All-City Palliative Care

Primary Palliative Care Initiatives Across Portland

Friday, May 6, 2022
Primary Palliative Care

- Foundational symptom management
- Discussions re: preferences, goals of treatment
- Shared decision making
- Advance Care Planning
- Code status discussions

Subspecialty Palliative Care

- Advanced management of refractory symptoms
- Management of psychosocial and spiritual distress
- Conflict resolution
- Complex decision making
Providence:
Mari Matsumoto, MSW, LCSW
Marianne Parshley, MD, FACP
Caroline Hurd, MD

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churd@uw.edu
Integrating Primary Palliative Care into Providence PMG Primary Care

Mari Matsumoto, LCSW (she/her)
Marianne Parshley, MD (she/her)
Caroline Hurd, MD (she/her)

All-City Palliative Care Lecture Series, May 6, 2022
WHY?
Specialty Palliative Care

→

Every PMG Patient w/ Serious Illness

= 27x Current Staff

~1,350 Clinicians!!
Vision of 2017 Palliative Care Steering Committee

- Specialist ~50 staff
- Advanced ~150 staff
- Intermediate ~500 staff
- Foundational ~20,000 staff
WHO?
PMG Primary Palliative Care Training Model

4 System Champions

Mentors

• Grad Cert 9-mo
• VitalTalk Faculty

https://pctc.uw.edu

www.vitaltalk.org
PMG Primary Palliative Care Training Model

4 System Champions
Mentors
• Grad Cert 9-mo
• VitalTalk Faculty

48+ Clinic Champions
Advanced
• Grad Cert 9-mo

>1000+ Clinicians
Intermediate Foundational
• Multiple training modalities using available & newly created resources
WHAT?
ACP Life Stages
(ACP=Advance Care Planning)

- HEALTHY
- CHRONIC ILLNESS
- SERIOUSLY ILL
- LAST 1-2 YEARS OF LIFE
- FINAL WEEKS TO MONTHS

Age 18

- **Advance Directive**
  Trusted Decision Maker
  Health Care Rep

- **GOC**
  Serious News

- **GOC**
  What Matters

- **POLST**
  (Portable Orders for Life-Sustaining Treatment)

- **HOSPICE**
PMG Primary Palliative Care Curriculum “PMG PPC”

<table>
<thead>
<tr>
<th>SESSION TYPE</th>
<th>0 “Pre-Work”</th>
<th>1 All Staff</th>
<th>2 All Staff</th>
<th>3 Small Groups By Level</th>
<th>4 Small Groups By Level</th>
<th>5 Small Groups By Level</th>
<th>6 All Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>SESSION FOCUS</td>
<td>INTRO TO PC AND ACP LIFE STAGES - Epic Tiles - 1st vs. Spec PC - Intro to Sage</td>
<td>EMOTIONS NURSE(S)</td>
<td>ACP/AD (Healthy)</td>
<td>101: ACP/AD (Chronic Illness)</td>
<td>101: SERIOUS NEWS (Serious Illness)</td>
<td>101: SERIOUS NEWS</td>
<td>GOC/POLST (Late Illness - POLST vs. AD - SICP Workflows - Specialty PC Ref.)</td>
</tr>
<tr>
<td>101 SKILLS SESSIONS</td>
<td>- Intro to OR AD - Prepare for Care - Complete own AD - Epic resources/tiles</td>
<td>101: AD Resources - Intro to OR AD - Prepare for Care - Complete own AD - Epic resources/tiles</td>
<td>101: ACP Initiate the Conversation - Ask about ADs - Explain ADs - Provide resources - Ask about trusted others - Epic: Update ER contacts</td>
<td>101: Serious News - Role specific headlines - NURSE(S) practice</td>
<td>101: Serious News - Role specific headlines - NURSE(S) practice</td>
<td>101: Serious News - Role specific headlines - NURSE(S) practice</td>
<td></td>
</tr>
<tr>
<td>CULTURE CHANGE</td>
<td>Munch/Learns AD readiness Snack Lecture: NURSE(S)</td>
<td>NURSES activity Snack lecture: NURSE(S)</td>
<td>AD Road to Success</td>
<td>AD Thermometer</td>
<td>Empowerment: Success Factors</td>
<td>Data Report Clinic Letters Celebration!</td>
<td></td>
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</tbody>
</table>

Reinforcement Activity
AD Readiness Trajectory and Munch/Learn

ADVANCE DIRECTIVE
Munch & Learn

Drop by to learn about the Oregon advance directive and why all adults should have one (even you!)

