A population health approach to advance care planning in primary care:

The "ACP @ DOC" Pilot

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Disclosures

- Azalea Kim equity owner social enterprise myProxy, Inc d/b/a TrueNorth Healthcare
- No other disclosures
Case

- Ms D, a 74 year old female with severe COPD, stage III CKD, and recent hospitalization for a new diagnosis of systolic heart failure presenting for hospital follow-up. She has three new medicines that were started during this hospitalization.

- You realize that with her age and co-morbidities, she could have a further decline in the near future and should start thinking about the “what if’s”

- You then realize your next patient is already roomed, so you hand her a folder with a copy of an advance directive and plan to discuss it at the next visit

- Which doesn’t happen.
Objectives

Participants will be able to…

- Explain ACP and Primary Care’s Role
- Describe one innovative example where ACP is incorporated into primary care (“ACP @ DOC” Pilot)
- Utilize tips for having the ACP conversation
What do we mean by ACP?

“Advance Care Planning is a process of understanding, reflecting on and discussing future medical decisions, including end-of-life wishes.”

- From the Center To Advance Palliative Care website www.capc.org
ACP: What do we mean? What do we need?

• **Uncover gaps in understanding** about individual medical situations and then work with medical providers to bridge those gaps.

• **Engage patients about values, beliefs, preferences, & goals.**

• **Help people communicate effectively with their chosen health care agents** about their values and goals of care.

• **Help patients document** their elected health care agents and goals of care.

• **Ensure that documented plans are easily retrievable** by health care professionals who may need access.

*From “What Kind Of Advance Care Planning Should CMS Pay For?” Health Affairs Blog, March 2015*
Why ACP in Primary Care?

90% of people say that talking with their loved ones about end-of-life care is important.

27% have actually done so.

Source: The Conversation Project National Survey (2013)
Why ACP in Primary Care?

80% of people say that if seriously ill, they would want to talk to their doctor about their wishes for medical treatment toward the end of their life.

7% report having had this conversation with their doctor.

Source: Survey of Californians by the California HealthCare Foundation (2012)
The Problem Across Stakeholders

**Patients**
- Majority want to talk to doctors about wishes if seriously ill.
- A small minority do.

**Surrogates & Caregivers**
- Often make medical decisions on behalf of loved ones.
- Seldom have patients communicated wishes to surrogates.

**Primary Care Practices**
- Have close and longitudinal relationships with patients.
- Don’t have the time or resources to engage readily in ACP.

**Payors & Health Systems**
- Recognize importance of ACP in the value-based landscape.
- Lack a broadly applicable strategy to integrate ACP across populations.

Primary Care = Epicenter of population health activities
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ACP @ DOC* Pilot

I. Predictive Model & Outreach

II. Practice Pathway for ACP appointments with Patient Navigators

III. Documentation for Provider Alignment

Guide patients and families

Pilot funded by Duke Institute for Healthcare Innovation (DIHI)

*DOC = Duke Outpatient Clinic
I. Predictive Model & Outreach

• ID appropriate patient population via predictive model, validated as “concordant” with PCP review

• Predictive model takes into account: Age, Co-morbidity index, and hospitalizations

• Outreach via scheduling hub staff and Patient Navigators to invite patients and key stakeholders (i.e., caregivers, family members) to a dedicated “Care Planning Appointment” with patient navigator at DOC
II. Practice Pathway

• Two Patient Navigators who conduct ACP dedicated appointments:
  ➢ Trained in social work
  ➢ Onboarding to include inpatient palliative care rounding and simulation-based communications training

• Patient navigator activities targeted to consensus outcomes for ACP encounters

• Patient and surrogate education that emphasizes:
  ➢ Health literacy
  ➢ Ongoing communication between patients and surrogates

• To promote practice culture to support ACP, “eat and learn” for all staff to share own experiences around end-of-life care and APC and learn about DOC’s ACP pilot.
Duke Outpatient Clinic "Care Planning" (ACP)
Visit Note

If this ACP discussion was part of a primary care visit or other visit note please see note dated: ***

**Context**
*What is the patient's experience with ACP (both for self care or in caring for others)?*

**HCPOA/Advocate/Surrogate Information**
Before this visit the patient {did/did not(default):32030} have legal HCPOA designation scanned into the chart.

