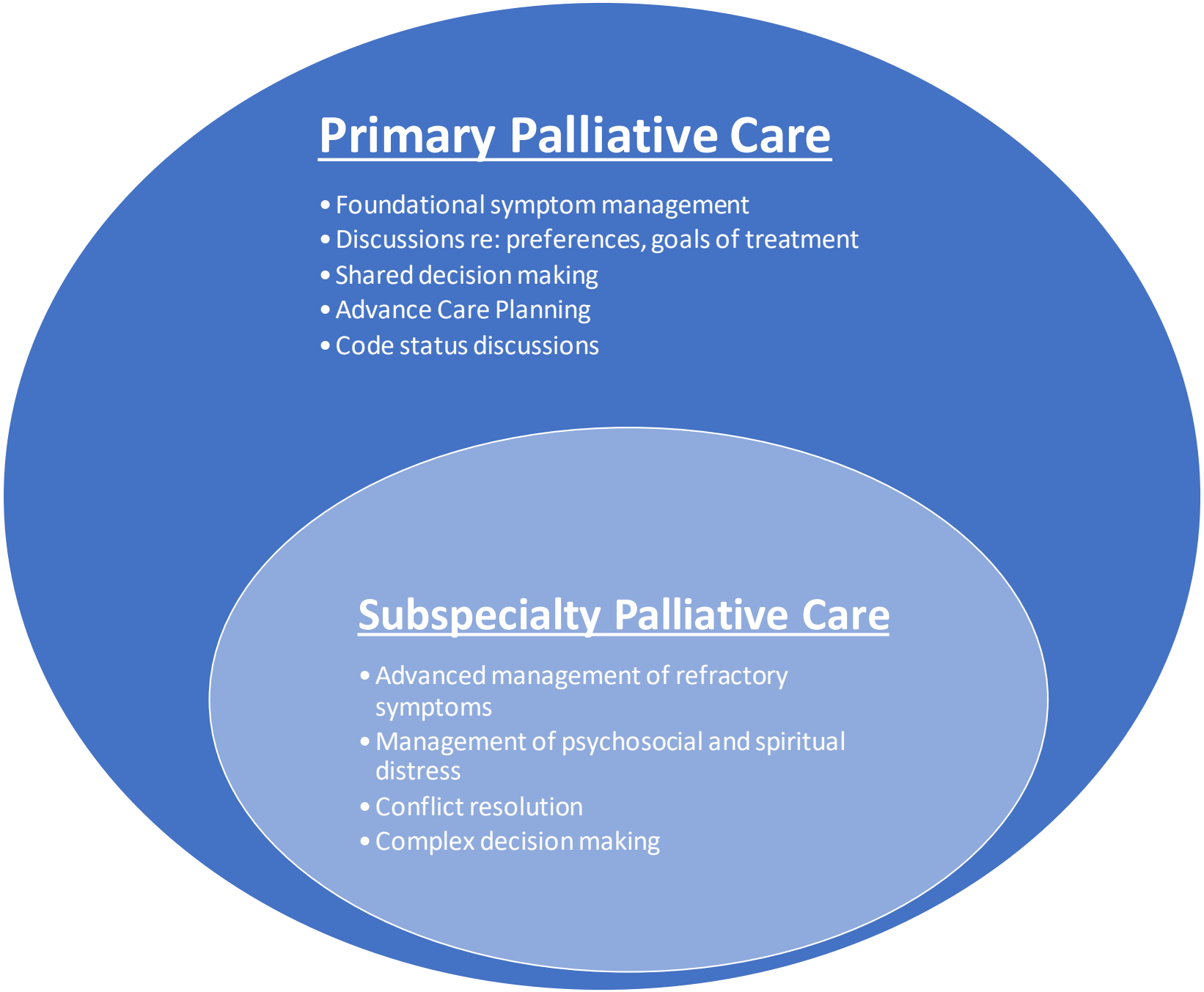
All-City Palliative Care

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:

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Marianne Parshley, MD, FACP — marianne.parshley@providence.org

Caroline Hurd, MD — 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

Providence

Graduate Certificate in Palliative Care
Building Interprofessional Communities of Practice

powered by VITAL talk

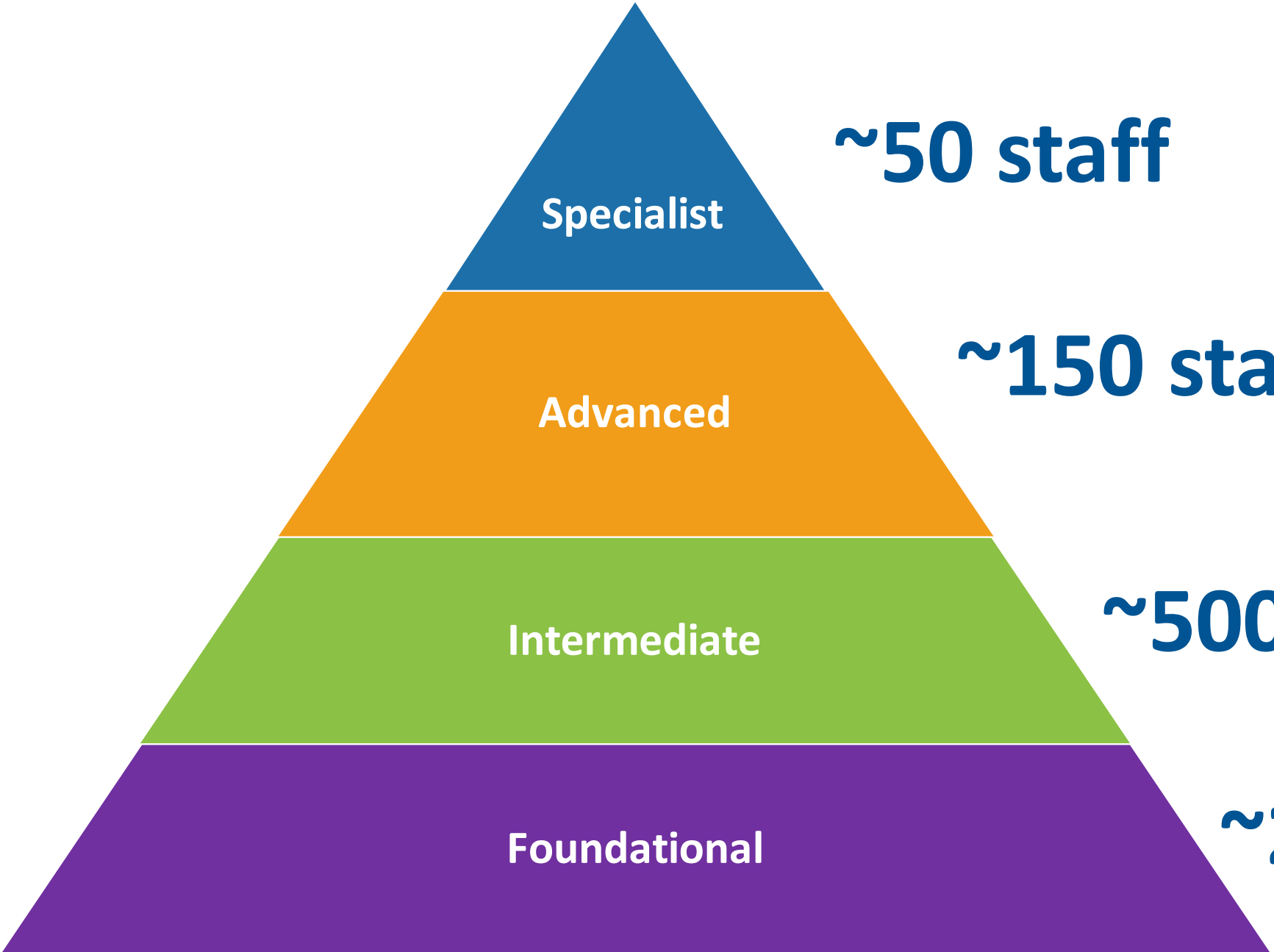
CAMBIA health foundation

WHY?

Specialty Palliative Care → Every PMG Patient w/ Serious Illness = 27x Current Staff

~1,350 Clinicians!!

Vision of 2017 Palliative Care Steering Committee



~50 staff

~150 staff

~500 staff

~20,000 staff

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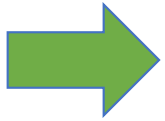
WHO?

