



Testimony Provided To:

U.S. Senate Special Committee on Aging
Hearing on Advance Directives and End of Life Care
September 24, 2008

By:

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Chairman Kohl, Senator Smith, Senator Whitehouse and the members of the Special Committee on Aging, thank you for giving me the chance to talk with you about advance care planning today.

For the past 30 years, I've worked in healthcare. The last 26 years I have held a variety of positions with Gundersen Lutheran, and integrated health care system headquartered in La Crosse, Wisconsin with clinics and healthcare services in Wisconsin, Minnesota and Iowa.

Dying is an uncomfortable subject to discuss. Most of us don't even want to think about it. But when the healthcare we receive at the end of life is patient-centered, coordinated and proportional to the patient's wishes – never more and never less – the healthcare process of dying results in a higher quality care delivered at a lower cost.

As I speak to you today, it's not only as an employee of the medical center who has led the nation in advance care planning. I am here today to tell my personal story in hopes of showing how advance care planning is more than just about filling out the paperwork. Today is about what it means to take care of loved ones when they are sick and how we choose as individuals to be taken care of when we are sick. Today is about supporting you in your work to make sure that the choices of each patient are honored and respected by the healthcare facility caring for them at the end of their life.

In 1986 Gundersen began to work on an advance care planning model. In 1991, the entire La Crosse community built on this model by committing to an innovative system of advance care directives. They

made sure it went beyond just filling out paperwork or a legal document. They made sure the advance directive was in every person's medical record where and when it was needed. And they made sure medical professionals had the training to know how to comply with a patient's wishes. The system was designed by health care professionals and was implemented when there were no electronic medical records.

In 1989 I knew nothing about end of life planning and advance directives. I also didn't know that my close friend would be diagnosed with a terminal brain tumor. I didn't know that this experience would prepare me for my father's death many years later. Both experiences taught me that end of life planning is an act of love and courage. I offer the story of two very different deaths in hopes that you will see the value advance care planning has as part of the U.S. healthcare system.

In May 1989 my friend Annette experienced headaches so severe that she went to the emergency room on a Sunday afternoon. That day, she was diagnosed with a brain tumor. She was just 28 years old. Annette went through surgery that week to determine the severity of the tumor. She and I were both stunned when the neurosurgeon told us the tumor was a Grade IV out of V malignancy. Although the surgery was successful, she was given six months to live - perhaps a year if they could slow the growth with radiation treatment. The radiation started a few weeks later and during the next weeks we both focused on dealing with treatments, side effects and how frightening this all was for both of us.

The hospital chaplain was the first individual to discuss with Annette whether she wanted to talk about her treatment in the event that she could not speak for herself. At the time, I remember being upset that anyone would ask her to discuss such a sensitive subject at such a fragile, emotional time. To my surprise she was relieved to have the topic on the table. With the chaplain, and later her physician, we went over her decisions. Annette asked me to be the person who made sure her treatment choices were honored. I wasn't sure I could do it.

With the help of an attorney and the pastoral care department at the hospital, we secured the needed documentation for health care power of attorney as well as power of attorney. Before I came to Washington today, I reviewed Annette's advance directive – written nearly 20 years ago – on it there was a handwritten note from Annette that I had forgotten. It read "I would like Joan to be my 'health care agent' because she's been a great friend to me for many, many years. We've talked and agreed that she would make all my decisions for me." Through those documents we codified what care Annette wanted as her illness progressed. But more importantly, through the discussions that were facilitated as we filled out these documents, I became very comfortable and fully understood what she wanted and why it was important to her. Those discussions allowed me and her loved one's to cope with what was happening to Annette. We were so fortunate that the medical center and the staff there were supportive of her decisions, too. Because of this, we were certain that everyone was on the same page and her treatment plan reflected her wishes.

We also became more knowledgeable about the legal implications and limitations of the existing system. For example, we found out that emergency care and her acute and hospital care were not coordinated by any uniform standard. So we taped a copy of Annette's advance directives and my healthcare power of attorney to her bed and on the door of our house in case an emergency happened. That way, even in an emergency, Annette would receive the care she wanted, and she would not receive care she didn't want. We both carried paper copies with us in the event the unexpected happened.

Two years after Annette's original diagnosis, she no longer had the ability to communicate. Her treatment wishes were well established in her care plan, and any treatment options considered those wishes. I was with her when she died on Christmas Day 1991. As she had chosen, she received only the care that she wanted. It proved to be the greatest gift that I could have ever given her and that in and of itself gave me comfort in the months following her death. This advance directive – then and now – allowed all of Annette's loved ones to move beyond her death and celebrate her life.

