AMERICA'S PHYSICIAN GROUPS

Innovative Approaches to Advanced Illness Care

Leanne M. Yanni, MD
Executive Medical Director of Comprehensive Care
Bon Secours Mercy Health
Leanne_Yanni@bshsi.org

Serious Illness Journey, 2011-2018

- Strategic Quality Plan: Unparalleled Palliative Care
- Commit to enhance Palliative Care Specialty Services
  - Achieve JC Advanced Certification for Palliative Care
  - Honored by American Hospital Association's Circle of Life Award
- Implement required JC metrics for Advanced Certification for Palliative Care
- Partner with Anthem to develop Palliative Care QHIP Bonus Program
- Initiate Palliative Care screening for high risk congestive heart failure patients
  - Data demonstrates reduced readmissions in high risk CHF patients with palliative care consultation
- Create *Policy For Determining Medically Unnecessary Care Not Required*
- Participate in NCQA Serious Illness project
- Develop(ing) EHR process to identify high risk patients and satisfy unmet palliative care needs

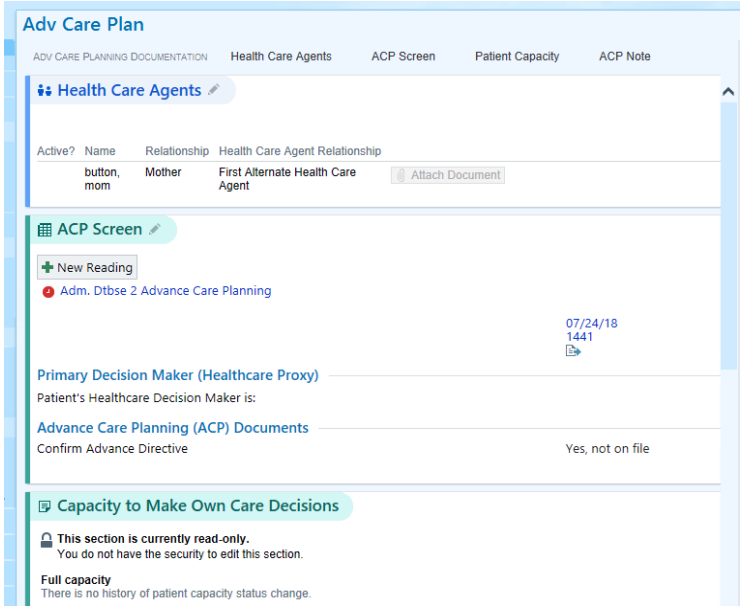
Advance Care Planning Journey, 2012-2018

- Recognize Advance Care Planning (ACP) documentation issues
- Initiate ACP system wide Electronic Health Record change (EPIC)
- Participate in Richmond Academy of Medicine's Honoring Choices® Virginia
- Integrate ACP education into provider compliance training
- Educate providers on Medicare ACP Billing Codes
- Create ACP physician quality metric
- Implement Physician Orders for Scope of Treatment (POST) in Virginia
- Participate in CMS Congestive Heart Failure bundle with new Advance Care Planning metric

Initiate ACP system wide Electronic Health Record change (EPIC)

3 Key Components

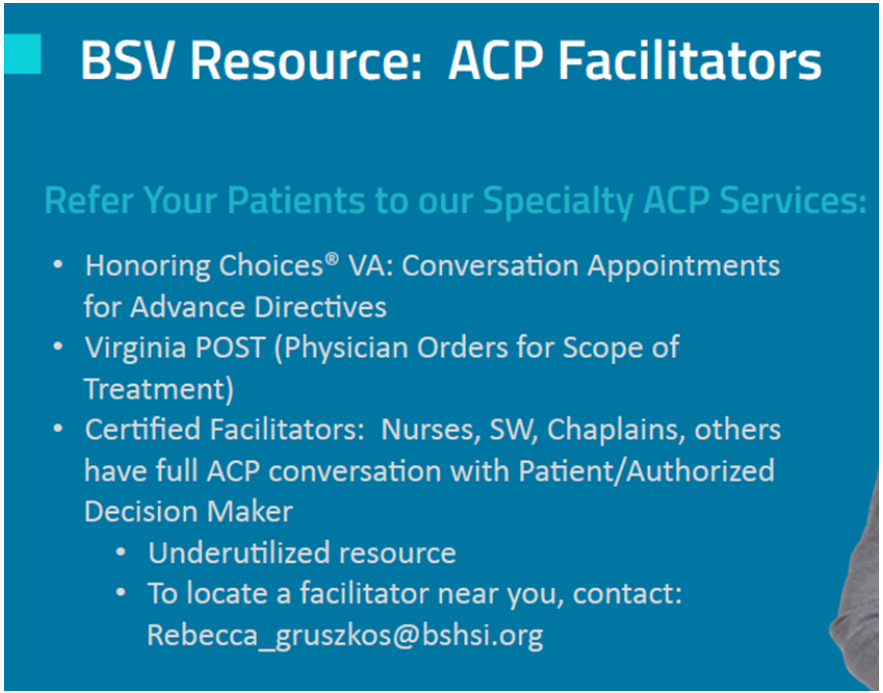
- DECISION MAKER
  - Single discrete field for medical decision maker
- DOCUMENTS
  - Reorganization of Document Types with “ACP-”
- CONVERSATIONS
  - Creation of ACP Note



