Healthcare Directives Registry
Arizona
a contexture® solution.

Engaging patients in advance care planning conversations and the use of the Arizona Healthcare Directives Registry (AzHDR)

Goals for today

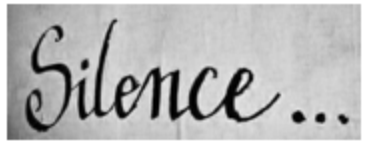
- Explore challenges related to advance care planning
- Trends in advance care planning
- Building out workflows to increase communication around advance care planning
- Complete your own advance directive and register it with the AzHDR
- Explore this topic with your colleagues
- Take the steps to become a subscriber (at no cost) to the AzHDR

If not **NOW**,
then
WHEN?
If not **ME**,
then **WHO**?

The Why behind Advance Directives

30-35% of Americans have an advance directive

70% prefer to die at home; 76% die in an institution



50% of patients are unable to participate in healthcare decisions when the time comes to make them

90% of people say talking with loved ones about their healthcare is important; only 27% have done so

Research published by the American Geriatrics Society in 2018 showed that 99% of physicians believe it is important to have end-of-life care conversations, yet only 29% report having formal training to equip them

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Disconnect between perceptions and reality of where patients are

89%

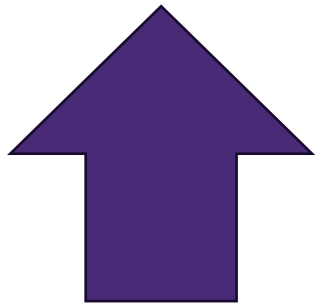
Are equally or more comfortable talking about death than average

75%

Say Medicare should cover end-of-life discussions

67%

Are most comfortable discussing their wishes with a doctor

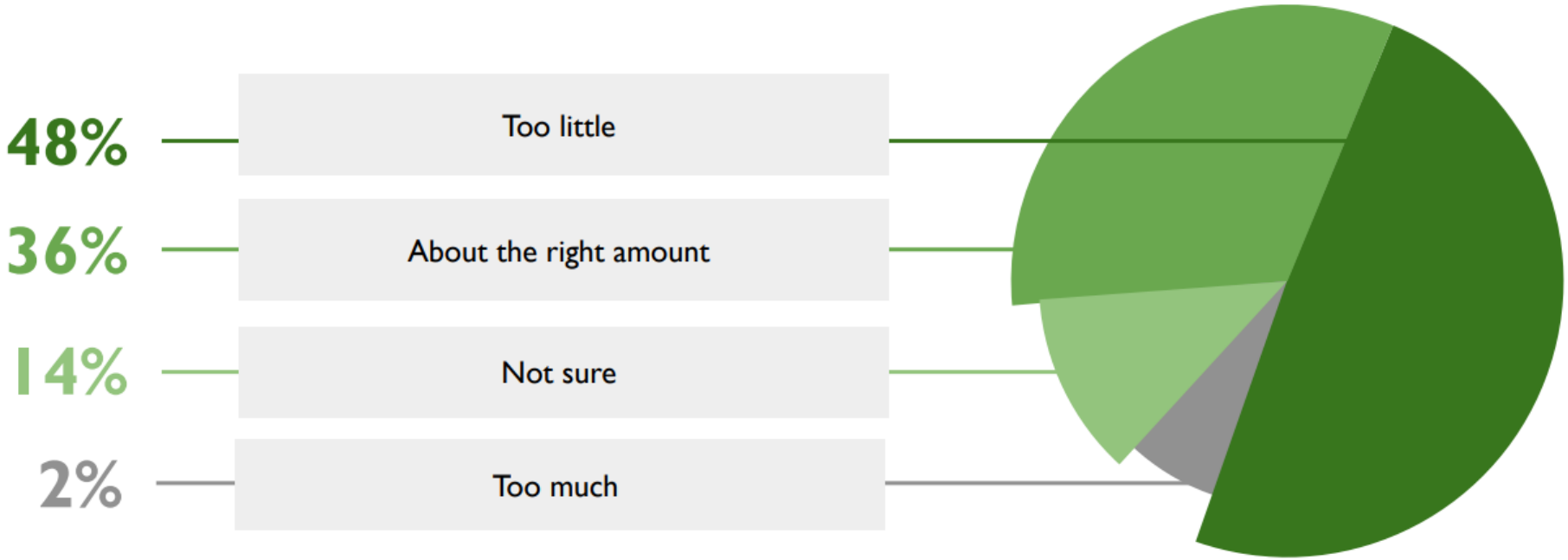


NPHI_Survey Report (hospiceinnovations.org) 2022

Opening the door to advance care planning conversations

Control over End-of-Life Decisions

Nearly half of respondents feel people in the US have too little control over decisions about their own medical care at the end of life.



NPHI Survey Report (hospiceinnovations.org)

The What – Advance Directive Documents

- The AzHDR will accept **healthcare directives** submitted in compliance with **Arizona Healthcare Directives Law** (ARS 36-2301-3287), including:
  - Living Will
  - Health Care Power of Attorney
  - Mental Health Care Power of Attorney
  - Prehospital Medical Care Directives (DNR/Orange Form)

- Additional focus on incorporating other documents into the registry that are part of the **advance care planning (ACP) continuum**, include but are not limited to the POLST, organ donation and HIPPA documents.