The experience with Annette changed how I viewed end of life planning and I completed my own advance directives. I have shared them with my husband, my extended family, and my child when he became an adult. From time to time we have a check-in discussion and it proves to be a good avenue to share other messages of support and appreciation.

My second experience with end of life planning was a very different situation. With Annette, she was young and her illness lasted for two and a half years. Several years later, my siblings and I were confronted with the mortality of our own parents – specifically, my dad who was 84 but died very suddenly and unexpectedly in 2004.

My Dad knew how he wanted to live and his choices reflected his values. At the age of 13 he quit school to take care of 4 younger brothers and help on the farm after his mother died. He served in WWII and came home, married my mother, and had seven children. After a few years of selling and trucking produce, he opened his own business which he operated until he retired. He and my mom were devout Catholics, shared good health and were active people.

One unexpected afternoon, my Dad let my siblings and I know that he and my Mom wanted to talk with us about how they wanted to be cared for in the event that they could not speak for each other or themselves. Throughout the discussion when one of us would say, "Dad, you can't mean that..." he would let us know that indeed was what he meant. My mother wanted to make sure everyone understood what they wanted so there would be no disputes. By the end of the conversation, we were clear on who would be making the decisions and each of us had a copy of their wishes. What proved to be most important was that we all understood what those written words meant.

On December 18th, 2004 my sister called me to let me know Dad had been taken to the emergency room. Just the day before when we had talked he was fine.

When Dad was diagnosed with bleeding in his brain he was transferred from the local emergency room in Minnesota to nearby Gundersen Lutheran Medical Center in Wisconsin. The medical staffs were made aware that he had an advance care plan in place and all the steps were taken to ensure that any treatment would incorporate those wishes. By 2004, Gundersen Lutheran had incorporated advance care planning into their electronic medical record allowing for information to be easily communicated to any health care practitioner. That Saturday was a blur but by the end of the day the bleeding had stopped. Although he had some weakness, the prognosis was good and it looked like he would be discharged on Sunday or Monday.

On Sunday he was making good progress and he was anxious to go home. Our physician wanted to keep him one more night. About 6:30 p.m. I went home to shower and change and planned to spend the

night with my Dad. As I left the hospital I remember letting the nurse know that I would be back in 30 minutes and that he was doing fine and asked her to call me if he needed anything that I could bring from home. At that time I lived less than 5 minutes from the medical center and so I was surprised when 10 minutes after I got home the hospital called and said that my Dad was in trouble. I called my sister who lives close and told her what had happened.

By the time I got back to the hospital my Dad had lost feeling in his right side, so the doctors wanted to take him down for a CT scan to determine what was happening. My sister arrived just as they were wheeling him down and reassured him that we would be there when he got back and that my Mom and brother would be there soon. Dad's last words to my sister were "no more."

By the time Dad was back from his test, the physician sat down with us to explain Dad had experienced a significant bleed and he would no longer be able to talk, walk or feed himself. Within a short period of time he would need life support as his breathing would be compromised. He provided us with some treatment options, but it was clear that my Dad would never regain functionality. I remember asking my mom if she understood what the doctor had said and if she needed him to repeat anything or had any questions. She confidently nodded her head and said to him. "Thank you doctor, your work is done here. He is in God's hands now." It was just after midnight.

From that point on the support we received centered around making my Dad comfortable and helping us adjust knowing that he only had a short time left. The medical and support staff were all respectful of our decisions and helped us through these final hours. He received his last rights, our family surrounded his bed, and my mom, his wife of over 50 years, was holding his hand when he died just 2 days after his unexpected Emergency Room visit. As a family, we've never had to wonder whether it was the right thing to not seek additional treatment or if we made the right decisions. As a family, we're all comfortable with the way that dad chose to die. Since, we've been able to spend our time helping mom and enjoying what time we have left with her.

Closing Remarks:

I urge this Committee to give the rest of the country what patients in La Crosse, Wisconsin have had access to for many years; a system that allows people to make their wishes known and healthcare organizations that value and respect those choices.

By expanding Gundersen's end of life care model across the nation, you will be providing families and loved ones with support to have one of the most important conversations of their life. This will allow families to come together, rather than be torn apart, when they need each other most. Through your efforts healthcare systems will engage their patients in the right discussions, developing the mechanisms to incorporate those wishes into treatment plans. On behalf of my father and my friend Annette, I ask you to give others the opportunity to experience this gift of love and give the medical community the ability to fulfill the wishes of their patients.