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

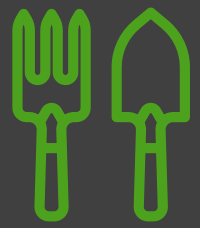
- Grad Cert 9-mo

>1000+ Clinicians

Intermediate Foundational

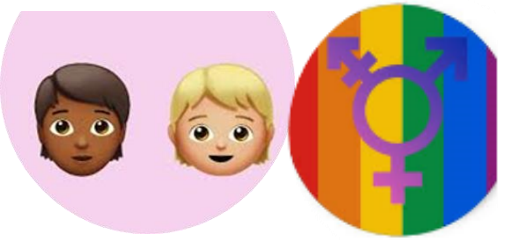
- Multiple training modalities using available & newly created resources

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				EOL
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"

INTRO TO ACP/PC

EMOTIONS

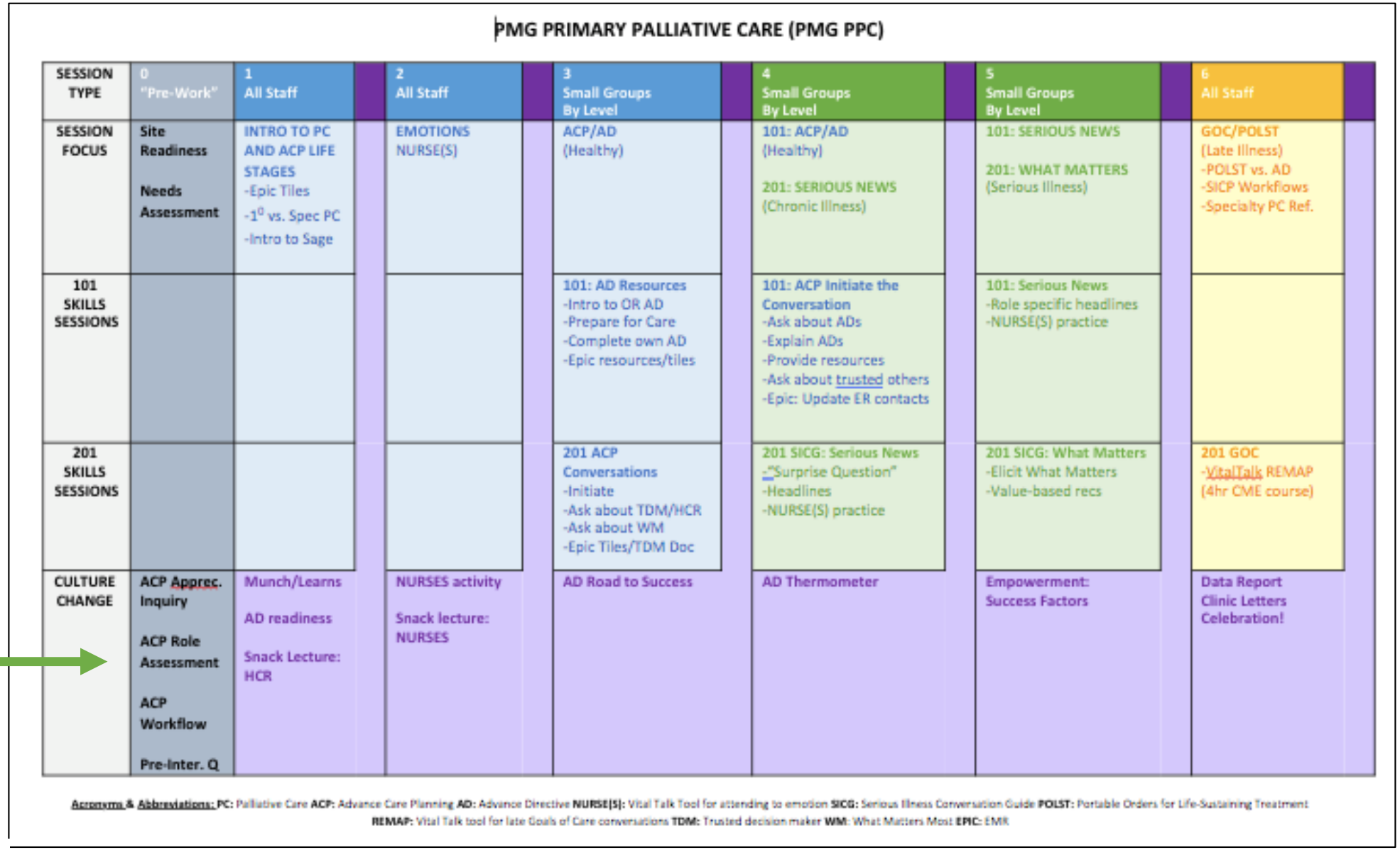
ACP/ADs

CULTURE CHANGE

SERIOUS NEWS

VALUES WHAT MATTERS

LATE ILLNESS POLST REMAP



PMG PRIMARY PALLIATIVE CARE (PMG PPC)

SESSION TYPE	0 "Pre-Work"	1 All Staff	2 All Staff	3 Small Groups By Level	4 Small Groups By Level	5 Small Groups By Level	6 All Staff
SESSION FOCUS	Site Readiness Needs Assessment	INTRO TO PC AND ACP LIFE STAGES -Epic Tiles -1^{0} vs. Spec PC -Intro to Sage	EMOTIONS NURSE(S)	ACP/AD (Healthy)	101: ACP/AD (Healthy) 201: SERIOUS NEWS (Chronic Illness)	101: SERIOUS NEWS 201: WHAT MATTERS (Serious Illness)	GOC/POLST (Late Illness) -POLST vs. AD -SICP Workflows -Specialty PC Ref.
101 SKILLS SESSIONS				101: AD Resources -Intro to OR AD -Prepare for Care -Complete own AD -Epic resources/tiles	101: ACP Initiate the Conversation -Ask about ADs -Explain ADs -Provide resources -Ask about trusted others -Epic: Update ER contacts	101: Serious News -Role specific headlines -NURSE(S) practice	
201 SKILLS SESSIONS				201 ACP Conversations -Initiate -Ask about TDM/HCR -Ask about WM -Epic Tiles/TDM Doc	201 SICG: Serious News -"Surprise Question" -Headlines -NURSE(S) practice	201 SICG: What Matters -Elicit What Matters -Value-based recs	201 GOC -VitalTalk REMAP (4hr CME course)
CULTURE CHANGE	ACP Apprec. Inquiry ACP Role Assessment ACP Workflow Pre-Inter. Q	Munch/Learns AD readiness Snack Lecture: HCR	NURSES activity Snack lecture: NURSES	AD Road to Success	AD Thermometer	Empowerment: Success Factors	Data Report Clinic Letters Celebration!

Acronyms & Abbreviations: **PC:** Palliative Care **ACP:** Advance Care Planning **AD:** Advance Directive **NURSE(S):** Vital Talk Tool for attending to emotion **SICG:** Serious Illness Conversation Guide **POLST:** Portable Orders for Life-Sustaining Treatment **REMAP:** Vital Talk tool for late Goals of Care conversations **TDM:** Trusted decision maker **WM:** What Matters Most **EPIC:** EMR

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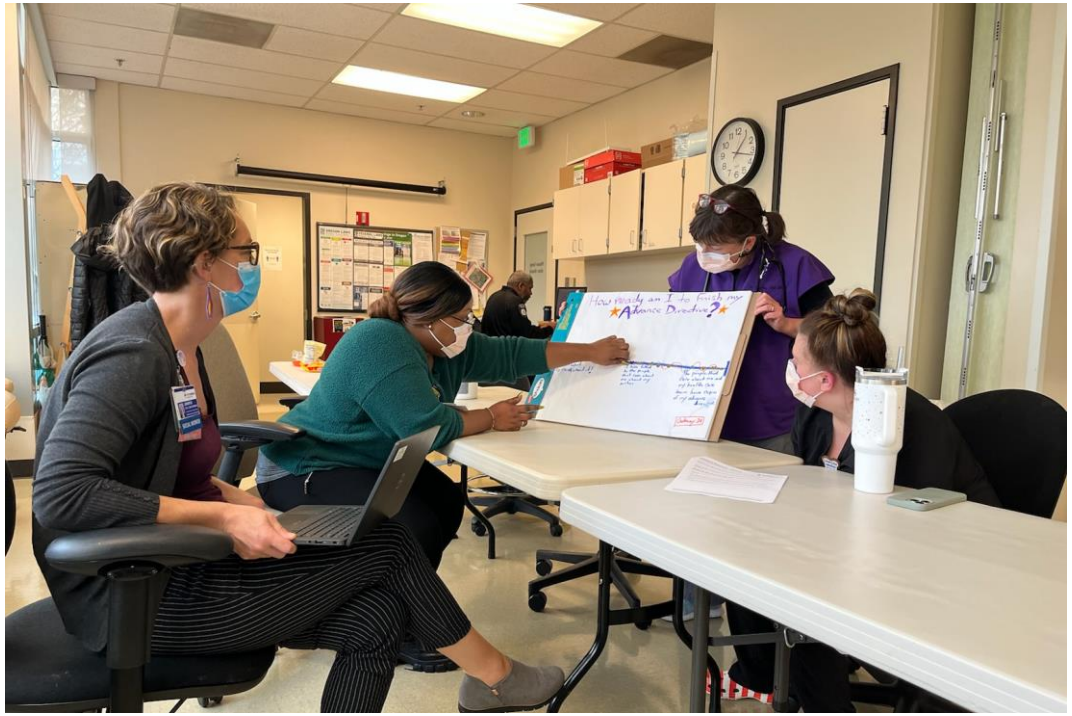
Reinforcement Activity