AMERICA'S PHYSICIAN GROUPS

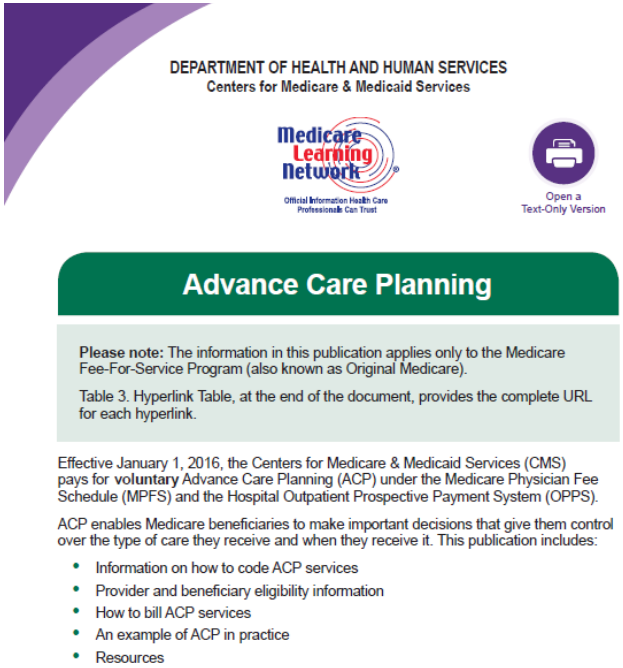
Participate in Richmond Academy of Medicine's Honoring Choices® Virginia

- Modeled after Respecting Choices®
- Partnership with regional health systems
- Focus: Primary Care
- Key: Health System ACP Coordinator



Educate Providers on Medicare ACP Billing Codes

- CMS releases ACP Billing Codes January 2016
- EHR “short cuts” created to meet requirements for ACP billing
- “Short cuts” integrated into Medicare Wellness visits



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Open a Text-Only Version

Advance Care Planning

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Table 3. Hyperlink Table, at the end of the document, provides the complete URL for each hyperlink.

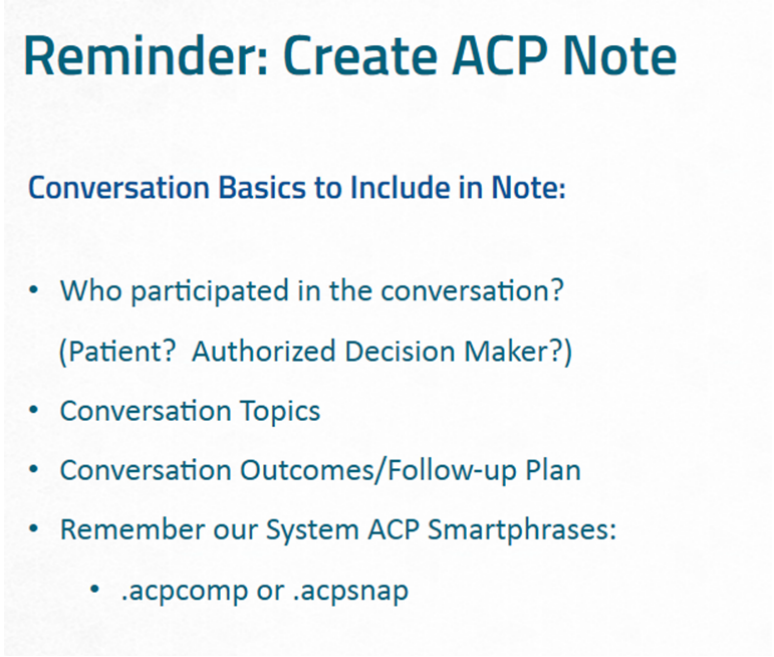
Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for **voluntary** Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS).

ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it. This publication includes:

- Information on how to code ACP services
- Provider and beneficiary eligibility information
- How to bill ACP services
- An example of ACP in practice
- Resources

Create ACP Physician Quality Metric

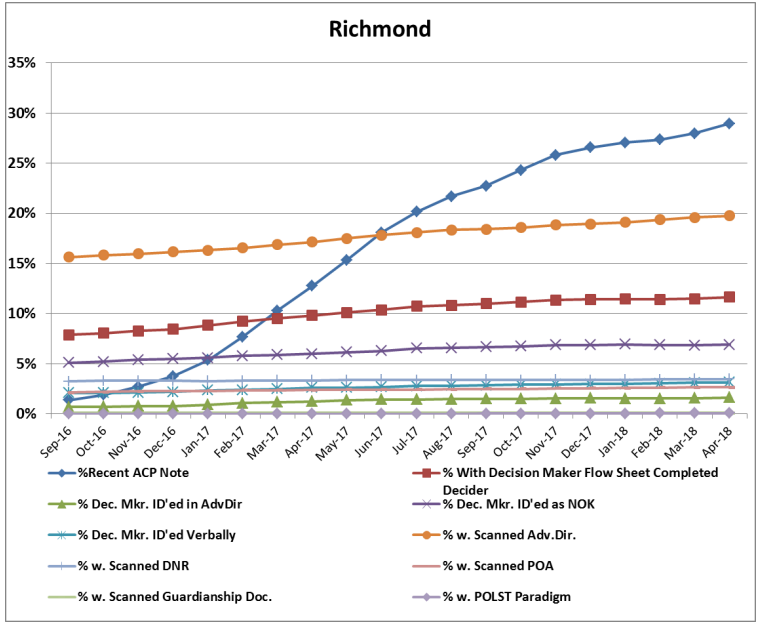
- Goal: Normalize ACP conversations
- NQF standard 0326:
  - Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan



Phase of assessing ACP Quality

- Chart review to assess outcomes
  - Decision maker
  - Documents (Advance Directive, POST, Durable DNR)
  - Conversation (responses of patient/decision-maker)

ACP Note Correlation with ACP Scanned Documents & Decision Maker Information



AMERICA'S PHYSICIAN GROUPS

Bringing it all Together for Outcomes

Key

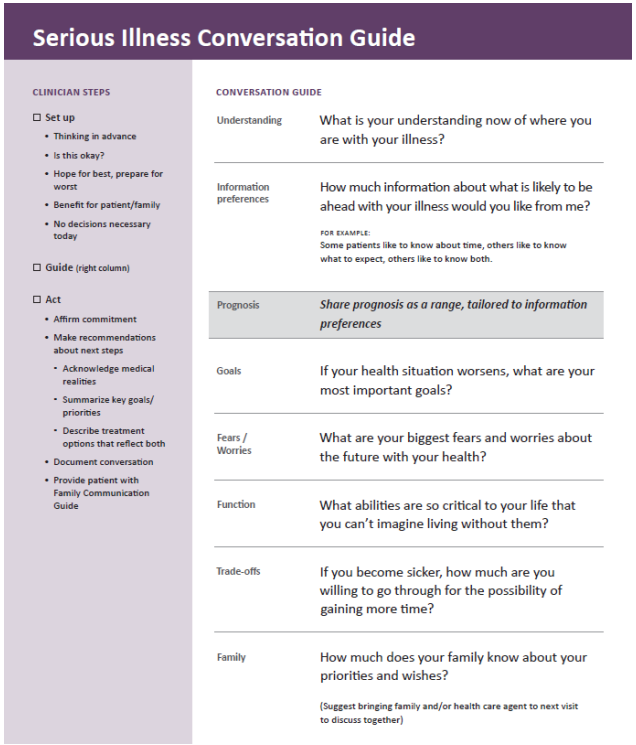
- Integrated ACP efforts are the building blocks for a serious illness tool to address unmet palliative care needs

The Surprise Question (pilot in specific diagnoses)

- Would you be surprised if this patient died in a year?

If NO: Address Unmet Palliative Care Needs

- Advanced Care Planning / Decision Maker & Documents
- Goals of care / Treatment Preferences
- Resuscitation Order
- Depression
- Pain
- Spiritual Care
- Caregiver Burden



Serious Illness Conversation Guide

CLINICIAN STEPS

☐ Set up
- Thinking in advance
- Is this okay?
- Hope for best, prepare for worst
- Benefit for patient/family
- No decisions necessary today

☐ Guide (right column)

☐ Act
- Affirm commitment
- Make recommendations about next steps
  - Acknowledge medical realities
  - Summarize key goals/ priorities
  - Describe treatment options that reflect both
- Document conversation
- Provide patient with Family Communication Guide

CONVERSATION GUIDE

Understanding	What is your understanding now of where you are with your illness?
Information preferences	How much information about what is likely to be ahead with your illness would you like from me? FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.
Prognosis	*Share prognosis as a range, tailored to information preferences*
Goals	If your health situation worsens, what are your most important goals?
Fears / Worries	What are your biggest fears and worries about the future with your health?
Function	What abilities are so critical to your life that you can't imagine living without them?
Trade-offs	If you become sicker, how much are you willing to go through for the possibility of gaining more time?
Family	How much does your family know about your priorities and wishes? (Suggest bringing family and/or health care agent to next visit to discuss together)

AMERICA'S PHYSICIAN GROUPS