I wanted to share my personal story today, but please take a minute to read the information in the attached document, which outlines Gundersen Lutheran's end of life care system. As you will see, the cost of dying at Gundersen Lutheran is about \$18,000 and family satisfaction is extremely high. In

comparison, the national average cost of dying is more than \$25,000, and at many of the nation's leading healthcare organizations the cost is as high as \$31,000 and \$58,000.

As you move forward, my strongest recommendation to you is to remove barriers and create incentives to expand this successful end of life care model nationwide. The work and proven results of Gundersen Lutheran's experience are transforming end of life care to increase continuity of care, quality of care, and respect for patients' wishes, while lowering the cost of care and reducing over-utilization of the healthcare system. This model can be implemented across the nation in every setting whether the medical record is paper or electronic. In addition, we encourage that the six principles outlined in our written testimony be incorporated into any policy or regulation related to advance care planning:

1. Health care professionals should help all adults understand and document their end-of-life care goals and preferences as well as designate an end-of-life care decision-maker.
2. There should be a process to convert treatment goals and preferences into medical orders to ensure information is transferable and honored.
3. Universal implementation of electronic medical records and internet-based personal health records shall include and integrate timely information relevant to the patient's advance directive.
4. If no advance directive exists at the time of need, any authentic expression of an individual's goals, values or wishes with respect to healthcare should be honored.
5. Federal support for research, education, and expansion of best practices relating to the quality and continuity of care related to advance directives and the end of life.
6. Medicare would reimburse organizations at a higher level if certain advance care planning outcomes are met. For example, if 85% or more adult decedents had a written advance directive found in the medical record at the site of care, and the wishes expressed in the document were consistent with the treatment provided. Rather than reimbursing for a specific event, payment would be hinged on outcomes that meet performance benchmarks.

Thank you for this opportunity to speak to you today about this important issue.





Policy and Regulatory Principles for Advance Care Planning

- 1) Health care professionals should encourage and offer assistance to all adults, helping individuals to understand and document their end-of-life care goals and preferences as well as designate an end-of-life care decision-maker.
- 2) Health care professionals should have a process to convert treatment goals and preferences of persons with life-limiting illness into medical orders (e.g. the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Initiative) to ensure that information is transferable and applied across all care settings.
- 3) In the absence of a validly executed advance directive, any authentic expression of an individual's goals, values, or wishes with respect to health care should be honored.
- 4) Universal implementation of electronic medical records and internet-based personal health records shall prominently include and integrate timely information about patient proxy designations, care goals and preferences, and medical orders for life-sustaining treatment. This information should be stored within the electronic health record system of the individual's community-based hospital, not a national data warehouse.
- 5) The federal government should support research, education, and development of best practices relating to the quality and continuity of care planning and care implementation for persons with life-limiting illnesses across care settings.
- 6) Medicare would reimburse organizations at a higher level if certain advance care planning outcomes are met. For example, if 85% or more adult decedents had a written advance directive found in the medical record at the site of care, and the wishes expressed in the document were consistent with the treatment provided. Rather than reimbursing for a specific event, payment would be hinged on outcomes that meet performance benchmarks.

Transforming Healthcare at the End of Life



Gundersen Lutheran Health System is leading the nation with an innovative end-of-life program that provides the right healthcare to patients in the end stages of their lives. Our system increases continuity of care, quality of life and respect for the patient's wishes, while lowering the cost of care and reducing over-utilization of the healthcare system.

The system is based on well-established, existing programs at Gundersen Lutheran, including:

- A community-wide advance directives program which makes advance directives available to every person, ensures they are available wherever and whenever patients need them and ensures healthcare professionals comply with the patient's treatment choices.
- Hospice and palliative care programs, which assist patients with advanced diseases through the physical, psychosocial and spiritual aspects of aging and dying.

- Coordination of these services by use of electronic medical records, which can be accessed by all medical professionals in the health system and region at all sites of care.

The future of healthcare

Gundersen Lutheran's approach to advance directives has led to the development of a model of care we're calling Late Life Primary Care, which encompasses advance directives, palliative care and hospice. When all of these programs work together, the Late Life Primary Care approach can save between \$3,000 and \$6,000 per patient, per year. Gundersen Lutheran has presented the Late Life Primary Care concept to the Centers for Medicare and Medicaid Services (CMS) as a model to change the way end-of-life care is delivered on a national scale. The entire proposal is available for review.