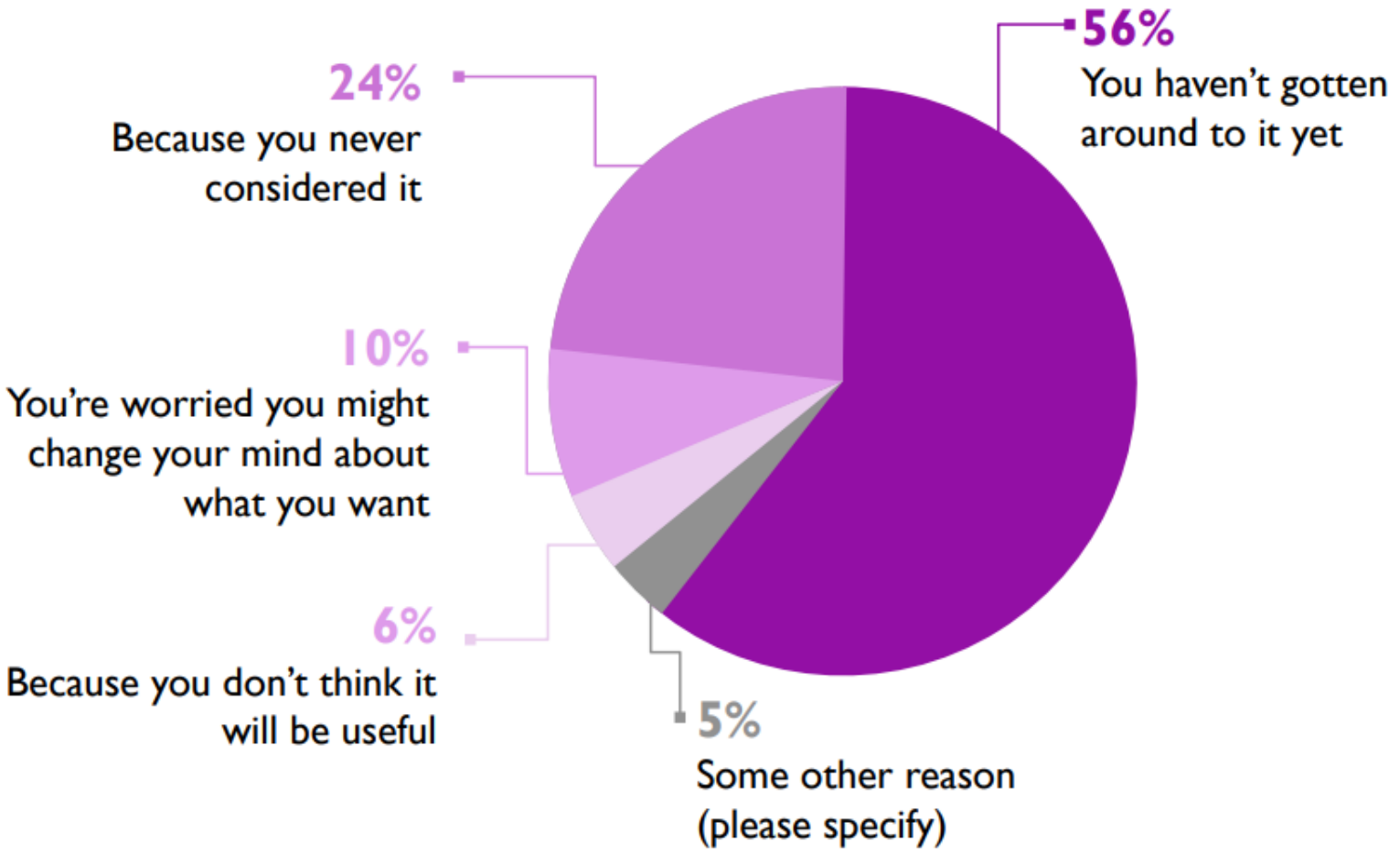
Offer forms that are reflective of your patients – language, culture, faith

Advance directives are documents of **choice** and not of limitation. Identifying these documents as such opens the landscape to a wider patient population, while enhancing health **equity**.

State Surrogacy/Next of Kin Statute

- Your spouse, unless legally separated
- Your adult child. If there is more than one adult child, a majority consent will take precedence
- Your parent
- Your domestic partner if no other person has assumed any financial responsibility for you
- Your brother or sister
- Your close friend

Why are Americans not completing advance directives



NPHI Survey Report (hospiceinnovations.org)

Barriers to advance care planning – Healthcare

The federal Patient Self-Determination Act of 1990 requires hospitals, nursing homes, and other facilities to provide information about advance directives to patients, regardless of age or diagnosis and to keep a record of any completed documents.

Despite this mandate, the implementation of these regulations, and the rate of advance directive completion has remained low.

Research over the last twenty years continues to identify similar themes by healthcare providers:

- Discomfort with the topic (another provider/specialty is better prepared for conversation)
- Lack of institutional support (more financial incentives may be needed)
- Lack of reimbursement (CMS does have a code but often is not utilized)
- Lack of time (opportunities exist to share the workflow with other departments or community teams)
- Waiting for the patient to initiate the discussion (see previous slide)

Overcoming barriers to increase health equity

Stage of ACP	Clinicians Reporting Difficulty…	Clinicians Overcoming Difficulty…
Initiation	Rely on preconceived notions regarding patients' willingness to participate in ACP	Reject stereotypes and assess individual preferences for engaging in ACP
Process	Feel anxious discussing ACP with structurally marginalized patients	Believe developing strategies for ACP with all patients is a professional duty and embrace anxiety in difficult conversations
Outcome	Seek to achieve specific documentation-based ACP outcomes	Value a range of of ACP outcomes, including conversations, documentation of preferences, completion of DNR forms, etc.

Note: ACP = advance care planning.

The Journals of Gerontology: Series A, Volume 77, Issue 2, February 2022, Pages 339-346 https://doi.org/10.1093/gerona/glab091

