

Advance Care Planning – Regional Solutions

It is imperative that national health care reform initiatives recognize, and be based upon, the value of informed discussions between patients and their health provider that focus on the patient's goals for care and guide the patient's treatment preferences for their last months and years of life. Further, once these tough conversations occur, it is essential that health care professionals follow these medical orders in an emergency. This is the essence of the "Orders for Life-Sustaining Treatment" Program. It is about honoring patient preferences for care and not about "Death Panels" or euthanasia. The [Community-wide End-of-life/Palliative Care Initiative](#) has made significant strides in addressing advance care planning consultations through:

1. Community Conversations on Compassionate Care (CCCC) Program

The [CCCC Program](#) is an award-winning program that combines storytelling with "Five Easy Steps" to promote conversations that help you complete your Health Care Proxy and Living Will. Healthy individuals learn why they should complete their advance directive through using a collection of [Advance Care Planning](#) resources on-line, reading the [Advance Care Planning booklet](#), or viewing an array of [Community Conversations on Compassionate Care videos](#) that illustrates stories from real patients and families and explains the Advance Care Planning process using the Five Easy Steps:

1. Learn about Advance Directives
2. Remove Barriers
3. Motivate Yourself
4. Complete Your Health Care Proxy and Living Will
 - Have Conversations with Your Family and Health Care Provider
 - Choose the Right Health Care Agent
 - Discuss Your Values, Beliefs and What is Important to You
 - Understand Life-Sustaining Treatment
 - Share Copies of Your Completed Advance Directives
5. Review and Update

2. Medical Orders for Life-Sustaining Treatment (MOLST) Program

The [Community-wide End-of-life/Palliative Care Initiative](#) developed the [Medical Orders for Life-Sustaining Treatment \(MOLST\) Program](#), New York State's Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program. Collaborators across New York are working on statewide implementation.

On July 9, 2008, Governor David A. Paterson signed into law a bill that helps to ensure a person's end-of-life wishes are followed whether the person is at home, in a nursing home or in any other non-hospital setting. The new law amends NYS public health law and permanently permits use of the MOLST form in the community throughout New York State. In signing the legislation, Governor Paterson said, "People should be allowed as much say in their end-of-life care as they would have at any other time. This bill will allow many people who are critically ill to make enduring decisions on the care they will receive. These will be difficult decisions for every person to make, but they should have the freedom to make them."

3. Physician Reimbursement for Advance Care Counseling

Currently, physicians do not receive adequate reimbursement for having thoughtful conversations on advance care planning. CMS, the major agency that oversees Medicare and Medicaid, only pays for face-to-face conversation with a patient and does not compensate for non-face-to-face time with family, surrogate decision-makers or patients who lack capacity, in the absence of face-to-face discussion. Key physician leaders are attending the ["Beyond the Health Care Proxy: Advance Care Planning for Patients with Serious Illness"](#) conference in November to learn how to get it right and get paid for having thoughtful advance care planning conversations with their patients with serious illness. This conference is presented and developed by the Unwarranted Clinical Variations in End-of-life Care Workgroup jointly led by the University of Rochester Medical Center and Excellus BlueCross BlueShield.

4. Overcoming Functional Health Illiteracy

Nationally there is a lack of consumer education, tools and resources provided or made available to patients and families on advance care planning. The [Community-wide End-of-life/Palliative Care Initiative](#) developed the [CompassionAndSupport.org](#) Web site in 2002 to educate the community on advance care planning, MOLST, palliative care, pain management and hospice care and related topics. Through the generous funding of the Medical Society of the State of New York and Excellus BlueCross BlueShield, the Web site was enhanced in 2007. A new section for [Professionals](#) was added and the section for [Patients and Families](#) was improved. Since the launch of the upgraded Web site, we have received 95,946 visits or hits with over 332,046 pages. Half of the visits are from New York State, with the remaining from the other states and 132 other countries.