Name of HCPOA: ***
Relationship of HCPOA to patient: ***
Contact information for HCPOA: ***

If a backup HCPOA was also designated, you can list his/her information here: ***

At the end of this visit, the status of the HCPOA designation was:
*(ex: completed, signed by notary and scanned into chart, partially completed and not yet notarized, incomplete)*
GET TO KNOW THE PATIENT
Here is some background information on the patient. Use quotations as much as possible:

The patient's fears and worries were described to me as follows:
***

The patient's self-reported definitions of quality of life are as follows:
***

The patient's self-reported opinion on the most important functional abilities are as follows:
***

What is the patient's understanding about his/her illness?
***

What has the patient been told by doctors about his/her illness?
***

What does the patient's family/friends/caregivers understand about the patient's illness?
***

Other important areas of discussion:
***
**Goals Assessment:**

The patient's most important goals were described to me as follows:
***

The patient's family/friends/caregivers understand his/her goals to be as follows:
***

**Questions for Follow-up**

*What questions does the patient have for his/her doctors (i.e., PCP, specialists) regarding illness? Use quotations as much as possible*

A followup appointment to further discuss ACP with PCP {was was not:24377} done.

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**Coding Summary for Advance Care Planning**

<table>
<thead>
<tr>
<th>Discussion Held With:</th>
<th>Patient □ Family □ Surrogate □</th>
<th>Legal Forms Completed during this encounter? Y or □ N □</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Face to Face time discussing Advanced Care Planning:</strong></td>
<td>*** Minutes</td>
<td></td>
</tr>
</tbody>
</table>

(Minimum of 16 required for 99497)

**Advanced Care Planning Discussion Included:** Details as described above

**NOTE:** Structured ACP documentation included above is required for billing purposes. For most routine office encounters, bill CPTs 99497 and 99498. If ACP is discussed during a Medicare AWV, add a modifier 33. Billing can also be done in an inpatient environment, outside of ICUs.
Patient Education Materials

- Cards and Posters

CARE PLANNING: LET’S TALK ABOUT THE FUTURE
As your primary care doctors, we want to make sure we are prepared for anything. One way to do this is something called Care Planning.

WHAT IS CARE PLANNING?
Care Planning is to plan for what to do if you ever got very sick. It means talking about your goals for health, wishes for medical care, and how we can plan for times of illness in the future. Our goal is to give you a voice in your care. This is especially important if you have a chronic disease or a serious illness.

WHO SHOULD DO CARE PLANNING?
Care Planning is for everyone - at any age or stage of health. It should involve you, your loved ones, and your health care providers. We offer Care Planning to bring peace of mind to ALL of our patients.

WHAT IF I CHANGE MY MIND?
Your goals and preferences may change over time. We are by your side to help you through difficult decisions and update your Care Plan.

If you have any questions, please call us the Duke Outpatient Clinic at (919) 471-8344 and ask for the Care Planning Patient Navigator.

5 EASY STEPS FOR CARE PLANNING

STEP 1. CHOOSE AN ADVOCATE.
This person is also known as a legal healthcare power of attorney or surrogate. This is a person who can make medical decisions on your behalf. You should pick a person that you trust, is brave, and can be there if you need him or her. Your advocate can only make decisions if you are not able to make decisions for yourself.

STEP 2. COMPLETE THE LEGAL PAPERWORK TO CHOOSE AN ADVOCATE.
There are legal forms that need to be signed by you, two witnesses, and a notary. We provide this service on-site in the clinic.

STEP 3. SPEAK TO YOUR ADVOCATE
It is important that you share your wishes with your advocate(s). Otherwise, how will an advocate know about the kind of care you would want? Invite your loved ones to join our Care Planning appointments in-person or by phone.

STEP 4. TALK WITH YOUR PRIMARY CARE DOCTOR.
Many decisions are complex. We will set up follow-up appointments with your PCP to help talk through these issues.