Location: 2nd Floor Conference Room

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 19th</td>
<td>Tuesday</td>
<td>12:30 - 1:30 PM</td>
</tr>
<tr>
<td>April 4th</td>
<td>Monday</td>
<td>12:30 - 1:30 PM</td>
</tr>
</tbody>
</table>

It's never too early, but it can be too late. *Conversations Matter*
REMAP Workshops

- Started Summer 2020
- Virtual
- 4-hour course
- Free CME
- Incentives
- Alternate inpt/outpt

2022 MASTER GOALS OF CARE CONVERSATIONS

4-Hour Workshop for Serious Illness Communication Skills

- Practice a framework for discussing goals of care
- Elicit values and preferences for health care decisions
- Respond to emotions using empathic statements
- Create a plan of care that aligns with a patient's values

FOCUS AREA | DATE          | TIME (PT) |
------------|---------------|-----------|
INPATIENT   | February 9, 2022 | 1-5 PM    |
OUTPATIENT  | April 13, 2022  | 1-5 PM    |
INPATIENT   | June 15, 2022   | 1-5 PM    |
OUTPATIENT  | August 17, 2022 | 1-5 PM    |
INPATIENT   | September 21, 2022 | 1-5 PM |
OUTPATIENT  | November 16, 2022 | 1-5 PM   |

WHO SHOULD TAKE THIS COURSE

This course is designed for frontline healthcare professionals.
Prior training in serious illness communication skills is encouraged, but not required.

Registration: Click HERE (or scan QR code)
Questions: ORPalliativeCareEducation@providence.org

Providence Health & Services – Northern Oregon Region designates this live activity for a maximum of 3.50 AMA PRA Category 1 credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
WHERE ARE WE NOW?
Providence PMG PPC

16 Champions (~30% of goal)

4 Clinics (~150 clinicians)
# Primary Palliative Care Population-Based Completion Rates

Includes patients that have come into the clinics within the last 2 years, as of 3/1/2022

## All Clinics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current Period # Patients</th>
<th>Current Period % of Patients</th>
<th>Baseline Period 8/31/2019 Population</th>
<th>Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (denominator)</td>
<td>54,332</td>
<td></td>
<td>41,620</td>
<td></td>
</tr>
<tr>
<td>Goals of Care (SIC)</td>
<td>7,183</td>
<td>13.2%</td>
<td>1.0%</td>
<td>+ 12.2%</td>
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</tbody>
</table>

## Champ Clinics

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<tr>
<th>Metric</th>
<th>Current Period # Patients</th>
<th>Current Period % of Patients</th>
<th>Baseline Period 8/31/2019 Population</th>
<th>Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (denominator)</td>
<td>8,253</td>
<td></td>
<td>6,120</td>
<td></td>
</tr>
<tr>
<td>Goals of Care (SIC)</td>
<td>1,669</td>
<td>20.2%</td>
<td>1.7%</td>
<td>+ 18.6%</td>
</tr>
</tbody>
</table>
Providence VitalTalk REMAP

12 VT Faculty
Interprofessional

13 Workshops
2020-2022

165 Clinicians
Use a headline to reframe info

Respond to Emotions with NURSE(S)

Elicit Values
HOW?
Contributors

• Providence Medical Group (PMG) – Primary Palliative Care (PPC) champions, mini geriatric fellows (MGF), leadership

• Providence Connections Palliative Care

• Population Health – Senior health, Data analytics

• Cambia Foundation

• University of Washington’s certificate program

• VitalTalk

• Our team members and leadership who help and support this work.
Let's connect

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Caroline Hurd
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Advance Care Planning Project

OHSU Family Medicine

Funded by Cambia Foundation

All City Palliative Care Portland Presentation

May 6, 2022
ACP Project at Gabriel Park Clinic

Why: ACP is not uniformly structured in the ambulatory setting

What: To impact future healthcare decisions to ensure goal-concordant care upstream

Target population: Medicare annual visits, chronically ill patients, seriously ill patients recently discharged from hospital, RN Care Managed patients (Epic risk level 3 & 4)

How: By implementing a systematic, standardized, structured, High Quality ACP process with a multidisciplinary team approach

Where: OHSU Family Medicine Gabriel Park Clinic in SW Portland

When: July 2021 - June 2024 (36 months)
How did your project get started and off the ground?