AD Readiness Trajectory and Munch/Learn



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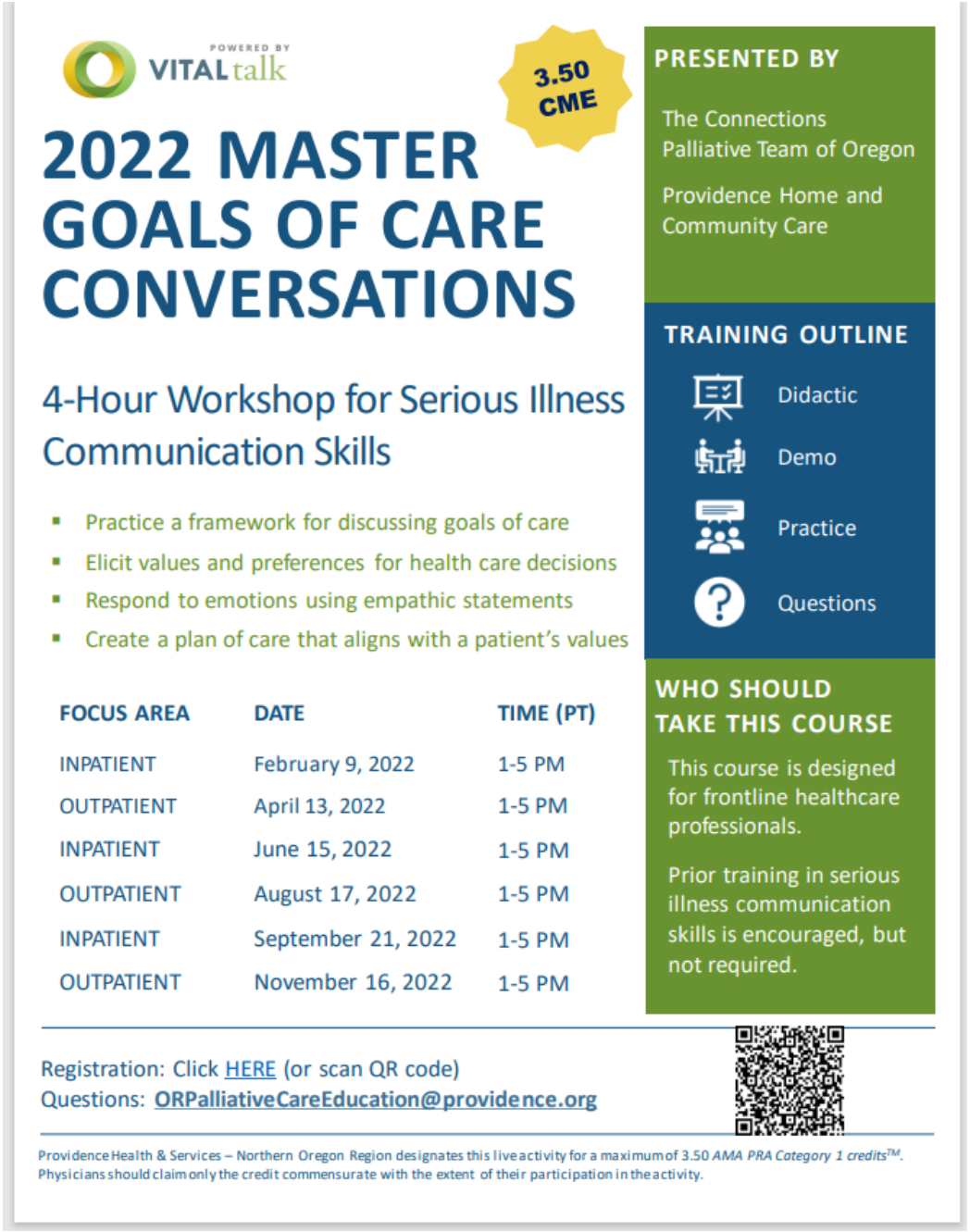
REMAP Workshops

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



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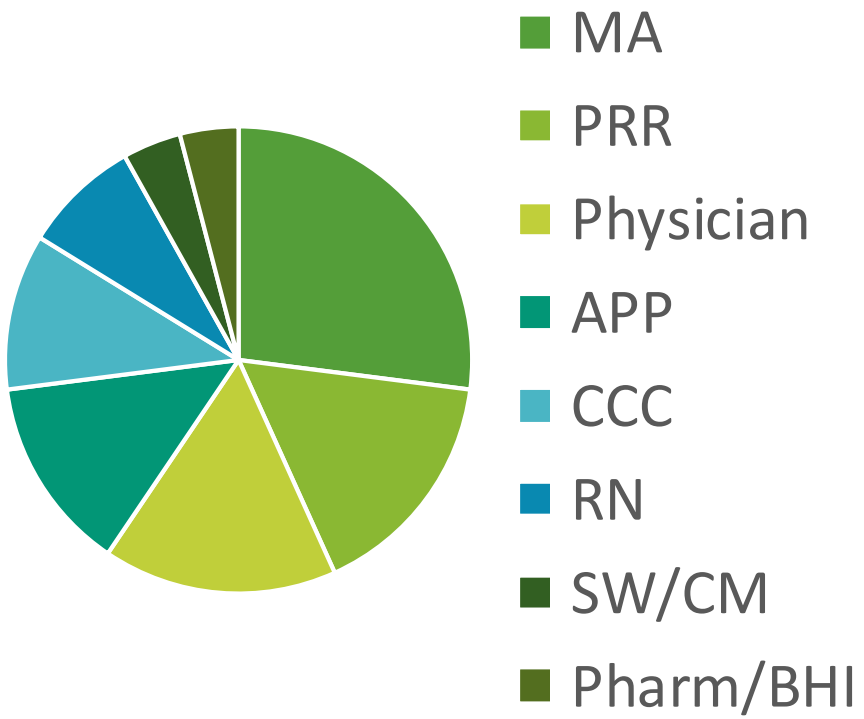
powered by VITAL talk

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

Providence Oregon
Senior Health

ALL CLINICS

Clinic: All | Ages: 65+ | Population: Seriously Ill Patients

Metric	current period # Patients	current period % of Patients	baseline period 8/31/2019	Change from Baseline
Population (denominator)	54,332		41,820	
Goals of Care (SIC)	7,183	13.2%	1.0%	+ 12.2%

CHAMP CLINICS

Clinic: Multiple values | Ages: 65+ | Population: Seriously Ill Patients

Metric	current period # Patients	current period % of Patients	baseline period 8/31/2019	Change from Baseline
Population (denominator)	8,253		6,120	
Goals of Care (SIC)	1,669	20.2%	1.7%	+ 18.6%