- Linguistics
- Ethnic and Culture Differences
- Underserved Communities
- Faith

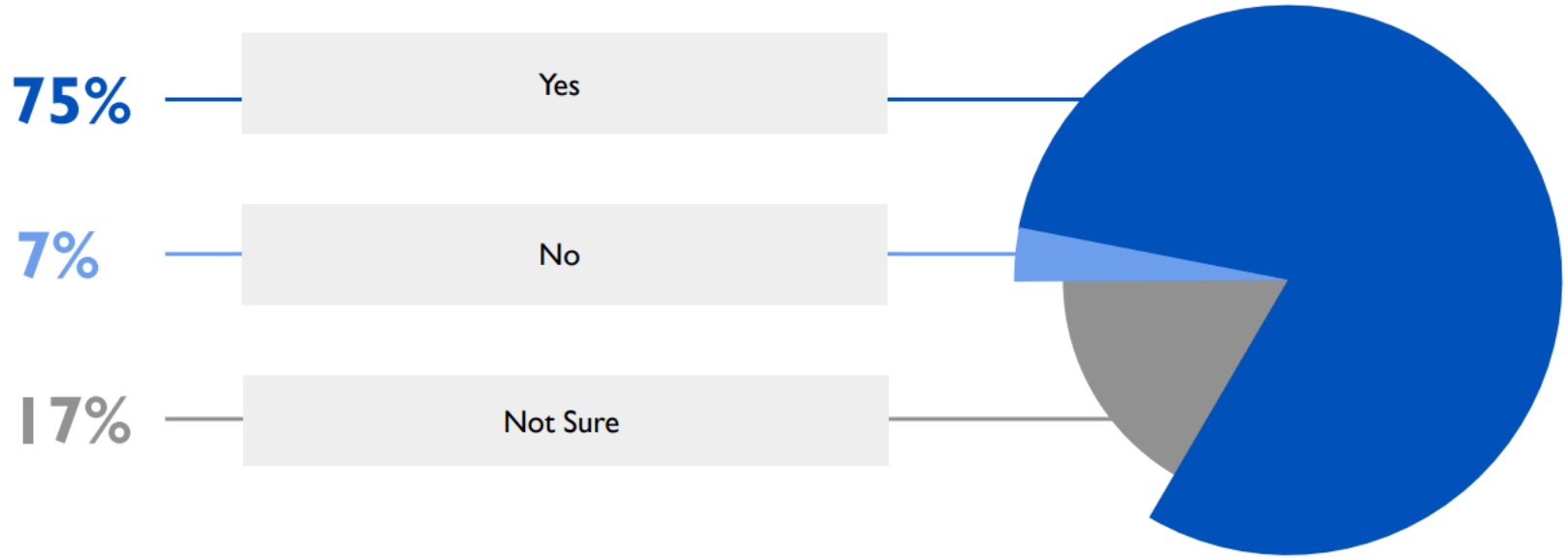
Missed Opportunities

“I am in need of an exigent Mental health power of attorney for my father who already has Alzheimer disease. His current medical power of attorney is not sufficient for inpatient care at a psychiatric hospital and is currently in a hospital emergency room with a psychiatric hold on him and cannot leave. He is in limbo until I can obtain this POA for mental health.”

Billing Advance Care Planning Conversations

Respondents want Medicare to cover end-of-life discussions

Three-quarters of respondents support coverage for doctor-patient conversations



[NPHI_Survey Report (hospiceinnovations.org)]

Healthcare worker: Do you have an advance directive document?

Patient: Yes/No

Healthcare worker: on to the next question

Are we asking this question to learn and educate or to check a box?

Recent Research

- **Tools for tomorrow: a scoping review of patient-facing tools for advance care planning- SAGE JOURNAL 6/24/24** Sean R. Riley et al
- Conclusion from Research “reveals an evolving landscape of ACP tools, marked by increasing diversity in delivery methods and a trend toward personalized, adaptable resources. The integration of technology and patient- and family-centered approaches signifies promising progress in End-of-Life care, offering new paths for engagement with patients and families.”

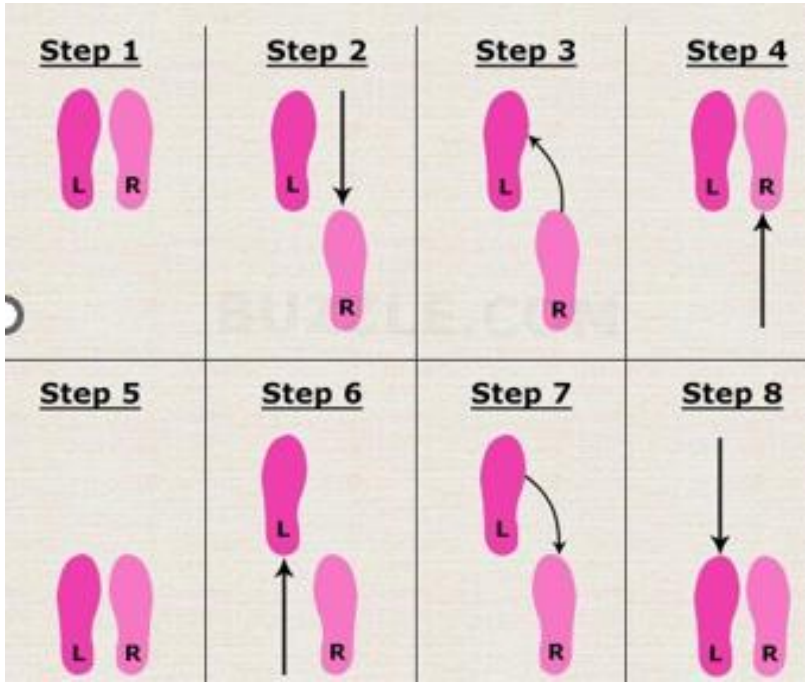
Normalizing the conversation

You are never too young or too healthy for advance directives

We ask patients who is their emergency contact, why do we not expand this and simply ask, if you could not communicate your health wishes at some point, would this be the person you would want to be your voice for these decisions.

We need to encourage ways in healthcare to build skills and confidence of both practitioners and patients to talk about health care wishes – particularly around end of life.

