Arizona Report on EOL
Public and Physician Views on EOL Care & Data Reports

**Physician Survey**
- Oct – Dec 2017
- 466 physicians: ±4.5%
- 68% care for patients near EOL
- Multi-specialties
- Data Source: ArMA/AOMA
- Joint Task Force on EOL Care

**Advance Directive Registry**
- 2005 – June 2018
- Source Data: Secretary of State’s Office

**Medicare Data: Hospitals & Hospice**
- 2016 Data
- Medicare 100% Medicare FFS Beneficiaries with Parts A and B
- Source: Medicare Standard Analytical Files

**Arizona Statewide Survey**
- August 18-22, 2018
- Telephone Survey conducted by Public Opinion Strategies
- 900 Adults; ±3.27
2016 Medicare Data

Inpatient Mortality Rate: 2.6%

Median Days Between Last Hospital Stay & Death: 26 Days

ED Visit Last 30 Days of Life: 51.7%

Median Days Between Last Hospital Stay & Death: 26 Days

Hospital ALOS Last Year of Life: 12.8 Days

ED Visit Last 30 Days of Life: 51.7%

ALOS in ICU Last Year of Life: 4.7 Days

100% Medicare FFS Beneficiaries with Parts A and B

Source: Medicare Standard Analytical Files

Thoughtful Life Conversations
Cancer Patients

- >10 Providers Last 6 Months of Life: 82%
- ICU Stay in Last 30 Days of Life: 38%
- ED Visit Last 30 Days of Life: 61%
- Received Hospice Care Last 30 Days of Life: 71%
- ALOS Hospice: 30 Days

Source: Medicare Standard Analytical Files

2016 Medicare Data

100% Medicare FFS Beneficiaries with Parts A and B
Observations/Recommendations

➢ Inpatient mortalities are low
➢ Inpatient days, Emergency Department visits, and ICU Days prior to death are an opportunity; they suggest there are opportunities for improved conversations about prognosis and treatment options the last year of life
➢ Hospice utilization is high
➢ The majority of Hospice referrals continue to be within the last 30 days of life
➢ Medicare beneficiaries with a cancer diagnosis at time of death have higher inpatient, Emergency Department and ICU utilization and see more health providers than non-cancer patients
➢ Earlier referrals to Palliative Care and Hospice along with increased sensitivity of healthcare providers and the public to serious illness conversations could result in decreased acute care services, improved symptom management, reduced suffering and improved well being.

2016 Medicare Data

100% Medicare FFS Beneficiaries with Parts A and B
Source: Medicare Standard Analytical Files
Physician Survey  
Survey completed by ArMA/AOMA end of 2017

37% Discuss EOL routinely with elderly patients

46% Discuss EOL when death is imminent

52% Report no training on Palliative Care or EOL Conversations

57% Discuss EOL with patients who have a terminal illness

55% Make referral to Palliative Care for patients with terminal illness

66% Fully support POLST in Arizona; 77% want education
Observations/Recommendations

➢ Provide physician education on communication skills
  ➢ Primary Care
  ➢ Hospitalists
  ➢ Specialty Focus
  ➢ Do team based training
➢ Educate the public on end-of-life care planning
➢ POLST has broad support and is met with interest
  ➢ Provide training and education for healthcare providers on POLST

Physician Survey | Survey completed by ArMA/AOMA end of 2017
Arizona Advance Directive Registry

Observations
- Trend showing increase in volume
- Older patients more likely to submit to registry
- Numbers are low demonstrating underutilization
- Not a valid/reliable measure of success for our work

Recommendations
- Remove deceased patients from registry
- Provide data on type of document(s) in registry
- Provide data on number of documents accessed
- Develop stakeholder group to evaluate barriers for using registry & implement changes
A solid majority of Arizonans have had a conversation with a loved one about their end-of-life care. Two in ten have had the same with their doctor.

Women and Baby Boomers are more likely than men and younger generations to say writing down their wishes is important.
A majority of men prefer their spouse while nearly a quarter of women prefer their children make their medical decisions for them.

The older you are the more likely you are to have had a conversation about your wishes for end-of-life care.

A majority trust a spouse or a family member to make medical decisions for them if they are unable to.
A national survey report from 2016 identified barriers to discussing and writing their wishes for end-of-life care include:

- Too many other things to do right now
- Don’t want to think about dying
- Loved one does not want to talk about it
- Too Young/Long Way Off
- Haven’t thought about it
- Don’t have anyone to talk to

- 59% of Arizonans report they do not have their wishes for end-of-life care written down
- 41% of Arizonans report they have not written their wishes for end-of-life care down because they have not gotten around to it.
- 22% of Arizonans report they have not written their wishes for end-of-life care down because they never considered it
- 20% of Arizonans report they have not written their wishes for end-of-life care down because they are still healthy, are young or don’t think it is necessary
White adults are more likely than Hispanics to have a written document describing their end-of-life care wishes.

POLST is a medical form only for seriously ill or frail individuals with a life expectancy of less than one year. A POLST medical form is completed by a healthcare professional with the patient only after a conversation about their illness and prognosis. It allows the patient to specify the types of treatments they want or do not want during a medical emergency or at the end of their life. The POLST form results in a medical order that follows the patient across different healthcare settings and healthcare professionals honor the patients wishes. A POLST form can be changed at any time and is always voluntary.
Observations/Recommendations

➢ Opportunities exist for community outreach and education about the value of advance care planning and documenting wishes for end-of-life care
➢ Opportunities exist to improve communications with healthcare professionals and their patients around end-of-life care planning
➢ The majority of Arizonans are not aware of the Arizona Advance Directive Registry
➢ There is solid support for POLST in Arizona and the majority say they would support a law that allows POLST
Thoughtful Life Conversations

Wishes Explored

WishesExpressed

Wishes Honored
Key Strategies & Activities

**Professional Education**

Professional Education for Healthcare Providers and Healthcare Systems
Improving provider competencies in advance care planning and end-of-life care

**Policy & Advocacy**

Thoughtful Life Conversations is at the center of policy reform in Arizona for improved payment and legislation supporting needed changes, such as payer reform for advance care planning, and adoption of standardized advance care planning for the seriously ill.

**Community Outreach**

Expanding opportunities for Arizonans to have their end-of-life wishes known and honored

**Communication**

Developing a communication network at the individual, the community and the societal level for knowledge dissemination and innovation diffusion.
Questions?

http://www.thoughtfullifeconversations.org/