Cost of Care in the Last Two Years of Life*

Hospital	Reimbursement per Deceased Patient (2-year total)	Reimbursement Per Day	Hospital Days per Deceased Patient
Gundersen Lutheran	\$18,359	\$1,355	13.5
Marshfield/St. Joseph's	\$23,249	\$1,126	20.6
U.S. National Average	\$25,860	\$1,096	23.6
University of Wisconsin	\$28,827	\$1,462	19.7
Cleveland Clinic	\$31,252	\$1,307	23.9
Mayo Clinic	\$31,816	\$1,497	21.3
UCLA	\$58,557	\$1,871	31.3

*Based on 2007 Dartmouth Atlas Study Methodology. The Dartmouth Atlas methodology examines hospital inpatient care for the last two years of a Medicare patient's life.

Advance Directives

Gundersen Lutheran's advance directives program is a proven model for improved end-of-life planning and decision making. What makes this program successful is a comprehensive, systematic approach that includes three key components:

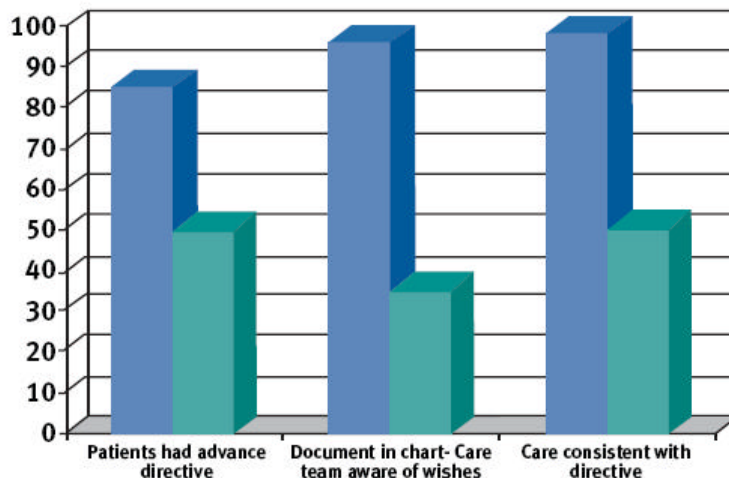
- **Community approach:** Systems have been set up to foster conversations about advance directives in the community using medical and community resources. For example, discussions about advance directives have been built into Gundersen Lutheran's hospital admissions process, and Gundersen Lutheran has trained advance care planning facilitators available to answer questions for patients at any time.
- **Availability of information as a standard practice:** This model allows advance directives to be available in patients' medical records so the directives are available wherever patients are and whenever they need them.
- **Professional education:** Having an advance directive is not enough. Healthcare professionals must also comply with it. Educating providers about advance directives has led to a high level of provider compliance with patients' treatment choices.

The program's focus on a systematic approach to advance directives has resulted in a high prevalence of planning by the time of death. End-of-life care plans are almost always available at the site of care, and there's consistency between the plans and actual decisions at the end of life. Studies at Gundersen Lutheran have shown patients with advance directives used about \$2,000 less in physician and hospital services in the last six months of life—the time period when most medical care expenses are incurred.

Results of our program

Since its inception in 1986, the Gundersen Lutheran advance directives system has had a significant impact on end-of-life planning and decision making. Data released by Gundersen Lutheran in 2008 show of all adult residents who died in La Crosse County over a six month period under the care of a physician (408), 90 percent had a written advance directive and all of these documents were found in the medical record where the patient died. Of these patients, 96 percent had an advance directive or Physician Order for Life-Sustaining Treatment (POLST) form in their medical records. These results have been sustained over a 12-year period.

Results of our program compared to national averages



National information: Research in Action, AHRQ, Issue #12, March 2003

La Crosse information: Hammes BJ, Rooney B. "Death and End-of-Life Planning in One Midwestern Community." *Archives of Internal Medicine*. 1998;158:383-390

■ La Crosse
■ Nationally

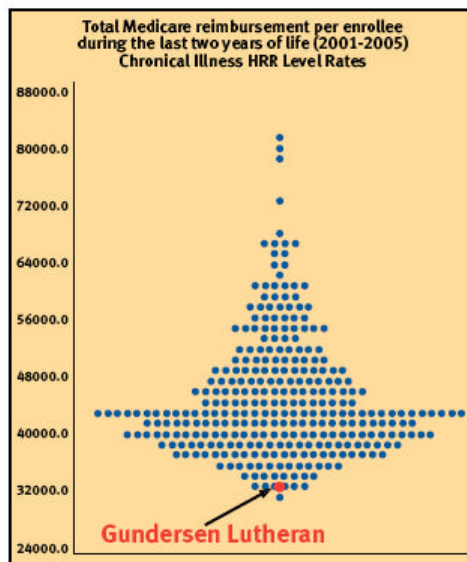
An internationally recognized program

Gundersen Lutheran's model for advance directives led to the development of the Gundersen Lutheran Respecting Choices® program. Respecting Choices has been implemented in more than 55 organizations or groups in the United States, is gradually becoming a model for end-of-life care in Australia under the funding of the Australian Ministry of Health, is being implemented in two large health authorities in Canada and is being adapted for use in Germany to increase the use, quality and validity of advance directives in nursing homes.