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Providence VitalTalk REMAP

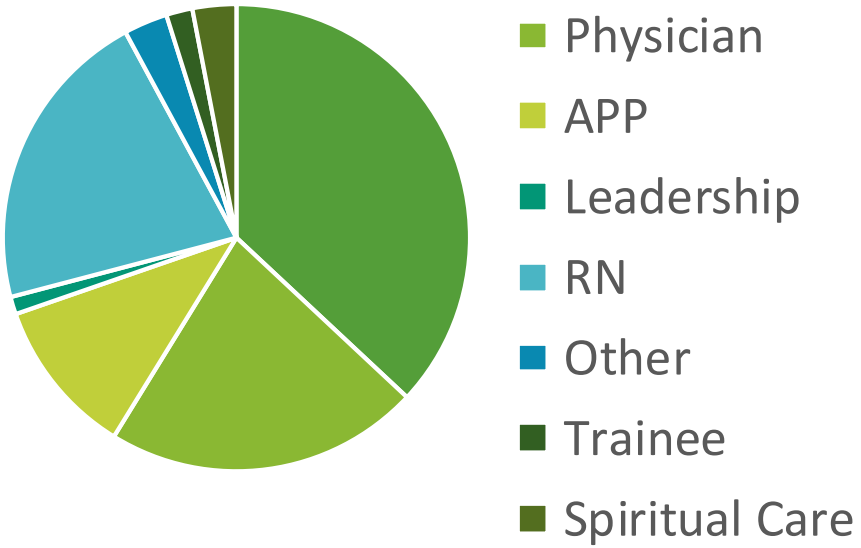
12 VT Faculty

Interprofessional

13 Workshops

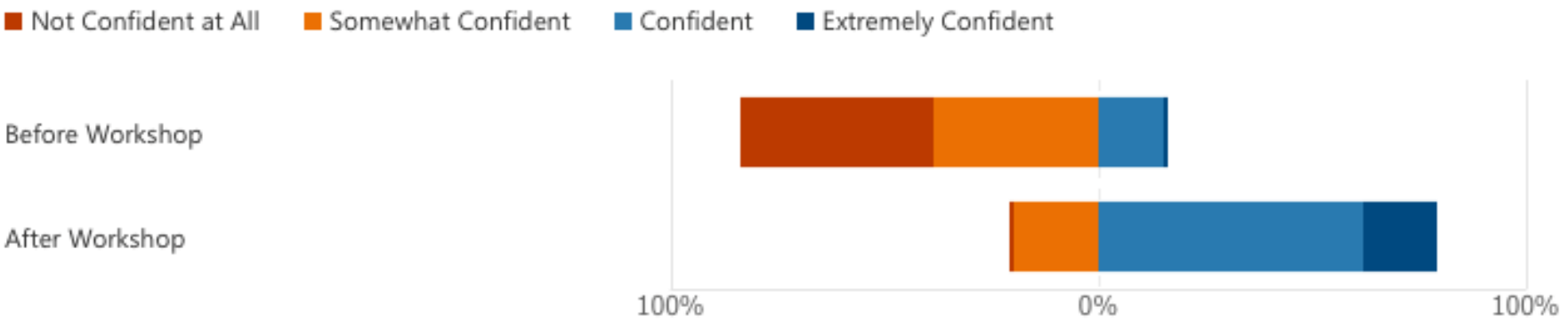
2020-2022

165 Clinicians

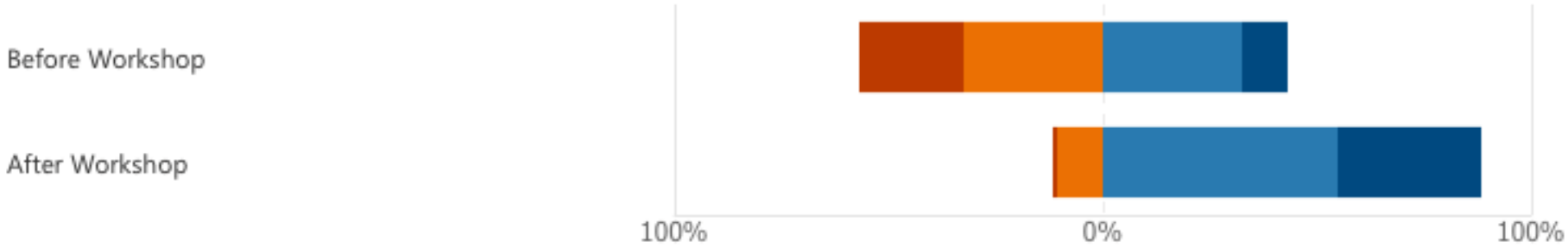


Providence VitalTalk REMAP

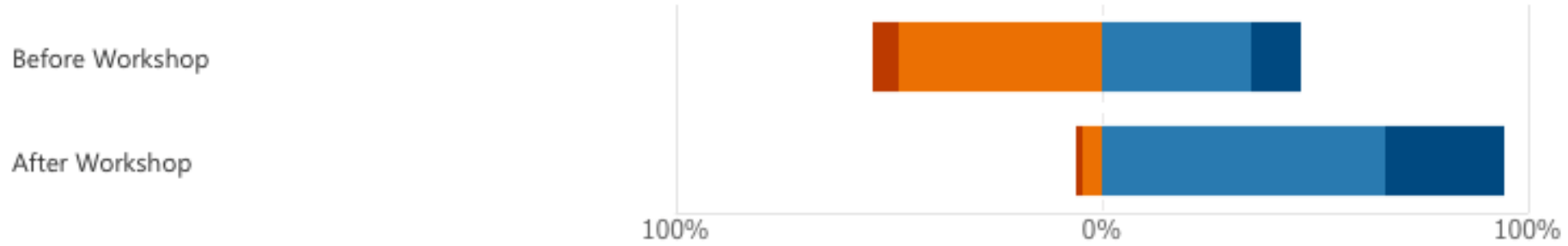
Use a headline to reframe info



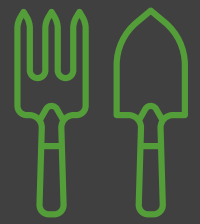
Respond to Emotions with NURSE(S)



Elicit Values



HOW?



DATA

LEADERSHIP

TEAM

TIME/FTE

ALIGN STRATEGIC GOALS

VISION

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.

Providence

Let's connect

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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
Corroboration
Funding

- 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

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

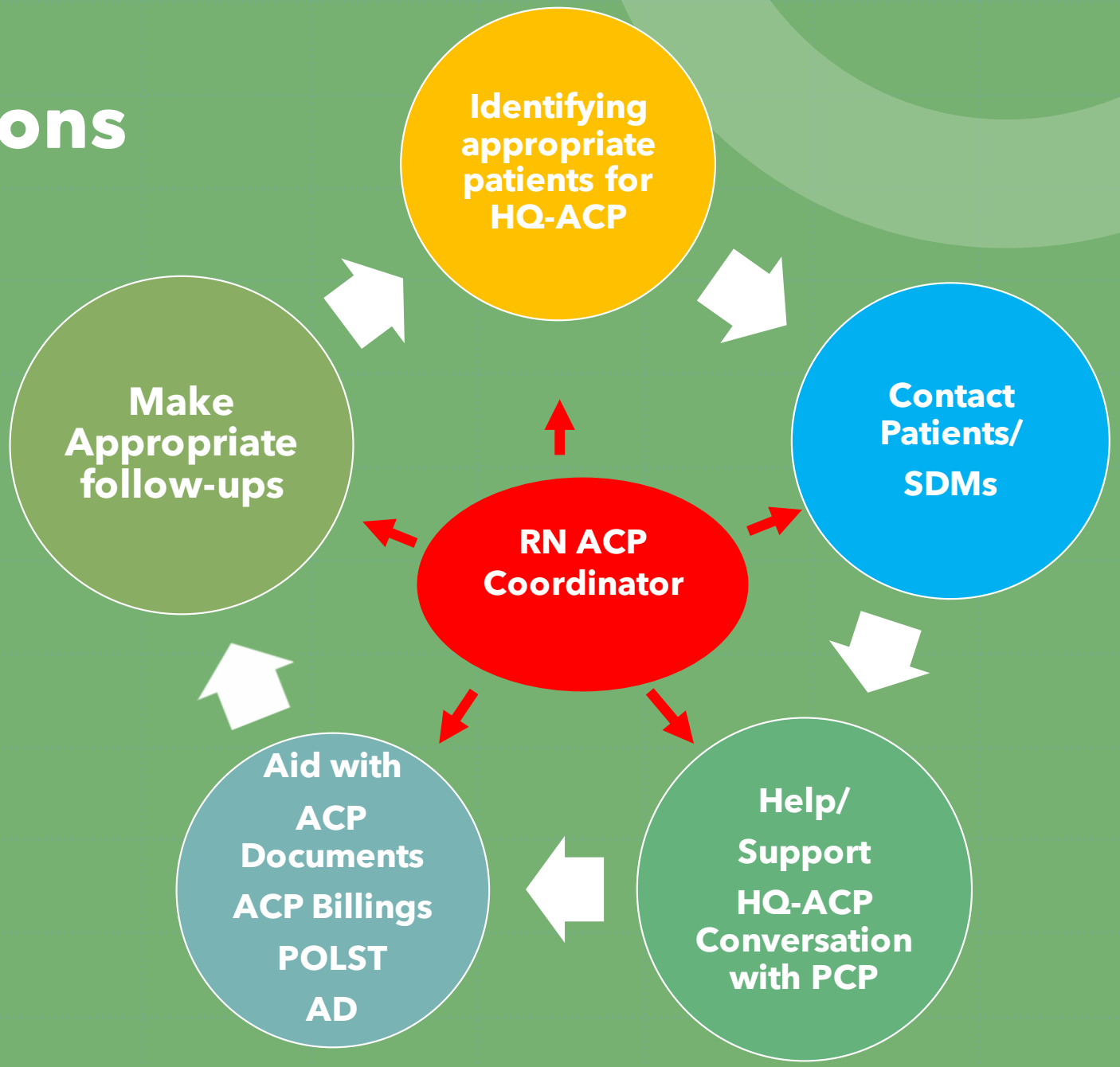
At least 16 minutes of provider face-to-face time

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

Goals are to Identifying patients' Values and preferences, appointing right SDM(s)

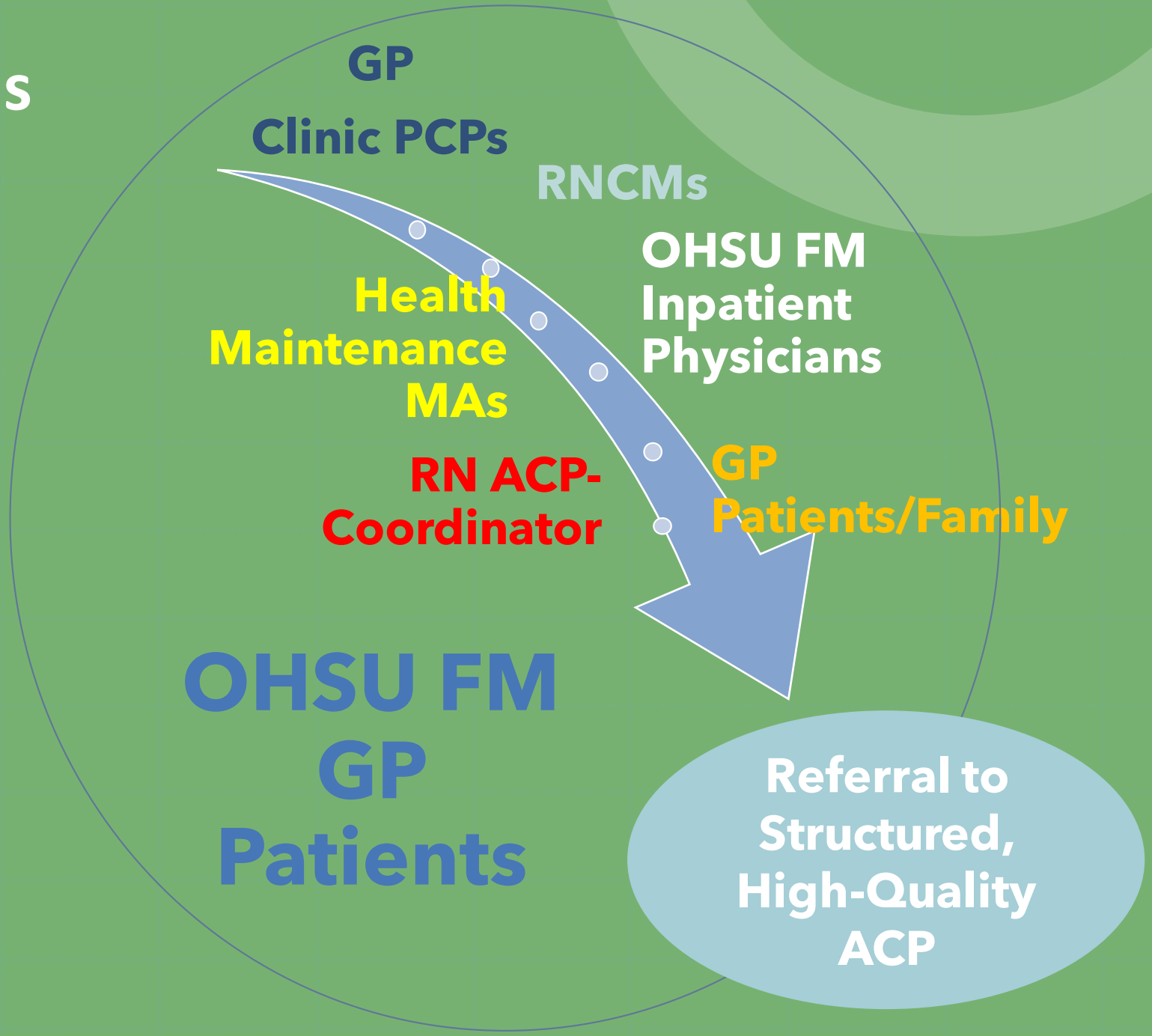
...Our Interventions

Structured High-Quality ACP Process



…Our Interventions

To Promote Referrals From Any Disciplines



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

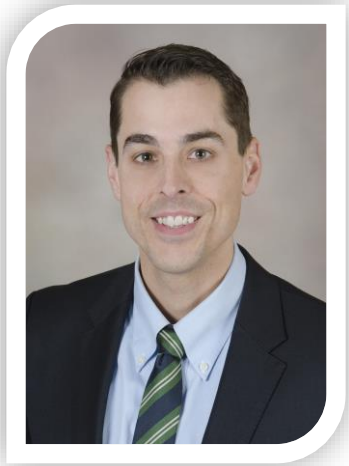
"That is a great question!"