**Passion**

- Passion for Palliative/Hospice and Geriatric care and Education
- Dr. Eriko Onishi, Dr. Sumathi Devarajan, Dr. Harry Krulewitch formed a team focused on ACP. Planned for 12 months during pandemic.
- Recommendations from Suzanne Sullivan from FM Business Development
- Collaborated with Annette Totem, PhD, Seiko Izumi, PhD from Meta-LARC ACP and Dr. Jason Webb
- Pitched grant to Cambia Foundation with input from FM Department Chair, Dr. Jen DeVoe

**Corroboration**
What resources did you need?

- Created an ACP RN Coordinator position and job description (0.6FTE)
- Pick the right clinic → Gabriel Park Clinic
- Pick the right Communication training method → Serious Illness Conversation Guide
- Train the medical professionals using the Serious Illness Conversation Guide
Our Interventions

To Conduct Structured High-Quality ACP Sessions

- Identify appropriate patients and conduct ACP in a timely manner
- Plot the adequate length of time for an ACP discussion
- Specific follow-up plans for the ACP discussion

High-Quality ACP Session

At least 16 minutes of provider face-to-face time

(ideally with ACP coordinator support and using the SIC guide)

Goals are to identifying patients’ Values and preferences, appointing right SDM(s)
…Our Interventions

Structured High-Quality ACP Process

Identifying appropriate patients for HQ-ACP

Contact Patients/SDMs

Help/Support HQ-ACP Conversation with PCP

Aid with ACP Documents ACP Billings POLST AD

Make Appropriate follow-ups

RN ACP Coordinator
...Our Interventions

To Promote
Referrals From
Any Disciplines

OHSU FM
GP
Patients

Referral to
Structured,
High-Quality
ACP
What question or need are you hoping to address with your intervention?

- Evaluate patient (or caregiver proxy) perceptions of the study intervention
- Evaluate GP medical professionals’ perception of the study intervention
- Study the conversation durations, noting the time needed to enter patient choices in EMR
- Evaluate Emergency Department utilization and hospitalization for patients in the study
- Evaluate retrospectively whether end of life experiences match end of life choices for patients who died during the study period
How is it going?

- 101 patients and counting since October 2021!
- 9 FM 2nd year Residents trained on Serious Illness Conversation Guide as part of Geriatric rotation
- Completed the first of many clinic staff SIC trainings
- Huge demand for ACP support/coordination. Like a geyser bursting through the surface!
- High receptivity from patients and team
  
  “That is a great question!”
  “No one has ever asked me that before.”
  “We read your ACP Note when he was admitted and it was really helpful.”
Questions?

THANK YOU!
OHSU:
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Jake Luty, MD
lutyj@ohsu.edu
Value Based Care
Surrogate Decision Maker and Advanced Care Planning systems work motivated by value based care engagement

DATE: May 6th, 2022 PRESENTED BY: Jacob Luty MD and James Clements MD
At All City Palliative Care Lecture Series, Portland OR
All patients have the right to make their ACP-SDM preference known.
Origins of Surrogate Decision Maker Work at OHSU

• 2016 priority – reducing inpatient mortality
• Opportunity = advance care planning
The ACP Navigator
% Documentation of Surrogate Decision Maker

PDSA 1 – Service Champion Outreach
% Documentation of Surrogate Decision Maker

PDSA 1 – Service Champion Outreach

PDSA 2 – Service Champion Outreach & Financial Incentive Period

Success!!
Back to reality...
Observed 2 Groups

Sustainers

Non-Sustainers

How/Why?
Advance Care Planning Improvement at OHSU

- **Next Steps:**
  - **AIM** – achieve >80% SDM for in-scope admissions in participating pilot sites by July 1st 2017 & see if we can better sustain our improvements
  - Interviews at point of care – *define best practices & key opportunities for improvement*
  - Create best practice ‘bundle’
    - Educational powerpoint, orientation materials, EMR dotphrases, patient list function, admission checklist
  - PDSA cycles, refine bundle in pilot sites (inpatient IM & FM teaching services, adult MICU)
  - EMR alert once standard practices in place
Run Chart – SDM Improvement Phase 2