Advance Directives and the Electronic Medical Record

A novel, sophisticated advance care planning electronic application has been embedded into Gundersen Lutheran's electronic medical record. That means a patient's advance directive is available for healthcare providers at all sites of care throughout the Gundersen Lutheran Health System. What is more, the advance care planning electronic application goes beyond the advance directive. It brings together all advance care planning practices at Gundersen Lutheran into one electronic system including:

- Guides practitioners through initiating and updating advance care planning conversations
- Allows the clinician to document that the patient was given advance care planning education
- Allows physicians to dictate advance care planning notes as part of their routine dictation and easily retrieve those notes
- Identifies the patient's healthcare agents (person given authority to make medical decisions for the patient) and other surrogates
- Assists with referrals to advance care planning facilitators



National Comparison: www.dartmouthatlas.org/data_tools.shtm

When compared with other hospitals in the country, Gundersen Lutheran ranks near the bottom when it comes to Medicare costs associated with chronic disease in a patient's last two years of life.

Hospital-based Palliative Care

Gundersen Lutheran developed its innovative hospital-based palliative care program three years ago. The program provides inpatient care for patients with end-stage disease suffering an acute medical crisis. Palliative care is an extension of hospice-style care that helps patients with advanced diseases and their families through the physical, psychosocial and spiritual aspects of aging and dying.

Gundersen Lutheran's innovative hospital-based palliative care program has shown to:

- Significantly reduce hospital costs: In the first 15 months of the program, hospital costs were reduced by approximately \$3,500 per patient in billed costs
- Increase admissions to hospice care: 32% increase since 2007
- Reduce hospital readmission rates: 6% versus 18% in a control population
- Result in higher ratings of satisfaction with care from families of patients who die in the hospital

Patients can also receive palliative care services in the outpatient setting, resulting in an increased continuity of care.

Next step: Model for Late Life Care

Gundersen Lutheran Health System is incorporating all of the elements of its advance directives program to create a national model for more efficient, high-quality care for patients nearing the end of life. Rather than focusing on disease management, dependent on medical specialists and a high use of medical services, this system is designed to efficiently help patients live as well as possible in their last two years of life.

This model of care is specifically designed for patients who have serious, eventually fatal, chronic conditions. It features an interdisciplinary care team dedicated to providing high quality, seamless medical care, individualized for each patient and family across all settings of care, from home to hospital. We call this new end-of-life model "Late Life Primary Care" and we expect it to reduce healthcare costs by 25 to 50 percent nationally.

Gundersen Lutheran Health System

Headquartered in La Crosse, Wis, Gundersen Lutheran Health System provides quality health services to patients at its hospital and clinics throughout western Wisconsin, southeastern Minnesota and northeastern Iowa. Gundersen Lutheran is a major tertiary teaching hospital, providing a broad range of emergency, specialty and primary care services to its patients.

As one of the nation's largest multi-specialty group medical practices, Gundersen Lutheran is comprised of nearly 700 medical, dental and associate staff, and supported by a staff of more than 6,000. The Health System has been named among the top 100 in the nation 13 times in the last 11 years.

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By the time I got back to the hospital my Dad had lost feeling in his right side, so the doctors wanted to take him down for a CT scan to determine what was happening. My sister arrived just as they were wheeling him down and reassured him that we would be there when he got back and that my Mom and brother would be there soon. Dad's last words to my sister were "no more."

By the time Dad was back from his test, the physician sat down with us to explain Dad had experienced a significant bleed and he would no longer be able to talk, walk or feed himself. Within a short period of time he would need life support as his breathing would be compromised. He provided us with some treatment options, but it was clear that my Dad would never regain functionality. I remember asking my mom if she understood what the doctor had said and if she needed him to repeat anything or had any questions. She confidently nodded her head and said to him. "Thank you doctor, your work is done here. He is in God's hands now." It was just after midnight.