"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:

James Clements, MD clemenja@ohsu.edu

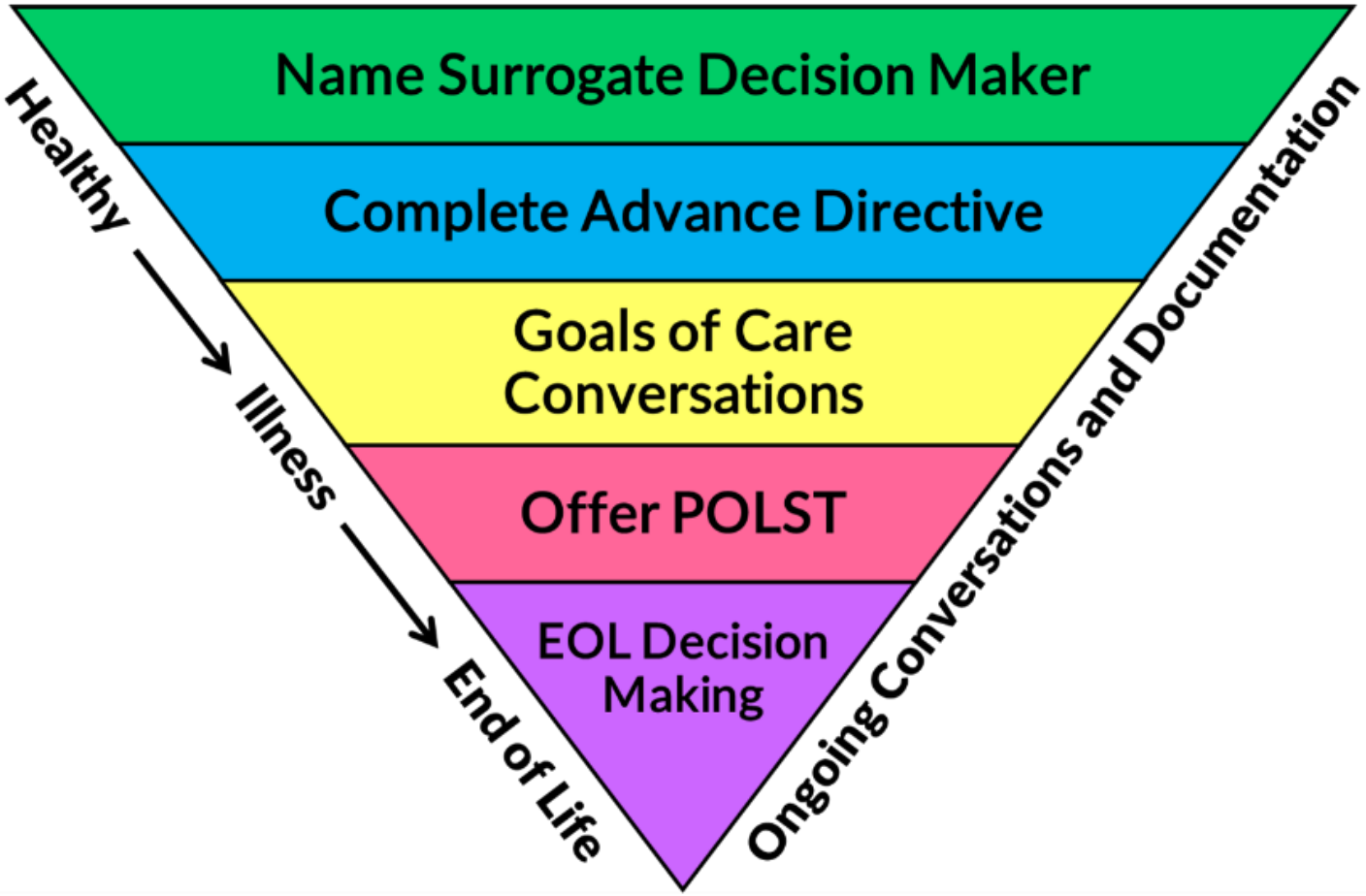
Jake Luty, MD lutyj@ohsu.edu

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

Advanced Care Planning-Surrogate Decision Maker



Continuum of Advance Care Planning

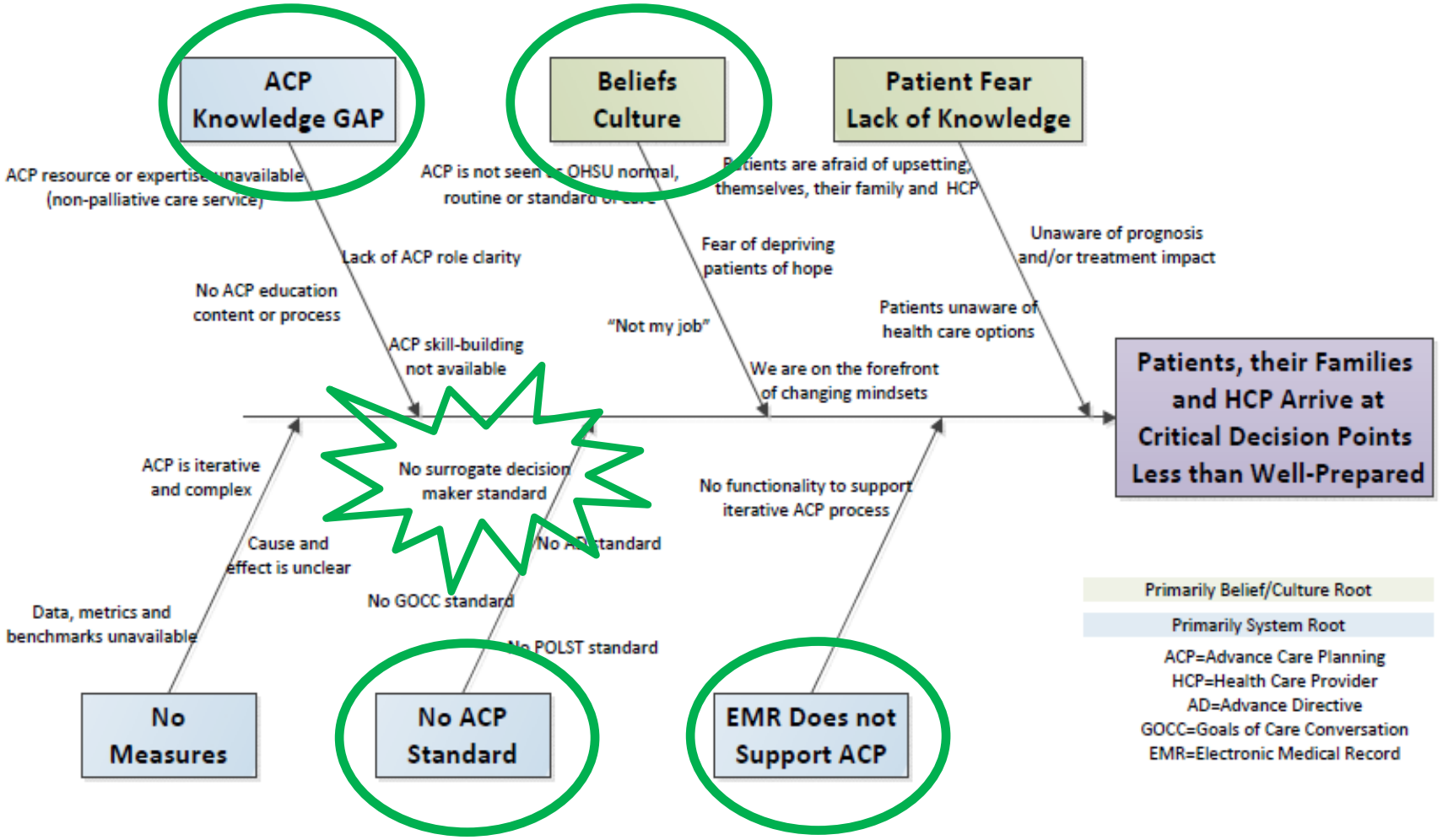
Izumi S, Fromme EK. A Model to Promote Clinicians' Understanding of the Continuum of Advance Care Planning. *Journal of Palliative Medicine. March 2017; 20(3):220-221.*