STEP 5. MAKE YOUR CARE PLAN AVAILABLE TO ALL DUKE HEALTH PROVIDERS
We will document the Care Plan in your electronic medical record. In doing so ALL providers taking care of you at Duke Health can understand your wishes. This is especially important for providers in the hospital.
Thank you for coming to your Care Planning appointment today. Today we were able to:

1. Made a plan in case you ever became very sick
2. Talked about your goals for health and wishes for medical care
3. Chose your healthcare advocate (also known as a healthcare power of attorney)
4. Submitted your legal form to the electronic health record at Duke

Here are some questions to help you talk to your advocate about your wishes:

- How comfortable are you with sharing your current health status with your advocate?
- Is your advocate comfortable making decisions on your behalf?
- What concerns do you and your advocate have about your current health?
- How do you and your advocate feel about certain medical interventions? For example:
  - Cardiopulmonary Resuscitation (CPR)
  - Mechanical ventilation
  - Dialysis
  - Feeding tubes
  - Hospice care
- What would your advocate do if your wishes conflicted with his or her own values?
- How would you define what quality of life means to you? And can you describe this to your advocate?

You should set up a time to talk to your advocate. After meeting with your advocate, come back to clinic. We can document this conversation in your medical record.

Adapted from Ariadne Labs www.ariadnelabs.org
III. Documentation for Provider Alignment

• ACP note template to enable consistent and focused documentation of critical ACP items
  ➢ Includes documentation of questions for the patient’s PCP and specialists
  ➢ Patient Navigators reach out to PCPs to facilitate next steps in conversation as needed

• HCPOA forms completed and notarized on site, and scanned into patient chart

• Exclusive use of the MaestroCare ACP activity as a central repository for ACP data for all Duke providers across specialty and location of service.
ACP Activity in Maestro Care (Epic)

When an ACP Document is on file for the patient, the ACP widget turns Orange. Clicking on the ACP widget in the banner will launch the ACP activity.

Opens this ACP Activity/Navigator
Measuring Impact in ACP: Patient-Centered Outcome Constructs Rated by ACP Delphi Panel Experts

1. Care received is consistent with goals
2. Patient decides on a surrogate
3. Document the surrogate decision maker
4. Discuss values and care preferences with the surrogate
5. Documents and recorded wishes accessible when needed
6. Identify what brings value to patient's life
7. Medical record contains physician treatment orders (e.g., POLST, code status) when it is clinically appropriate
8. Discuss values and care preferences with clinicians
9. Document values and care preferences
10. Medical record contains advance directive or documentation when patient refused

Monthly data extraction to track progress through performance services

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Introducing Advance Care Planning
• Can be via phone call or during a visit
  ➢ “How much information about what is likely to be ahead with your illness would you like to hear from me?” or “Given what has happened recently, I thought this might be a good time to talk about what to do now.”

Think about Agenda Setting
• Ask the patient for his or her main concerns.
  ➢ “If it is OK with you, I’d like to shift gears a little bit…”

Expect and Address Emotion
• Use the NURSE Acronym or other emotion-handling strategies
  • Name
  • Understand
  • Respect
  • Support
  • Explore

• 3 Fundamental Skills
  • Tell me more…
  • Ask-Tell-Ask
  • I wish…
ACP in the Outpatient Setting: Pointers and Pitfalls

- Set the agenda/ask permission
- **Goals** before treatments
- Look for the emotional cues and **RESPOND** to them!
- **Process**, not a destination

**Key Takeaways:**

- Communication is a skill you can learn, like any other procedure. Formal communication train is available.
- Listen to others and find your own comfortable phrases.
- Multiple providers, specifically **non-physician** providers, can engage patients and families in this conversation.
Resources To Improve Your Communication Skills

- **VitalTalk Tips App** (free for iOS and Android)
- **Vitalic.org** (free)
- **CAPC.org** (Duke has a membership)
Continuing Education Credits

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• For the **live** webinar, to obtain the credit you must:
  • Add your name to the chat box (to verify attendance)
  • Complete the survey. The survey will open automatically at the end of the webinar and the link will be sent in a follow-up email.

• If you did not register for this webinar and would like CE credit, contact julie.counts@duke.edu