Finding opportunities to expand Cultural Competence and Cultural Curiosity



Conversation Starters

- Newsletters
- Posters in Office
- Postcards
- Team meeting

https://www.advancecareplanning.org.au/

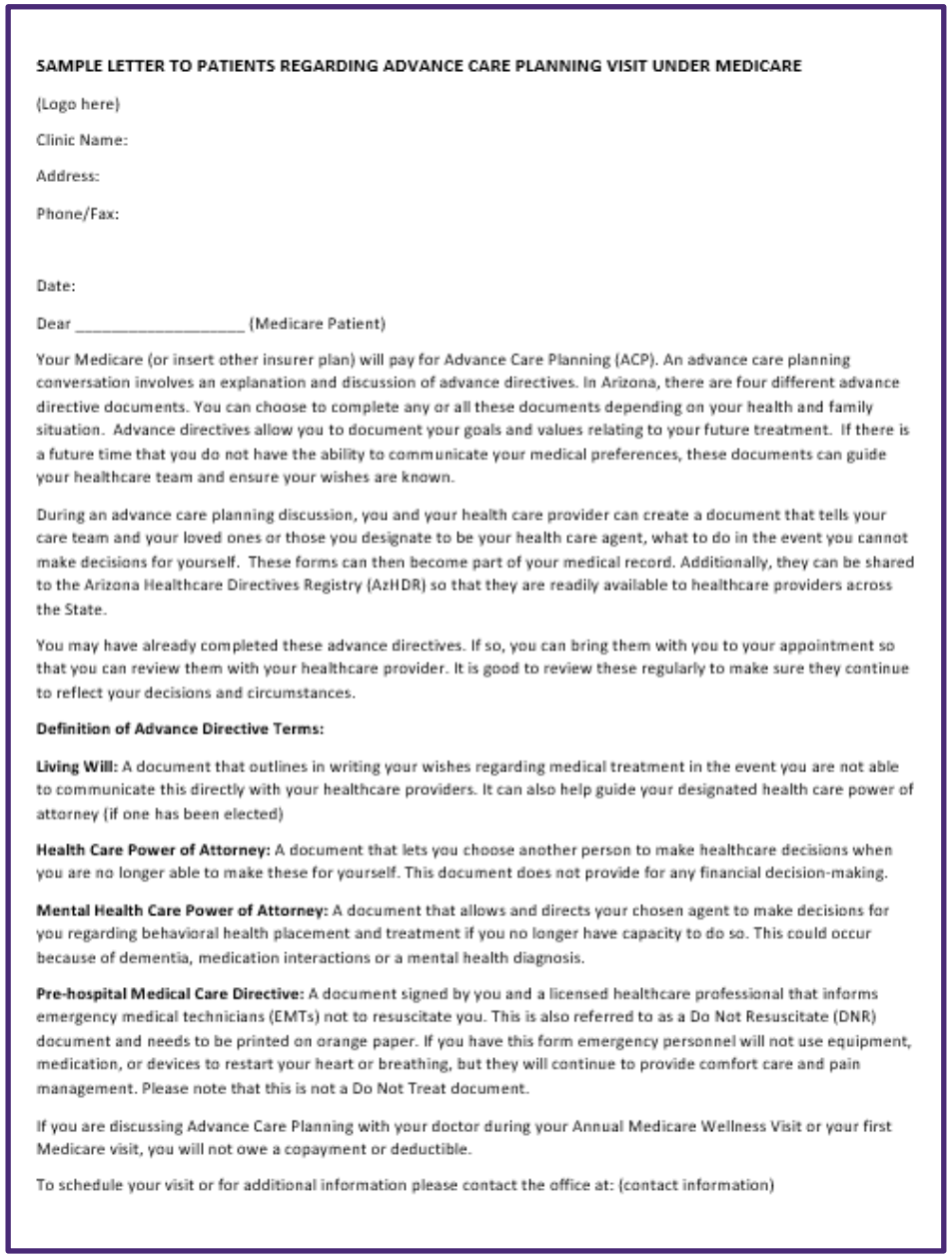
Develop a Plan

- Designate care team roles and responsibilities
- Establish an AWV and IPPE goal for completion (can be percent of client base over age 65 or percent of clients with coverage and diagnosis code of _____ (i.e., CHF, end stage renal) – AWV and IPPE great options as no cost sharing with patient
- Establish workflow process for outreach to patients, verification of eligibility, HRA Completion, assessment and follow up.
- Consider initiating with one clinic, one clinician, one diagnostic category
- Develop training plan for advance care planning with staff
- Designate a champion (examples from ADOA grant)
- Get set up with the Arizona Healthcare Directives Registry (AzHDR)

Setting up outreach

- Develop outreach tool – email, patient portal, mailer
- Consider follow-up call protocol for FAQs and visit set up
- Review identification process and initiate outreach within determined time frame for which patient would be eligible based on determined criteria

Setting the scene for success



SAMPLE LETTER TO PATIENTS REGARDING ADVANCE CARE PLANNING VISIT UNDER MEDICARE

(Logo here)

Clinic Name:

Address:

Phone/Fax:

Date:

Dear _____ (Medicare Patient)

Your Medicare (or insert other insurer plan) will pay for Advance Care Planning (ACP). An advance care planning conversation involves an explanation and discussion of advance directives. In Arizona, there are four different advance directive documents. You can choose to complete any or all these documents depending on your health and family situation. Advance directives allow you to document your goals and values relating to your future treatment. If there is a future time that you do not have the ability to communicate your medical preferences, these documents can guide your healthcare team and ensure your wishes are known.

During an advance care planning discussion, you and your health care provider can create a document that tells your care team and your loved ones or those you designate to be your health care agent, what to do in the event you cannot make decisions for yourself. These forms can then become part of your medical record. Additionally, they can be shared to the Arizona Healthcare Directives Registry (AzHDR) so that they are readily available to healthcare providers across the State.

You may have already completed these advance directives. If so, you can bring them with you to your appointment so that you can review them with your healthcare provider. It is good to review these regularly to make sure they continue to reflect your decisions and circumstances.

Definition of Advance Directive Terms:

Living Will: A document that outlines in writing your wishes regarding medical treatment in the event you are not able to communicate this directly with your healthcare providers. It can also help guide your designated health care power of attorney (if one has been elected)

Health Care Power of Attorney: A document that lets you choose another person to make healthcare decisions when you are no longer able to make these for yourself. This document does not provide for any financial decision-making.

Mental Health Care Power of Attorney: A document that allows and directs your chosen agent to make decisions for you regarding behavioral health placement and treatment if you no longer have capacity to do so. This could occur because of dementia, medication interactions or a mental health diagnosis.

Pre-hospital Medical Care Directive: A document signed by you and a licensed healthcare professional that informs emergency medical technicians (EMTs) not to resuscitate you. This is also referred to as a Do Not Resuscitate (DNR) document and needs to be printed on orange paper. If you have this form emergency personnel will not use equipment, medication, or devices to restart your heart or breathing, but they will continue to provide comfort care and pain management. Please note that this is not a Do Not Treat document.

If you are discussing Advance Care Planning with your doctor during your Annual Medicare Wellness Visit or your first Medicare visit, you will not owe a copayment or deductible.