From that point on the support we received centered around making my Dad comfortable and helping us adjust knowing that he only had a short time left. The medical and support staff were all respectful of our decisions and helped us through these final hours. He received his last rights, our family surrounded his bed, and my mom, his wife of over 50 years, was holding his hand when he died just 2 days after his unexpected Emergency Room visit. As a family, we've never had to wonder whether it was the right thing to not seek additional treatment or if we made the right decisions. As a family, we're all comfortable with the way that dad chose to die. Since, we've been able to spend our time helping mom and enjoying what time we have left with her.

Closing Remarks:

I urge this Committee to give the rest of the country what patients in La Crosse, Wisconsin have had access to for many years; a system that allows people to make their wishes known and healthcare organizations that value and respect those choices.

By expanding Gundersen's end of life care model across the nation, you will be providing families and loved ones with support to have one of the most important conversations of their life. This will allow families to come together, rather than be torn apart, when they need each other most. Through your efforts healthcare systems will engage their patients in the right discussions, developing the mechanisms to incorporate those wishes into treatment plans. On behalf of my father and my friend Annette, I ask you to give others the opportunity to experience this gift of love and give the medical community the ability to fulfill the wishes of their patients.

I wanted to share my personal story today, but please take a minute to read the information in the attached document, which outlines Gundersen Lutheran's end of life care system. As you will see, the cost of dying at Gundersen Lutheran is about \$18,000 and family satisfaction is extremely high. In

comparison, the national average cost of dying is more than \$25,000, and at many of the nation's leading healthcare organizations the cost is as high as \$31,000 and \$58,000.

As you move forward, my strongest recommendation to you is to remove barriers and create incentives to expand this successful end of life care model nationwide. The work and proven results of Gundersen Lutheran's experience are transforming end of life care to increase continuity of care, quality of care, and respect for patients' wishes, while lowering the cost of care and reducing over-utilization of the healthcare system. This model can be implemented across the nation in every setting whether the medical record is paper or electronic. In addition, we encourage that the six principles outlined in our written testimony be incorporated into any policy or regulation related to advance care planning:

1. Health care professionals should help all adults understand and document their end-of-life care goals and preferences as well as designate an end-of-life care decision-maker.
2. There should be a process to convert treatment goals and preferences into medical orders to ensure information is transferable and honored.
3. Universal implementation of electronic medical records and internet-based personal health records shall include and integrate timely information relevant to the patient's advance directive.
4. If no advance directive exists at the time of need, any authentic expression of an individual's goals, values or wishes with respect to healthcare should be honored.
5. Federal support for research, education, and expansion of best practices relating to the quality and continuity of care related to advance directives and the end of life.
6. Medicare would reimburse organizations at a higher level if certain advance care planning outcomes are met. For example, if 85% or more adult decedents had a written advance directive found in the medical record at the site of care, and the wishes expressed in the document were consistent with the treatment provided. Rather than reimbursing for a specific event, payment would be hinged on outcomes that meet performance benchmarks.

Thank you for this opportunity to speak to you today about this important issue.





Policy and Regulatory Principles for Advance Care Planning

- 1) Health care professionals should encourage and offer assistance to all adults, helping individuals to understand and document their end-of-life care goals and preferences as well as designate an end-of-life care decision-maker.
- 2) Health care professionals should have a process to convert treatment goals and preferences of persons with life-limiting illness into medical orders (e.g. the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Initiative) to ensure that information is transferable and applied across all care settings.
- 3) In the absence of a validly executed advance directive, any authentic expression of an individual's goals, values, or wishes with respect to health care should be honored.
- 4) Universal implementation of electronic medical records and internet-based personal health records shall prominently include and integrate timely information about patient proxy designations, care goals and preferences, and medical orders for life-sustaining treatment. This information should be stored within the electronic health record system of the individual's community-based hospital, not a national data warehouse.
- 5) The federal government should support research, education, and development of best practices relating to the quality and continuity of care planning and care implementation for persons with life-limiting illnesses across care settings.
- 6) Medicare would reimburse organizations at a higher level if certain advance care planning outcomes are met. For example, if 85% or more adult decedents had a written advance directive found in the medical record at the site of care, and the wishes expressed in the document were consistent with the treatment provided. Rather than reimbursing for a specific event, payment would be hinged on outcomes that meet performance benchmarks.

Transforming Healthcare at the End of Life



Gundersen Lutheran Health System is leading the nation with an innovative end-of-life program that provides the right healthcare to patients in the end stages of their lives. Our system increases continuity of care, quality of life and respect for the patient's wishes, while lowering the cost of care and reducing over-utilization of the healthcare system.

The system is based on well-established, existing programs at Gundersen Lutheran, including:

- A community-wide advance directives program which makes advance directives available to every person, ensures they are available wherever and whenever patients need them and ensures healthcare professionals comply with the patient's treatment choices.
- Hospice and palliative care programs, which assist patients with advanced diseases through the physical, psychosocial and spiritual aspects of aging and dying.

