Respecting Choices: Financial Facts and Figures

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ABSTRACT

Respecting Choices, an advance care planning program developed in LaCrosse, Wisconsin's Gundersen Health System and highlighted in a previous column, engages patients in informed discussions about end-of-life decision-making. Its aim is the establishment of effective systems that allow individuals to consider future medical situations and have their personal values and goals respected if they may one day be unable to speak for themselves.

Bioethics, End-of-Life, Decision-Making

INTRODUCTION

Respecting Choices, an advance care planning program developed in LaCrosse, Wisconsin's Gundersen Health System and highlighted in a previous column, engages patients in informed discussions about end-of-life decision-making. Its aim is the establishment of effective systems that allow individuals to consider future medical situations and have their personal values and goals respected if they may one day be unable to speak for themselves. However, the program's association with a lower utilization of acute care services is drawing the attention of healthcare administrators and policymakers at multiple levels, and the culture of silence regarding the costs of end-of-life care seems to be changing. Programs such as this one are proving that the identification, documentation and honoring of patient preferences at the end-of-life results in both reduced spending and use of resources within health institutions. Patients are receiving the care they request, and health systems are cutting costs.

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II. FINANCIAL FACTS AND FIGURES

Health spending at the end-of-life has been cited as wasteful, exorbitant, and often unwanted by the patient receiving the care. In keeping patient preferences at the center of all decision-making, the cost savings of *Respecting Choices* are telling, and its designer, Bud Hammes, calls it "a blessing and unexpected event."

According to *Dartmouth Atlas*, Gundersen's average reimbursement per patient in the last 24 months of life was $18,359 – a figure nearly $7,500 less than the U.S. hospital average of $25,860. Hospital days per patient in the last two years of life averaged 13.5 days; that number is half the U.S. average of 23.5 days.

Evidence reveals that when asked, most do not wish to spend their last days and weeks receiving high-intensity care. When end-of-life preferences are known and subsequently respected, unwanted tests, treatments and hospital days are reduced. Expensive resources with no benefit are avoided, and overall costs decline.

These costs matter now more than ever, Hammes says, citing the current shift from a fee-for-service healthcare payment system as a reason interest in *Respecting Choices* implementation is growing. "Now, organizations are being held more accountable for quality of service," Hammes says. "If they can provide high quality care providing fewer services, there's clear incentive. The *Respecting Choices* model fits with this new payment system perfectly."

That win-win has made *Respecting Choices* the recent focus of national media attention, as the model is sprouting across the country and globe. Internationally, Hammes has been behind program development in Australia, Singapore and Germany. Closer to home, Kaiser Permanente is implementing *Respecting Choices* system-wide, and medical societies in Wisconsin and Minnesota have spearheaded state-wide projects. In early September, *Respecting Choices* facilitator training begins in Richmond, Virginia. Pilot sites in three health systems there are slated to open in early 2015, which is when the South Carolina Medical Association plans to roll out a preliminary phase of *Respecting Choices* in six hospital systems.

III. Local Programs: Financing and Implementation

As fees to implement Respecting Choices range from $190,000 to $500,000 – a figure tied to size and speed of start-up – those establishing such advance care planning programs are not seeking immediate payoff. "Healthcare is a business, and it has to look at the cost of doing things – training staff, redesigning systems, facilitation of the conversation – all of that has cost," Hammes says. "So you have to look at what is the value of this work."

The answer to that, he says, is clear. "The primary purpose is not to save money, but to prepare families to make critical decisions. In doing so, we improve care." Those currently seeking to do just that offer possible funding models for others considering implementation.

A. Minnesota

When Twin Cities Medical Society members voted to implement *Respecting Choices* in 2008, they were seeking a project to make their own; the desire to improve end-of-life care resonated throughout the

organization and the community surrounding it. “This is universal, and everybody has dealt with a good death and a bad death,” says Sue Schettle, CEO of the Twin Cities Medical Society. “The notion of patient-centered care and shared decision-making is wonderful, and everyone knows we can be doing a better job at this.”