To schedule your visit or for additional information please contact the office at: (contact information)

www.CMS.gov

Best Practice can pay. ACP Billing Codes

Code	Description
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician of other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	Each additional 30 minutes (List separately in addition to code for primary procedure).

This benefit has been widely used, with about 14,000 providers billing almost $35 million in 2016 when CMS first offered.

Different conversations based on the individual

- Young or Healthy Patients
  - Healthcare Power of Attorney with Mental Health Authority
  - Focus more on what is successful living vs what is wanted at end of life
  - Discussion focus is on “who would be your person if you cannot communicate your healthcare wishes”
  - If an accident were to occur would your medical wishes be known

- Next level Conversations
  - Patients that due to age or diagnosis there is a recognition that healthcare decisions about potential treatments, or interventions could arise in a “short” period
  - Patients with diagnosis that can impact cognition

- End of life Conversations
  - A life limiting new or progressed diagnosis
  - Out of hospital DNR discussion and paper work

It’s not how fast you are but how good you are with the baton hand-off.

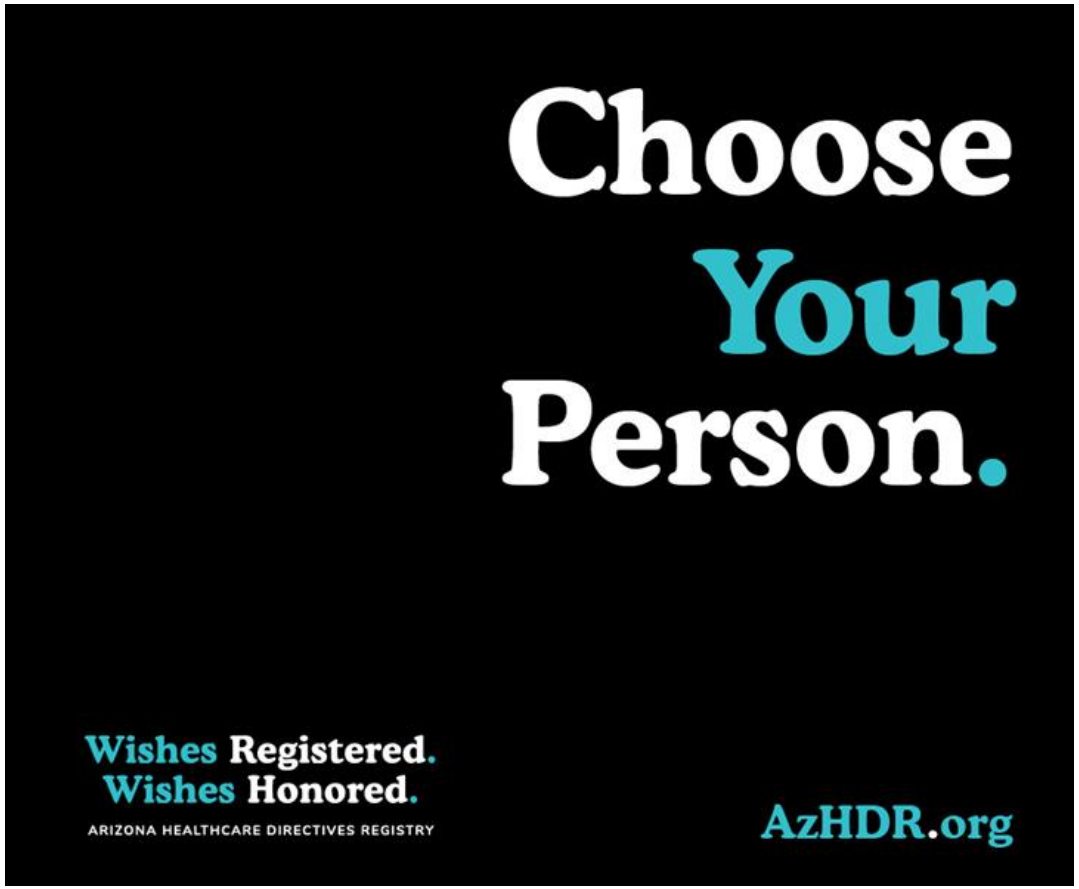
When documents aren't completed within healthcare "walls"

- Not every conversation needs to end with a completed document itself but with actionable follow up steps, many of which do not include follow up visits directly
  - Provide documents to patients and their families
  - If completing the Orange DNR out of hospital form sign an orange copy and not rely on them to find orange paper
  - Share a list of FAQ – available on AzHDR.org site
  - Become a participating subscriber to the AzHDR (at no cost), which eases the process of registration of documents to the AzHDR
  - Provide a list of who can assist with advance directive documents – available on AzHDR.org site. Includes but is not limited to Area Agency on Aging, Faith Community, Legal Aid, Attorney, Senior Housing sites, Hospice, Home Health

Power of Community Engagement

Definition: “ Bringing together multiple stakeholders to create, scale, and align impact in ways that go beyond the capabilities of a single organization.”

- Identifying the value for all community members. Sharing the message in ways that connects to the audience.
  - Domestic Abuse Survivors
  - College Students
  - Maternity
  - Dementia
- Normalizing Conversations
- Training Community-Assistors
  - CHR/CHW
- Pilot Projects in AZ
  - Rural Hospitals
  - EMS/Fire
  - Mercy Care



AzHDR Portal

You will receive onboarding training that will go over the portal in more detail.

Additional Features of the Arizona Healthcare Directives Registry

- Provides a review and approval process to maintain the integrity of the registry.
- Seamless access to healthcare providers to search, view and upload advance directive documents on behalf of patients.
- Supports the full range of forms under the Arizona state statute for advance directives. And supports all form types that meet this definition(including out of state documents).
- Provides ongoing support and training for organization staff on both the technical aspects of the registry as well as training on the advance care planning continuum.
- Offers functionality for documents to be sorted by type in each account. This eases the retrievability of the needed document.