- Coordination of these services by use of electronic medical records, which can be accessed by all medical professionals in the health system and region at all sites of care.

The future of healthcare

Gundersen Lutheran's approach to advance directives has led to the development of a model of care we're calling Late Life Primary Care, which encompasses advance directives, palliative care and hospice. When all of these programs work together, the Late Life Primary Care approach can save between \$3,000 and \$6,000 per patient, per year. Gundersen Lutheran has presented the Late Life Primary Care concept to the Centers for Medicare and Medicaid Services (CMS) as a model to change the way end-of-life care is delivered on a national scale. The entire proposal is available for review.

Cost of Care in the Last Two Years of Life*

Hospital	Reimbursement per Deceased Patient (2 -year total)	Reimbursement Per Day	Hospital Days per Deceased Patient
Gundersen Lutheran	\$18,359	\$1,355	13.5
Marshfield/St. Joseph's	\$23,249	\$1,126	20.6
U.S. National Average	\$25,860	\$1,096	23.6
University of Wisconsin	\$28,827	\$1,462	19.7
Cleveland Clinic	\$31,252	\$1,307	23.9
Mayo Clinic	\$31,816	\$1,497	21.3
UCLA	\$58,557	\$1,871	31.3

*Based on 2007 Dartmouth Atlas Study Methodology. The Dartmouth Atlas methodology examines hospital inpatient care for the last two years of a Medicare patient's life.

Advance Directives

Gundersen Lutheran's advance directives program is a proven model for improved end-of-life planning and decision making. What makes this program successful is a comprehensive, systematic approach that includes three key components:

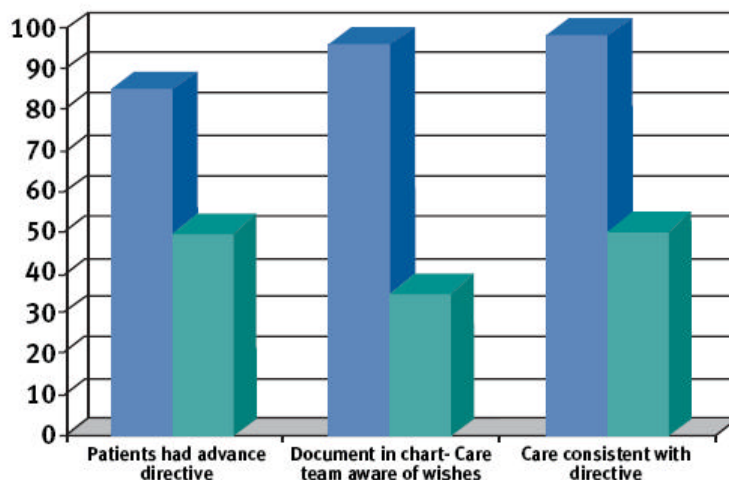
- **Community approach:** Systems have been set up to foster conversations about advance directives in the community using medical and community resources. For example, discussions about advance directives have been built into Gundersen Lutheran's hospital admissions process, and Gundersen Lutheran has trained advance care planning facilitators available to answer questions for patients at any time.
- **Availability of information as a standard practice:** This model allows advance directives to be available in patients' medical records so the directives are available wherever patients are and whenever they need them.
- **Professional education:** Having an advance directive is not enough. Healthcare professionals must also comply with it. Educating providers about advance directives has led to a high level of provider compliance with patients' treatment choices.

The program's focus on a systematic approach to advance directives has resulted in a high prevalence of planning by the time of death. End-of-life care plans are almost always available at the site of care, and there's consistency between the plans and actual decisions at the end of life. Studies at Gundersen Lutheran have shown patients with advance directives used about \$2,000 less in physician and hospital services in the last six months of life—the time period when most medical care expenses are incurred.

Results of our program

Since its inception in 1986, the Gundersen Lutheran advance directives system has had a significant impact on end-of-life planning and decision making. Data released by Gundersen Lutheran in 2008 show of all adult residents who died in La Crosse County over a six month period under the care of a physician (408), 90 percent had a written advance directive and all of these documents were found in the medical record where the patient died. Of these patients, 96 percent had an advance directive or Physician Order for Life-Sustaining Treatment (POLST) form in their medical records. These results have been sustained over a 12-year period.