The Society’s foundation and four influential CEOs in Minneapolis-St. Paul contributed $25,000 each, and “Honoring Choices Minnesota” launched with $125,000 in the bank. Hammes and Gundersen colleagues flew in and got to work.

As hospital-based pilot sites opened at a rate of about six a year, a fundraising dinner in 2009 secured $150,000 more. Facilitators are now in place in community centers, senior service organizations, and health clinics. “It’s sort of gone viral,” Schettle says.

The initiative has since partnered with public television and planned a three-year public engagement strategy. Additionally, about a dozen more funders were identified, including private insurance companies. About 1700 advance care planning facilitators have been trained so far, and roughly 35 percent of residents report having an advance directive – a figure above the national average. “All health systems in town knew we could do end-of-life care better,” Schettle says. ”The competitive nature of health systems can be put aside on this issue, and we can do it better. We’re in it for the long haul.”

B. Wisconsin

Though the Respecting Choices model was developed more than two decades ago in southwest Wisconsin, it was Minnesotan success that drew the attention of healthcare leaders in Madison. The 12,000-member Wisconsin Medical Society launched “Honoring Choices Wisconsin” in the fall of 2012, training 60 facilitators from primary care clinics across six health systems in the Milwaukee-Madison corridor.

“Getting health systems to collaborate was not too difficult,” says John Maycroft, director of policy development and initiatives. “What is difficult is helping organizations set up systems and workflows to make sure these conversations are routinely offered, scheduled, had, documented and entered in the medical record. You have to have full support to make sure everything works.” Maycroft is measuring the number of conversations offered, how many patients agree, how many conversations take place and the number of advance directives completed. So far, about three thousand facilitated dialogues have occurred as a result of “Honoring Choices Wisconsin.”

Private insurers provide a substantial portion of the initiative’s $350,000 annual budget. Humana, United HealthCare, Unity Health Insurance and WPS Health Insurance are among those supporting the effort.

“Honoring Choices Wisconsin” employs three full-time staff: a program lead, a program coordinator, and a community outreach coordinator. Community groups, clergy and senior service organizations will be key in the initiative’s continued success. “We found an incredible amount of pent-up energy, because people have come out of the woodwork to help,” Maycroft says. “We thought we could do it, and we were willing to work really hard to make it happen. So far, it looks darn good.”

C. Virginia

The Richmond Academy of Medicine has contributed the first $100,000 into a trust for this fall’s *Respecting Choices* facilitator training, beginning within three health systems on September 8th. Each participating organization is contributing the same amount for program development. When Academy members initially voted to lead such a project, neither financial costs nor incentives were broached, says Executive Director Deb

Love. “They wanted to do the best thing possible for the patient and family,” she says.

Such support had been brewing within the 2,300-member Academy for two years, since a physician member addressed colleagues with concerns about late hospice referrals. As the conversation continued, Love says members “were not just talking about physicians needing education to do earlier referrals, they were talking about a community education project.”

The Academy then convened a community meeting, inviting Hammes to speak to more than one hundred end-of-life care “stakeholders” in the state capital. When the *Respecting Choices* model was received enthusiastically, the Academy gathered a fifteen-person advisory board of nurses, social workers, chaplains, lawyers, and physicians. Support was unanimous, and agreement upon such a centralized approach to advance care planning was reached among three typically competitive health systems.

Thirty employees in all will initially receive facilitator training, establishing three pilot sites within each of the three health systems they represent. Advance care planning sessions will be offered to patients starting in January, 2015. Six months later, a second series of pilots are slated to open. By the end of next year, Love says efforts will have shifted from the hospital and into Richmond’s diverse communities. “We want to train an army of facilitators that are respected in their spheres of influence to carry this message forward,” she says.