Subscribing to the AzHDR

Healthcare Providers can search, view and upload documents

Legal and Financial Organizations can upload documents

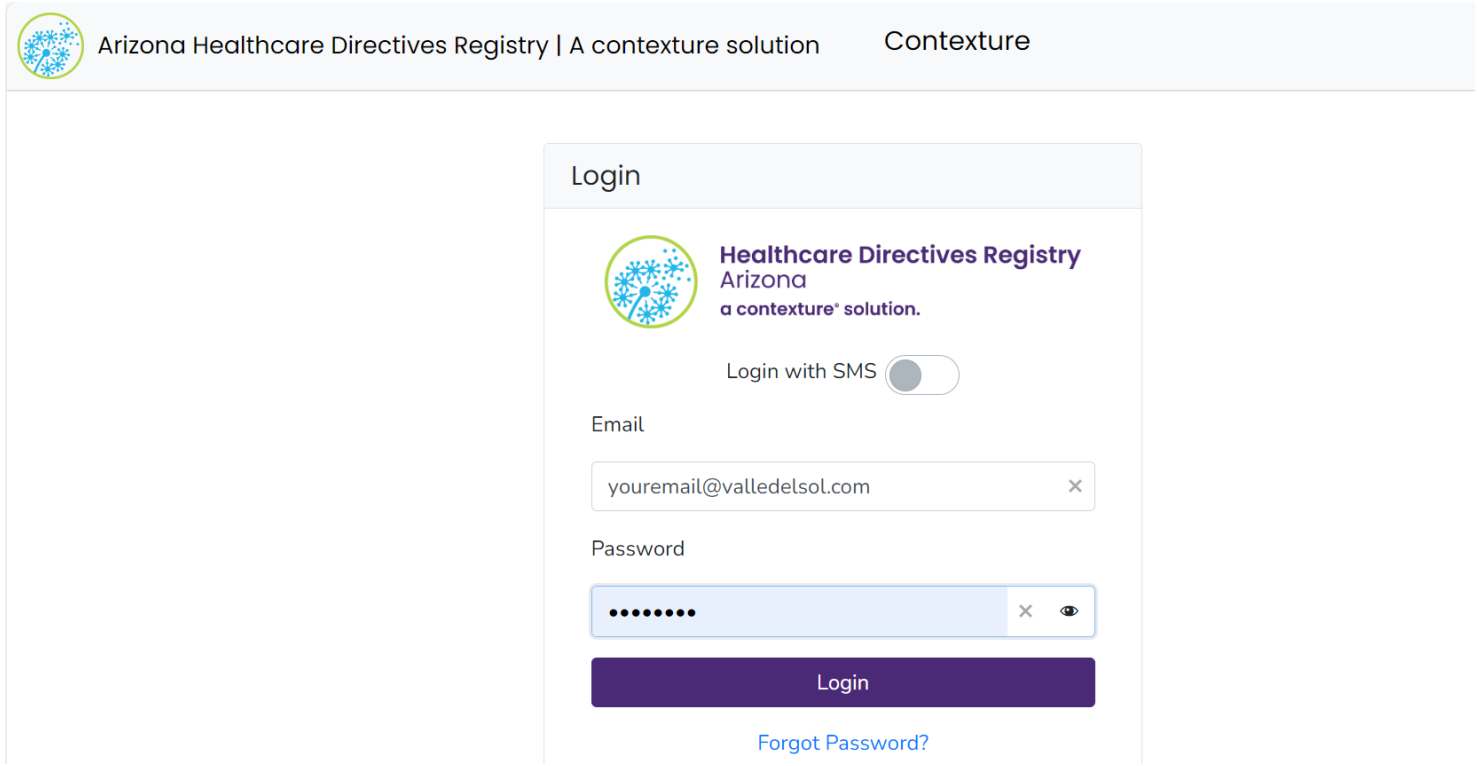
Community Based Organizations can upload documents

Since moving the registry to Contexture, we have increased provider participation by 400%.

No Cost to participate

- To participate, providers will complete simple paperwork
- Onboarding training is provided
- Additional staff training on advance care planning and advance directives is available
- AzHDR staff can participate in organizational and community events

