GAO Highlights

Highlights of GAO-19-231, a report to congressional requesters

February 2019

ADVANCE CARE PLANNING

Selected States' Efforts to Educate and Address Access Challenges

Why GAO Did This Study

Many individuals receive medical care for a serious or life-limiting condition during the last months of life, which may involve making difficult decisions about life-sustaining treatment. Advance care planning helps ensure that physicians, families, and friends have documentation outlining individuals' wishes under these circumstances.

GAO was asked to identify issues related to completing and accessing advance care planning documents. This report describes, among other things, (1) the challenges individuals and providers face completing and accessing the documents, and (2) selected states' strategies for improving individuals' and providers' understanding of and access to advance care planning documents.

GAO reviewed documents and interviewed officials from national stakeholder organizations involved in advance care planning or aging issues, and conducted a literature review of relevant articles published from January 2012 to April 2018 in peer-reviewed and other publications. In addition, GAO interviewed officials from state agencies and stakeholder organizations in California, Idaho, Oregon, and West Virginia. GAO selected those four states because they were active in encouraging advance care planning and had registries for completed documents that were in different stages of development.

The Department of Health and Human Services, states, and stakeholders provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-19-231. For more information, contact Carolyn L. Yocom at (202) 512-7114 or YocomC@gao.gov.

What GAO Found

Advance care planning documents—including advance directives and physician orders for life sustaining treatment (POLST)—allow individuals to express their wishes for end-of-life care. Advance directives, which include living wills and health care power of attorney, provide direction regarding care when an individual becomes incapacitated. POLST documents are appropriate for seriously ill individuals whose health status indicates the need for medical orders to be documented in their medical records.

Types of Advance Care Planning Documents

	What type of document	Who should have the document	Who completes the document	What the document communicates
Advance directives	Legal document	All competent adults	Individual	General treatment wishes (if incapacitated)
Physician orders for life sustaining treatment (POLST)	Medical orders	Any seriously ill or frail individuals (regardless of age)	Health care provider	Specific medical orders

Source: GAO analysis of National POLST Paradigm information. | GAO-19-231

Stakeholders from national organizations and officials in the four states GAO selected to review cited several challenges—affecting both individuals and health care providers—related to the use of advance care planning documents. In particular, they noted a lack of understanding about how to complete the documents and how to initiate conversations about advance care planning. They also cited challenges related to the difficulty of ensuring access to completed documents when needed, such as in an emergency situation.

Officials from state agencies and stakeholder organizations in the four selected states reported pursuing various strategies to improve understanding of advance care planning documents by conducting education efforts for individuals and providers. In addition, the states utilized strategies to improve access to completed documents, such as improving the electronic exchange of information between health records and a state registry, which is a central repository intended to improve access to the documents. Further, stakeholder officials reported strategies related to the acceptance of out-of-state advance care planning documents; all four selected states had statutory provisions that address the validity of documents executed in another state.