Results of our program compared to national averages



National information: Research in Action, AHRQ, Issue #12, March 2003

La Crosse information: Hammes BJ, Rooney B. "Death and End-of-Life Planning in One Midwestern Community." *Archives of Internal Medicine*. 1998;158:383-390

■ La Crosse
■ Nationally

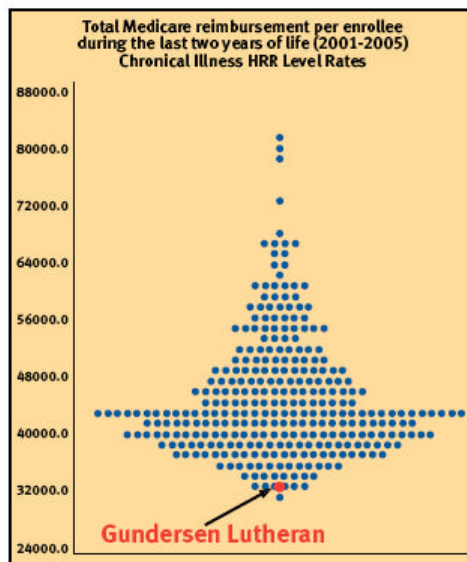
An internationally recognized program

Gundersen Lutheran's model for advance directives led to the development of the Gundersen Lutheran Respecting Choices® program. Respecting Choices has been implemented in more than 55 organizations or groups in the United States, is gradually becoming a model for end-of-life care in Australia under the funding of the Australian Ministry of Health, is being implemented in two large health authorities in Canada and is being adapted for use in Germany to increase the use, quality and validity of advance directives in nursing homes.

Advance Directives and the Electronic Medical Record

A novel, sophisticated advance care planning electronic application has been embedded into Gundersen Lutheran's electronic medical record. That means a patient's advance directive is available for healthcare providers at all sites of care throughout the Gundersen Lutheran Health System. What is more, the advance care planning electronic application goes beyond the advance directive. It brings together all advance care planning practices at Gundersen Lutheran into one electronic system including:

- Guides practitioners through initiating and updating advance care planning conversations
- Allows the clinician to document that the patient was given advance care planning education
- Allows physicians to dictate advance care planning notes as part of their routine dictation and easily retrieve those notes
- Identifies the patient's healthcare agents (person given authority to make medical decisions for the patient) and other surrogates
- Assists with referrals to advance care planning facilitators



National Comparison: www.dartmouthatlas.org/data_tools.shtm

When compared with other hospitals in the country, Gundersen Lutheran ranks near the bottom when it comes to Medicare costs associated with chronic disease in a patient's last two years of life.

Hospital-based Palliative Care

Gundersen Lutheran developed its innovative hospital-based palliative care program three years ago. The program provides inpatient care for patients with end-stage disease suffering an acute medical crisis. Palliative care is an extension of hospice-style care that helps patients with advanced diseases and their families through the physical, psychosocial and spiritual aspects of aging and dying.

Gundersen Lutheran's innovative hospital-based palliative care program has shown to:

- Significantly reduce hospital costs: In the first 15 months of the program, hospital costs were reduced by approximately \$3,500 per patient in billed costs
- Increase admissions to hospice care: 32% increase since 2007
- Reduce hospital readmission rates: 6% versus 18% in a control population
- Result in higher ratings of satisfaction with care from families of patients who die in the hospital

Patients can also receive palliative care services in the outpatient setting, resulting in an increased continuity of care.

Next step: Model for Late Life Care

Gundersen Lutheran Health System is incorporating all of the elements of its advance directives program to create a national model for more efficient, high-quality care for patients nearing the end of life. Rather than focusing on disease management, dependent on medical specialists and a high use of medical services, this system is designed to efficiently help patients live as well as possible in their last two years of life.

This model of care is specifically designed for patients who have serious, eventually fatal, chronic conditions. It features an interdisciplinary care team dedicated to providing high quality, seamless medical care, individualized for each patient and family across all settings of care, from home to hospital. We call this new end-of-life model "Late Life Primary Care" and we expect it to reduce healthcare costs by 25 to 50 percent nationally.

Gundersen Lutheran Health System

Headquartered in La Crosse, Wis, Gundersen Lutheran Health System provides quality health services to patients at its hospital and clinics throughout western Wisconsin, southeastern Minnesota and northeastern Iowa. Gundersen Lutheran is a major tertiary teaching hospital, providing a broad range of emergency, specialty and primary care services to its patients.

As one of the nation's largest multi-specialty group medical practices, Gundersen Lutheran is comprised of nearly 700 medical, dental and associate staff, and supported by a staff of more than 6,000. The Health System has been named among the top 100 in the nation 13 times in the last 11 years.

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