-workers might be critically important in getting — in covering your entire population with an advance care planning program.

KATHLEEN TAYLOR: Maria, any last thoughts on that?

MARIA MOEN: No, I think Ryan and Arul nailed it. You know, whether it's at a grassroots community, religious, spiritual, cultural level, or whether it's providers — I'm sorry if this term is a little bit gross — eating their own dog food, where you do one... I mean, that's the way you doctors learn, right? See one, do one, teach one. We all within the healthcare community need to have our own advance care plans. I think it helps to personalize your approach, and when we believe in it and we do it, then it's easier to evangelize, but I know we're out of time.

KATHLEEN TAYLOR: And the best way to teach people about conversation skills is, start with your own. This has been a wonderful conversation. I thank you all so much for your time and your energy and for sharing that with everyone who's been on the webinar, and everybody who will watch the archive. I'll remind everybody that, since all of you are *Five Wishes* users who are on

the webinar, we do work with all of the solutions that we've been talking about today. We have and we do and we will in the future, so if you have any questions about how your *Five Wishes* program can work with some of these, please let us know, and we can connect you with our speakers or anyone else.

And with that, I will say thank you for attending the program and I'll throw it back to Jennifer.

JENNIFER BOCCHIERI: Thank you. We did record the session, and we'll make the archive available within seven business days. You may access the recorded archive by visiting the Five Wishes Practice Community page at FiveWishes.org/Practice, just look under Webinars. And feel free to share that page and webinar link with your colleagues. We'll also be sending a follow-up email. So on behalf of *Five Wishes*, thank you to our speakers, and of course everyone, for joining. Have a wonderful day.

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This Five Wishes Practice Community Webinar was recorded live on September 20, 2022. To learn more about the Five Wishes Program for Healthcare or to participate in future live Webinars, please visit us at FiveWishes.org/Healthcare.