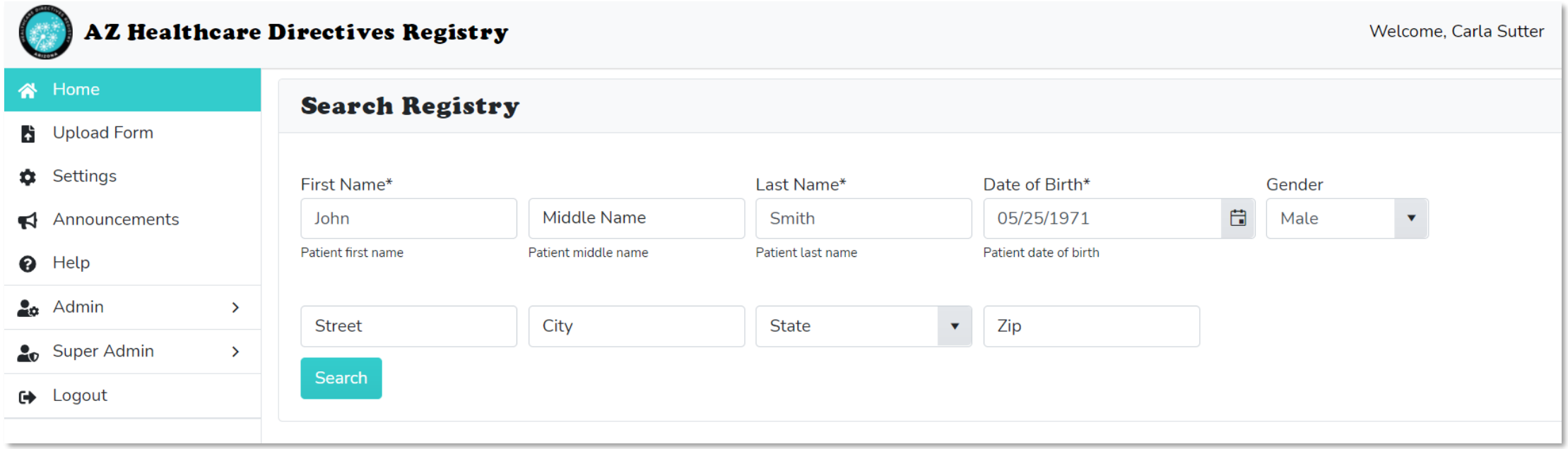
AzHDR Login for Providers



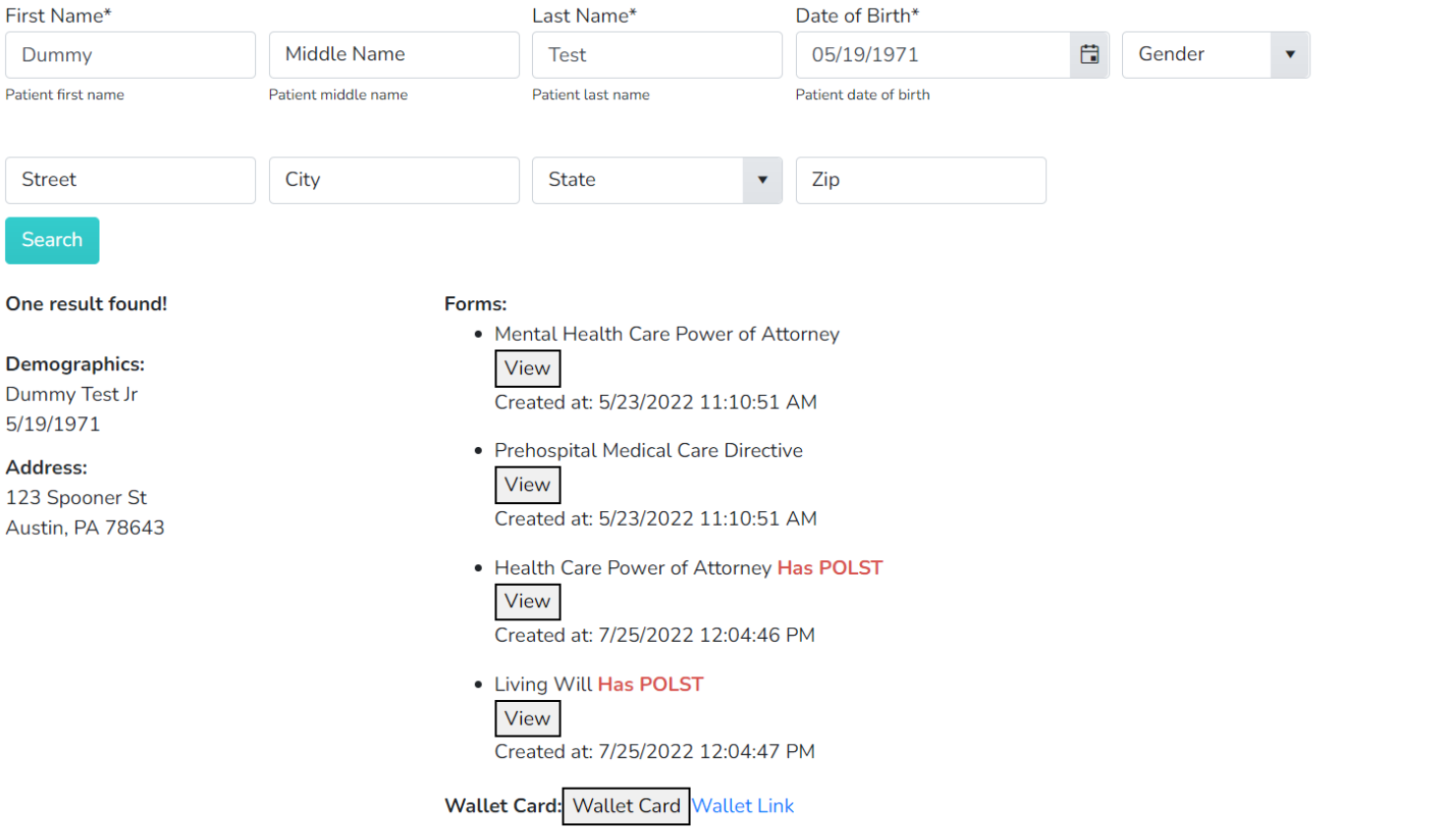
You will receive an email from support@azhdr.org sharing that you have been provided access to the AzHDR and to set up your account.

If you forget your password at any time, you can return to the portal login page and click “forgot password”