All patients have the right to make their ACP-SDM preference known

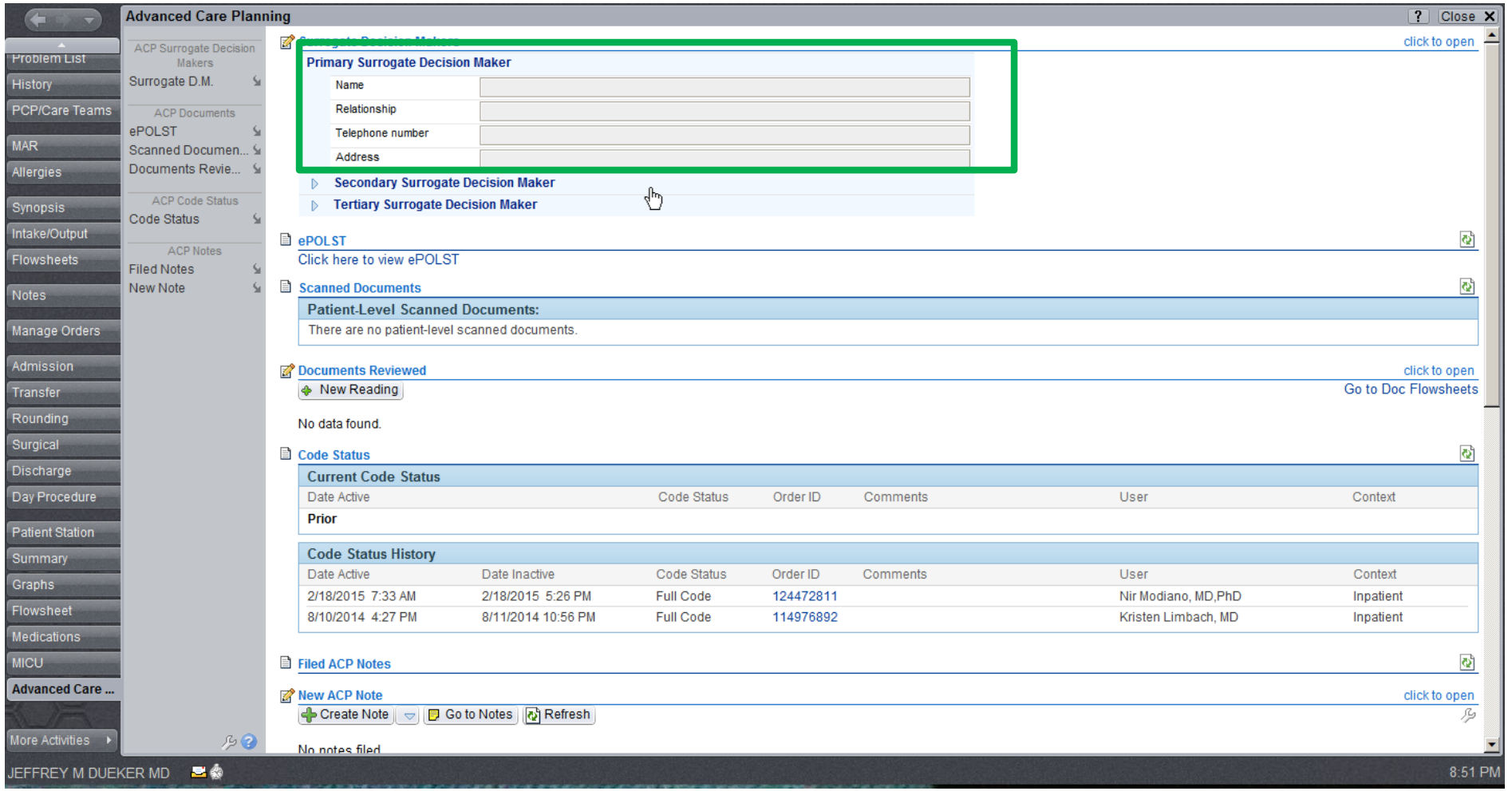
Origins of Surrogate Decision Maker Work at OHSU

- 2016 priority – reducing inpatient mortality
- Opportunity = advance care planning

OHSU


ACP Knowledge GAP
Beliefs Culture
Patient Fear Lack of Knowledge
ACP resource or expertise unavailable (non-palliative care service)
ACP is not seen as OHSU normal, routine or standard of care
Patients are afraid of upsetting themselves, their family and HCP
Lack of ACP role clarity
No ACP education content or process
ACP skill-building not available
Fear of depriving patients of hope
"Not my job"
We are on the forefront of changing mindsets
Unaware of prognosis and/or treatment impact
Patients unaware of health care options
Patients, their Families and HCP Arrive at Critical Decision Points Less than Well-Prepared
No surrogate decision maker standard
ACP is iterative and complex
Cause and effect is unclear
Data, metrics and benchmarks unavailable
No GOCC standard
No POLST standard
No functionality to support iterative ACP process
No Measures
No ACP Standard
EMR Does not Support ACP
Primarily Belief/Culture Root
Primarily System Root
ACP=Advance Care Planning
HCP=Health Care Provider
AD=Advance Directive
GOCC=Goals of Care Conversation
EMR=Electronic Medical Record

The ACP Navigator



OHSU


% Documentation of Surrogate Decision Maker
% SDM Documented
100%
90%
80%
70%
60%
50%
40%
UCL
30%
LCL
20%
10%
0%
% SDM
Dec 1-7
Dec 15-21
Jan 1-7
Jan 15-21
Jan 31-Feb 6
Feb 16-22
Feb 24-Mar 1
Mar 9-15
Mar23-29
Apr 6-12
Apr20-26
May4-10
May18-24
June1-7
June15-21
June29-July5
July13-19
July 27-Aug2
Aug 10-16
Aug 24-30
Sept 7-13
Sept 21-27
Oct 5 - Oct 11
Oct 19 - Oct 25
Nov 2 - Nov 8
Nov 16 - Nov 22
Nov 30 - Dec 6
Dec 14 - Dec 20
Dec 28 - Jan 3
Jan 11 - Jan 17
Jan 25 - Jan 31
Feb 8 - Feb 14