SDM Documentation Initiative

- Incentive
- PDSA Cycles
- Best Practice Alert

Month-Year

- Oct 15
- Dec 15
- Feb 16
- Apr 16
- Jun 16
- Aug 16
- Oct 16
- Dec 16
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- Apr 20
- Jun 20
- Aug 20
- Oct 20

SDM Present, %

- 100%
- 90%
- 80%
- 70%
- 60%
- 50%
- 40%
- 30%
- 20%
- 10%
- 0%

Intervention Group

Control Group
Key Learnings

• QI pilots aiming to improve inpatient advance care planning metrics can work

• EMR alerts can be helpful, but we should wait until standard practices are up and running to minimize alert fatigue

• Documenting surrogates is helpful, but we have a lot more work to do to ensure this leads to provision of increasingly goal-concordant care
OHSU Discovers Low Performance in CMS BPCIA Program Quality Metrics
Quality/Process Improvement Plan: SDM

• **Baseline**
  – HSQSC championed this work
  – Data from manually requesting this report weekly I.e. not a dashboard yet

1 week of Inpt Data from Nov 2021: 209/596 = ~35%
ACP/SDM Quality Metrics for CMS/BPCIA

• Background:
  – Quality measure is counted by claims submissions of the CPT codes in 12 months interval including the index stay
  – This same Metric is used in Primary Care First and other CMS programs
  – OHSU baseline performance very low (4\textsuperscript{TH} percentile) with a financial loss in BPCIA program
  – Mismatch of system work and CMS quality metric

<table>
<thead>
<tr>
<th>CPT Billing Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.</td>
</tr>
<tr>
<td>99498</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT II Tracking Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1123F</td>
<td>Advance care planning discussed and documented – advance care plan or surrogate decision-maker was documented in the medical record.</td>
</tr>
<tr>
<td>1124F</td>
<td>Advance care planning discussed and documented in the medical record – Beneficiary/patient did not wish to or was unable to provide an advance care plan or name a surrogate decision-maker. If patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, submit this CPT II code.</td>
</tr>
</tbody>
</table>
Surrogate Decision Maker Mark as Reviewed

Another Click Bites the Dust Thanks to Dr Scott Sallay
Intervention: Deployed 1/11/22

- Clicking “Mark as Reviewed”
  - CPT II 1123F will be automatically added to claims
- Clicking “Declined/Unable to Update”
  - CPT II 1124F will be automatically added to claims
- Any additional work to increase use of CPT I codes for full Advanced care planning will also help
- Rolled out across all settings at OHSU and HMC!!

Credit: Lunette Lott, Epic Health Planet Analyst
- Final Report will be in Webi/BOBJ.
- Filters for Units, Treatment Teams and Attending for better attribution
SDM Next Steps

• Technology/Epic Interventions
  – Epic Report being built
  – Epic workflow changes tickets in process
    • Smart phrase with clickable link
    • Treatment team list column clickable links

• People and Connections-
  – Primary Care already has this as a quality measure
  – Inpatient DOM adopting as quality measure
  – Full Change Management Roll out pending Epic workflow
Advanced Care Planning

Future Directions:
- BPCIA chart reviews show at risk readmissions in persons with serious illness and GOC conversations are not easy to find or unavailable (<25%)
  - No ACP and GOC Documentation standards in our system
- OHSU ACP A3
  - Tier 1 OPEX priority
  - Planning Underway
  - Standards for
    - Who, What, When
    - Broad stakeholder inclusion

Continuum of Advance Care Planning
Future ACP Work

Advanced Care Planning Navigator

• Currently available in Epic
• Exists for inpatient and outpatient
• Smartphrases with “book end” functions and allow for standard templates for ACP/GOC Conversations
• Possible quality measure for use of standard templates when serious illness present
• Institutional A3 for institutional approach underway
Thank You
All-City Survey

Please share additional reflections and suggestions with us at:
kettereb@ohsu.edu
webbja@ohsu.edu

https://ohsu.ca1.qualtrics.com/jfe/form/SV_5onvQTVh9FkWewu