AzHDR Search

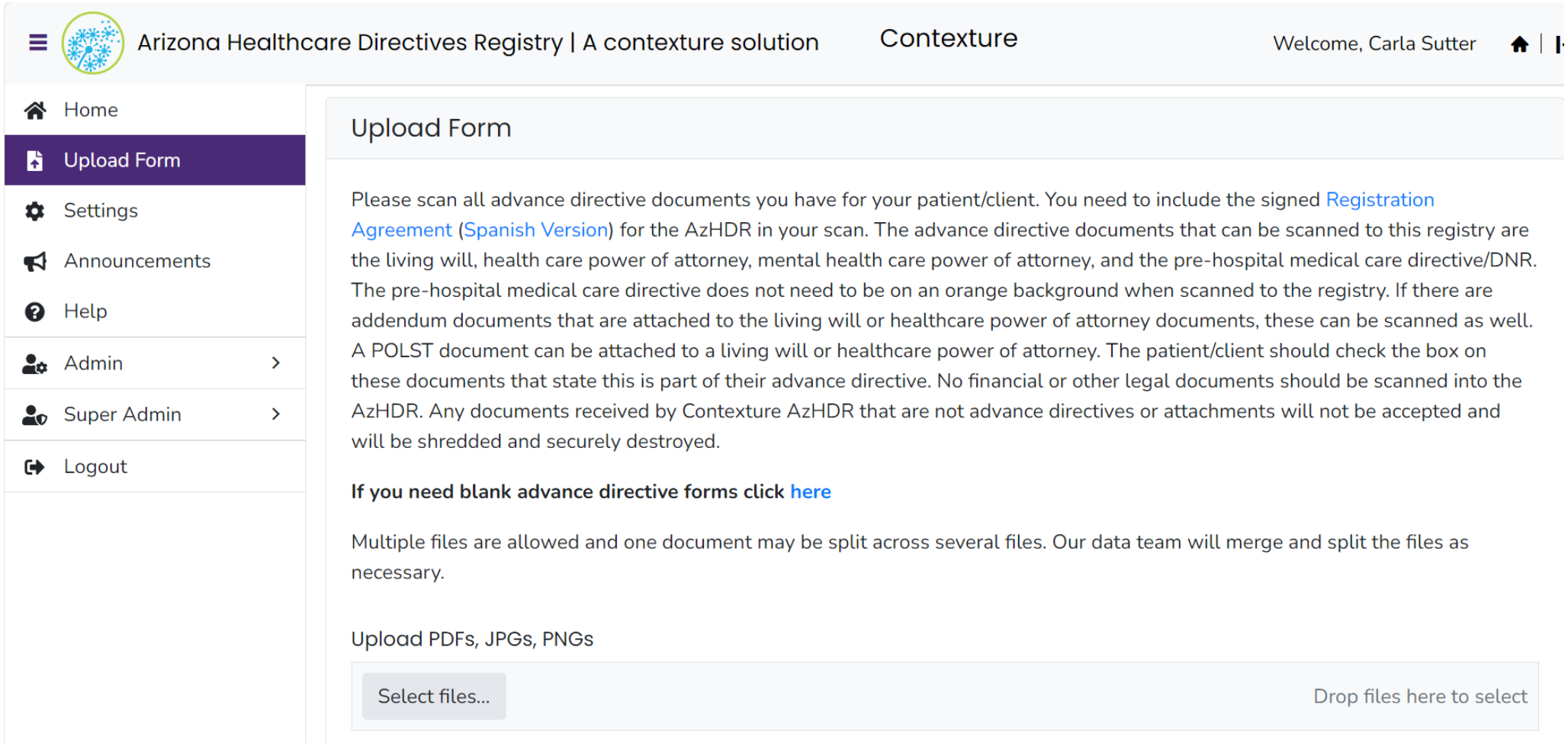


Documents in the AzHDR portal



- If you are a subscribing provider, your search will bring up any documents that are **active** in the registry.
- If your organization or the patient adds a duplicate document, such as another living will, the system will determine which date is most current and that will be the only document that shows as active.

Uploading documents



View-Only Wallet Card

My advance directives are registered with the **Arizona Healthcare Directives Registry**.

ARIZONA
Healthcare Directives Registry

Name: John Jacob Test III

I have registered my advance directives with the **Arizona Healthcare Directives Registry**. To view my documents, use the link or QR code below.

consumers.azhdr.org/v/TWYSTK

Questions?
Contact Contexture at either 602-368-6371 or **azhdr@contexture.org**.

View-Only Access to Account

Data for myyjxl

Demographics:
Dummy Test Jr.
DOB: 5/19/1971

Address:
123 spooner st asd
Austin, PA 78643

Forms:

- Prehospital Medical Care Directive
  View
  Created at: 5/23/2022 11:10:51 AM
- Health Care Power of Attorney
  View
  Created at: 5/23/2022 11:10:50 AM
- Living Will
  View
  Created at: 5/23/2022 11:10:50 AM
- Mental Health Care Power of Attorney
  View
  Created at: 5/23/2022 11:10:51 AM

Challenge


Let's Be Direct.
5
REASONS
You Need to Complete Your Own Advance Directives Before Assisting Others
The truth is that those who assist others with completing advance directives have no higher completion rate than the public. Why is that and why is it imperative to change that statistic? Do not be a statistic; instead, be at the forefront of advance care planning and be an example: start with your own.
Completing your own advance directives mirrors a role-playing exercise, with the added benefit of having completed the documents that will allow your healthcare wishes to be known.
This minimizes the burden that too many families face: having to make these decisions without knowing your preferences.
1
You are perpetuating a misconception about these documents.
It's a myth that these documents should only be completed by those of a certain age or diagnosis. Anyone can become incapacitated and lose the ability to make basic healthcare decisions. Not completing your own documents can perpetuate this myth and potentially increase the chance of you missing opportunities to have crucial conversations with your patients.
2
You have not experienced the challenges of communicating your priorities and values on paper.
It's much easier to talk about your healthcare choices than to document them on paper. Completing your own advance directives forces you to acknowledge your own mortality and express what you want for your healthcare in the event you cannot communicate. Going through the process helps ensure you can relate with your patients' difficulty in exploring these same challenges.
3
You cannot answer honestly when they ask if you have completed your own documents.
Patients often ask healthcare providers if they have completed their own advance directives. It's a legitimate concern; if these documents are important for patients to complete, then why haven't their providers? It can diminish the need and leave the patients questioning their validity. When you ask yourself why, your answer may surprise you, but it will offer clues to areas you may want to gain more knowledge in before working with others on their forms.
4
You will not know what information or questions you needed to complete the documents.
Until you have had to go through the advance directive forms as a user, it is more difficult to explain them as an instructor. Identifying what questions you needed follow-up guidance on from your own healthcare providers allows you to offer your own patients a list of follow-up questions to explore.
5
When you have not had to choose your own health care power of attorney, you can't understand why it's so hard for others to do the same.
One reason clients do not complete their advance directives is they don't know who to name as their healthcare agent. Many feel they will hurt a family member's feelings if they do not choose that person. Having to face this yourself helps you to work through this stressful area with clients.
ARIZONA Healthcare Directives Registry
Visit AzHDR.org for more information.

Resources

- Advance-Directive-Conversation-Guide_2024_web.pdf (anthc.org)
- https://implicit.harvard.edu/implicit/takeatest.html
- Microsoft Word - Curriculum Guide 2 22 22.docx (wcu.edu)
- My Advance Care Plan & Guide for Native Americans (iasquared.org)
- AzHDR.org

- Medicare Wellness Visit Guide Medicare Wellness Visits - ICN MLN6775421 February 2021 (cms.gov)
- American Academy of Family Physicians MWV guides Medicare -- FPM Toolbox (aafp.org)
- CMS Advance Care Planning Guide for Physicians Advance Care Planning (cms.gov)
- Sample Letter for Patients (attached to guide)

“One must be WISE in knowing what to prepare for and equally WISE in being prepared fo the unknowable” – Yup’ik Quote #Native Voices

Questions? Feedback?

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