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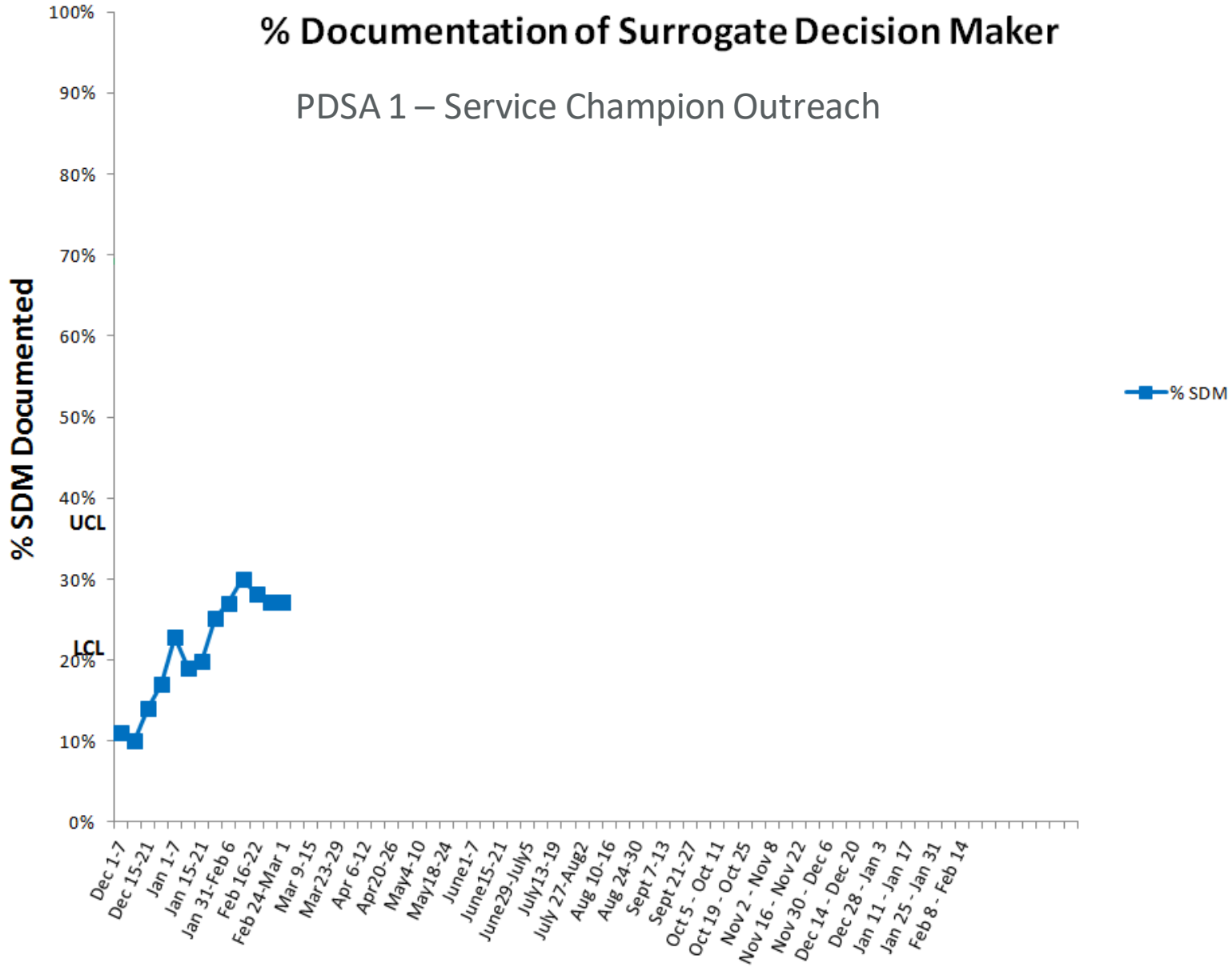
% Documentation of Surrogate Decision Maker
PDSA 1 – Service Champion Outreach
% SDM Documented
100%
90%
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10%
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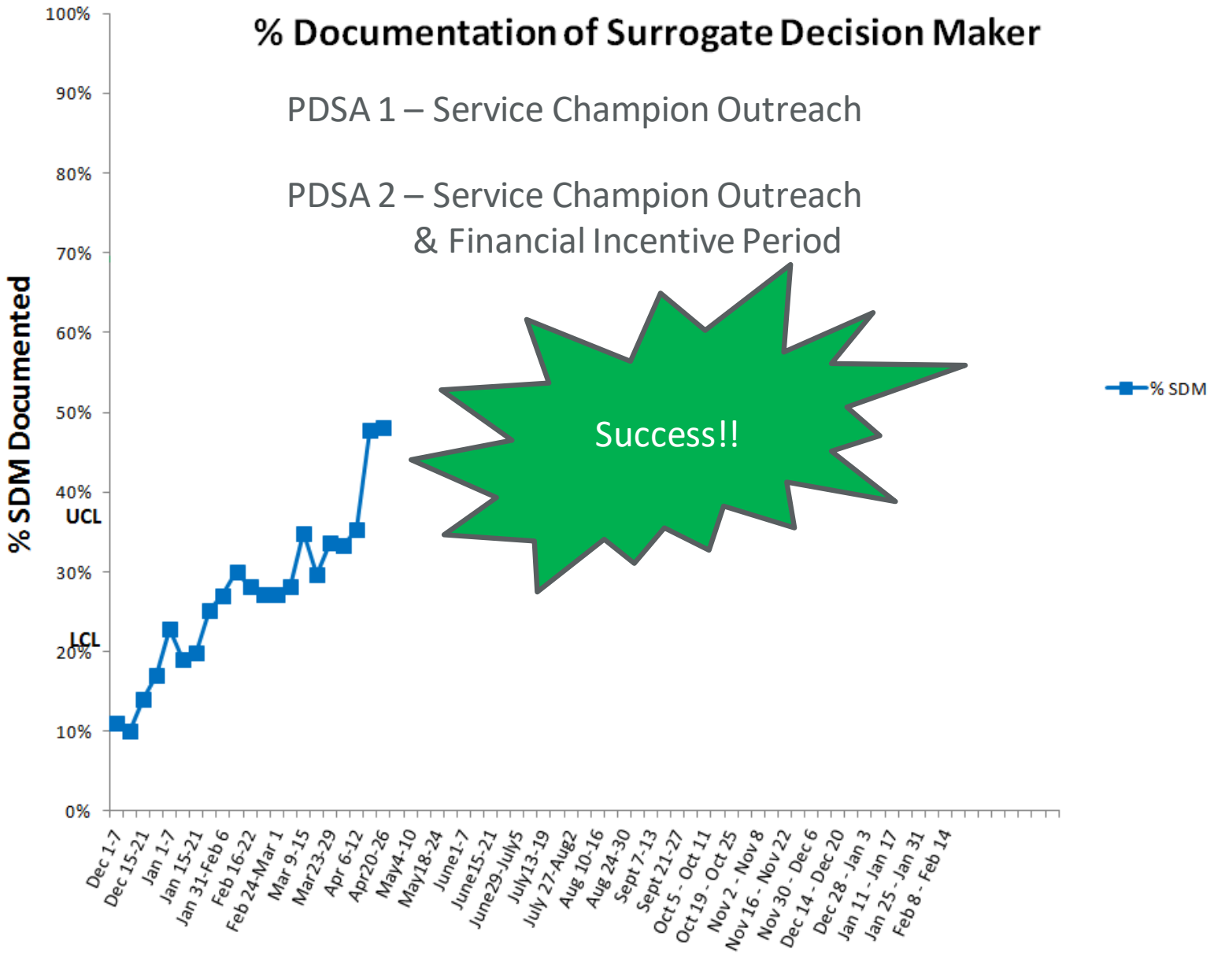
% Documentation of Surrogate Decision Maker
PDSA 1 – Service Champion Outreach
PDSA 2 – Service Champion Outreach & Financial Incentive Period
Success!!
% SDM Documented
100%
90%
80%
70%
60%
50%
40%
UCL
30%
LCL
20%
10%
0%
% SDM
Dec 1-7
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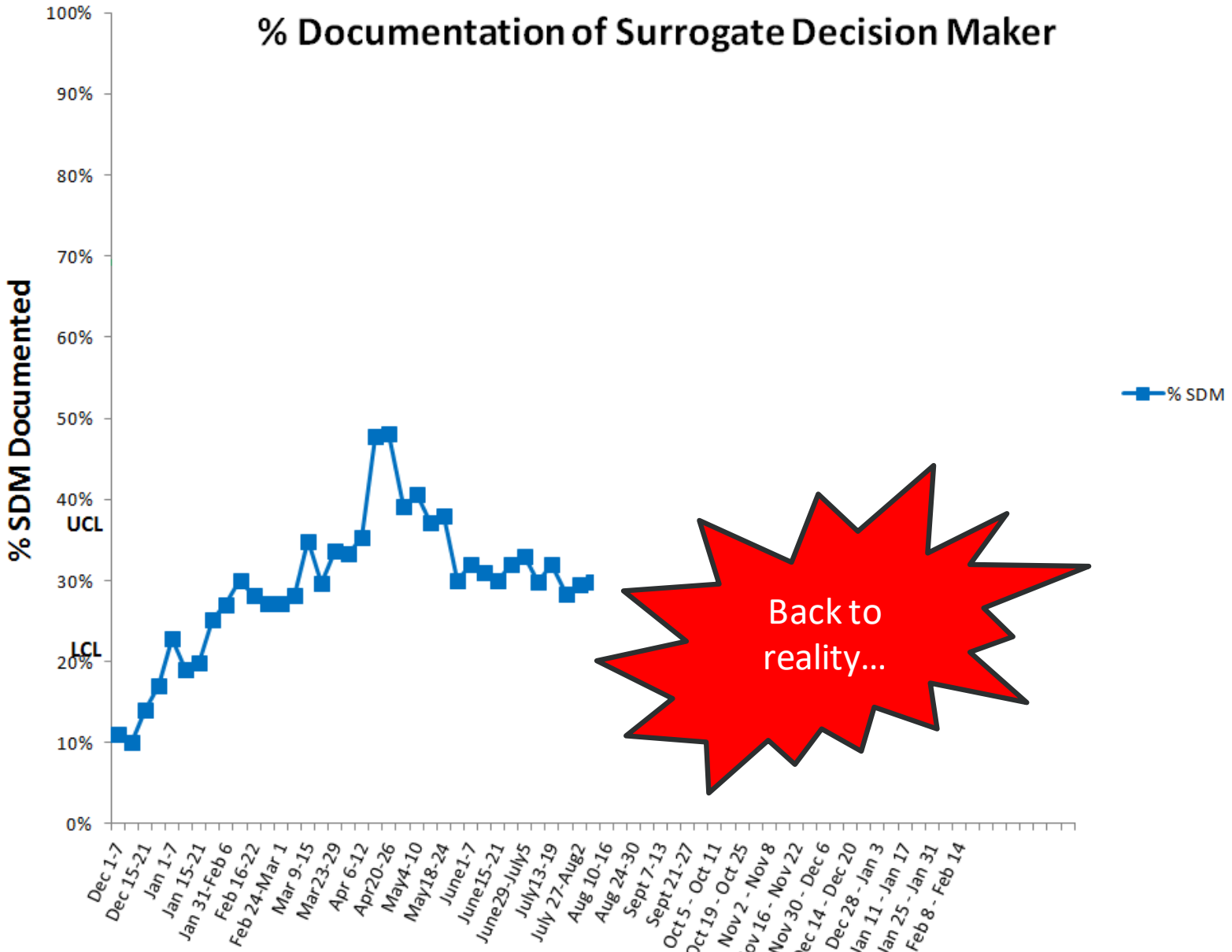
% Documentation of Surrogate Decision Maker
% SDM Documented
100%
90%
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60%
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UCL
LCL
% SDM
Back to reality…
Dec 1-7
Dec 15-21
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Jan 31-Feb 6
Feb 16-22
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Dec 14 - Dec 20
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Jan 25 - Jan 31
Feb 8 - Feb 14

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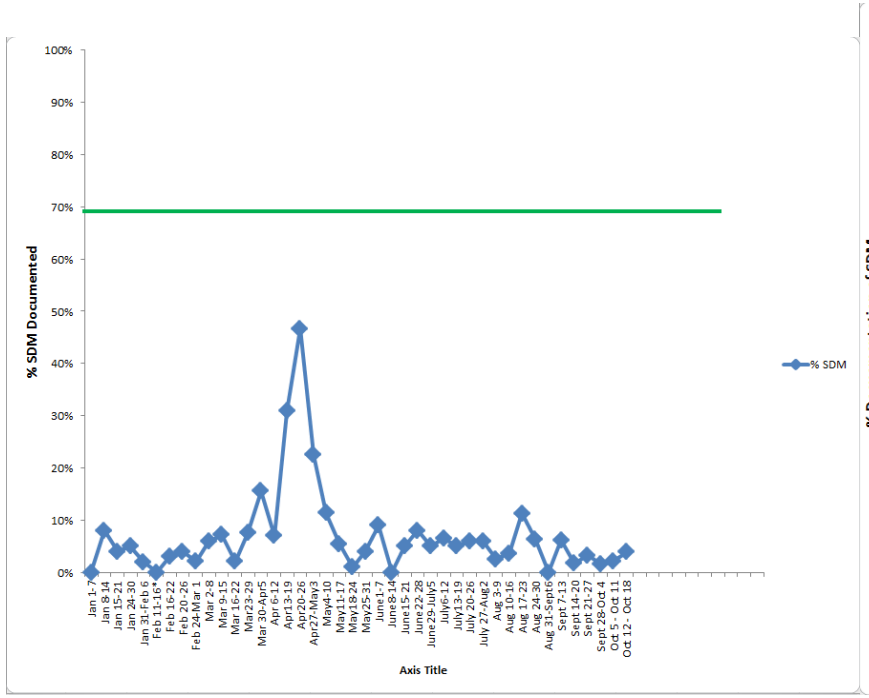
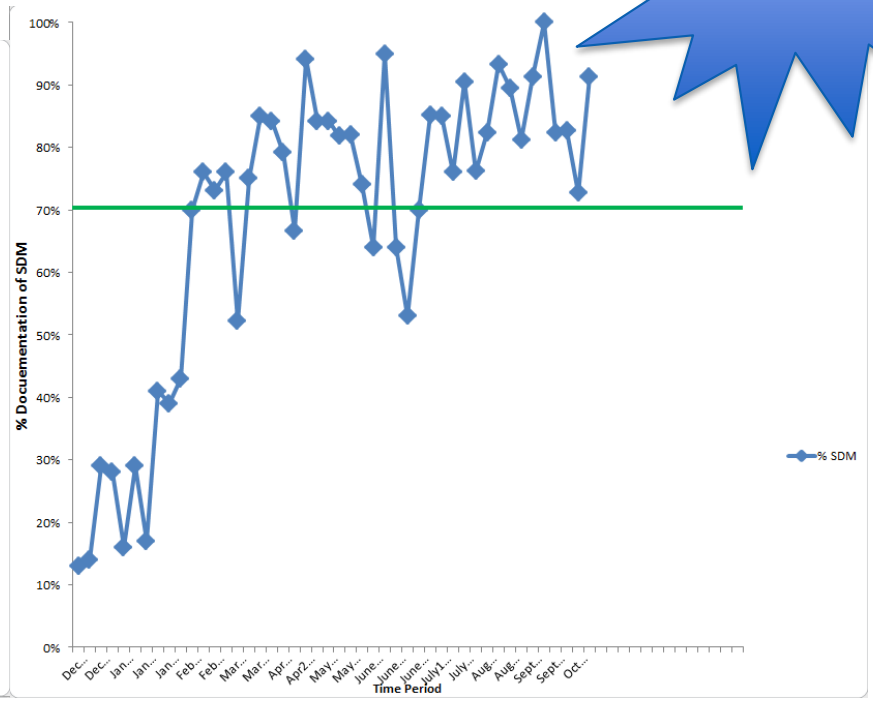
Observed 2 Groups

How/Why?



Non-Sustainers



Sustainers

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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**

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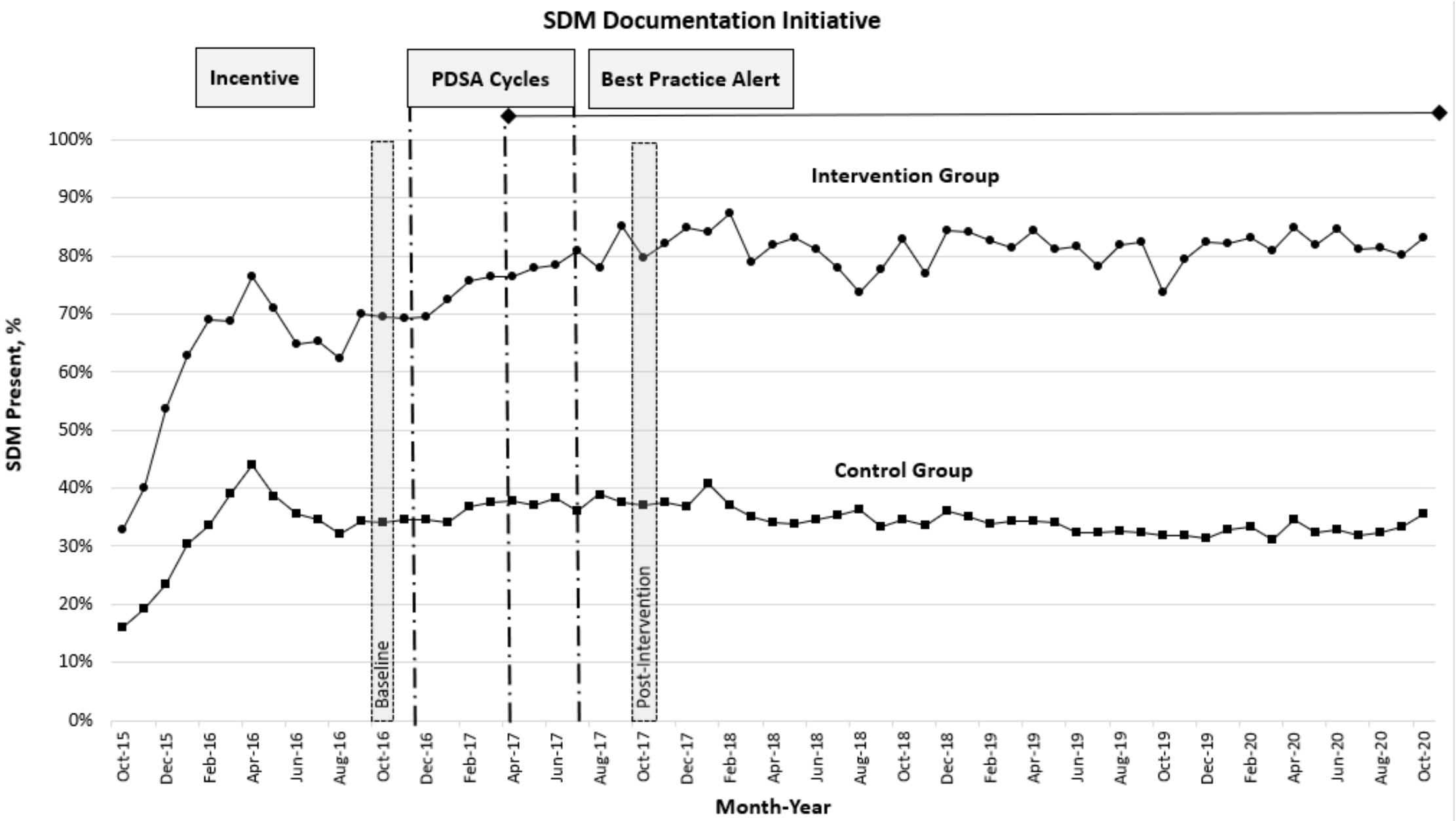
Run Chart – SDM Improvement Phase 2



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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

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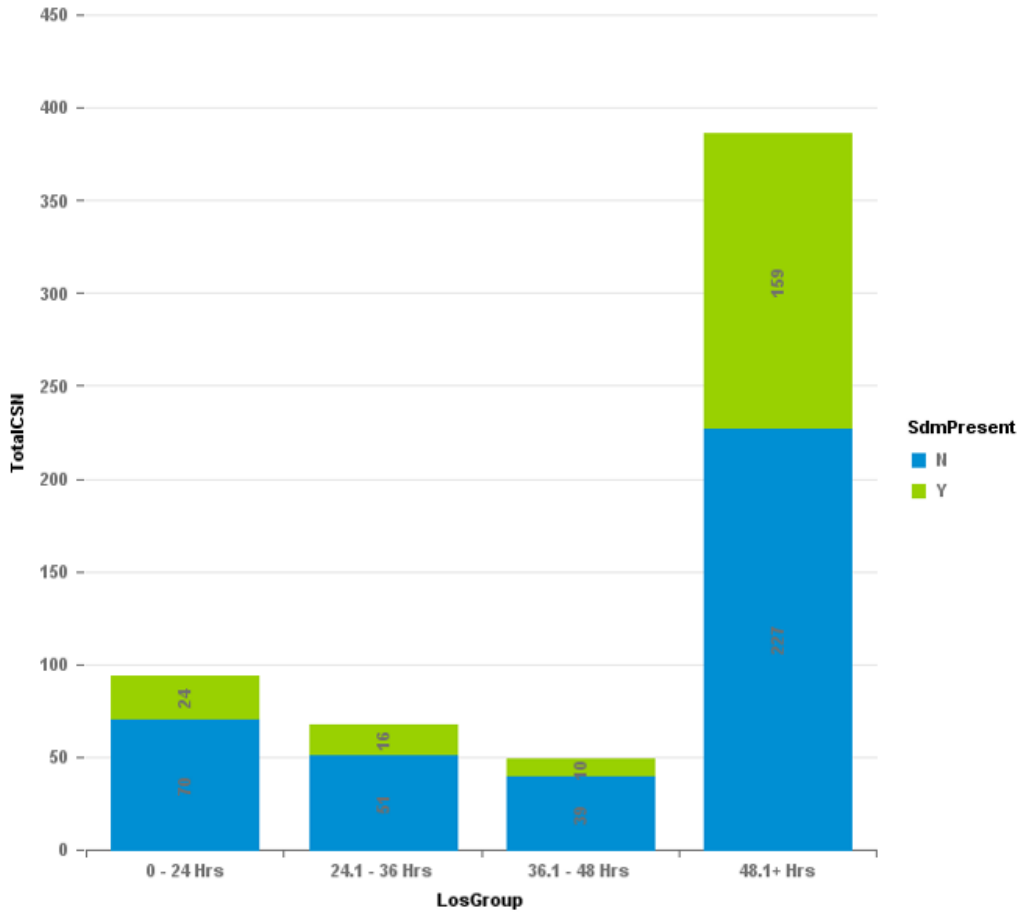
OHSU Discovers Low Performance in CMS BPCIA Program Quality Metrics

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%



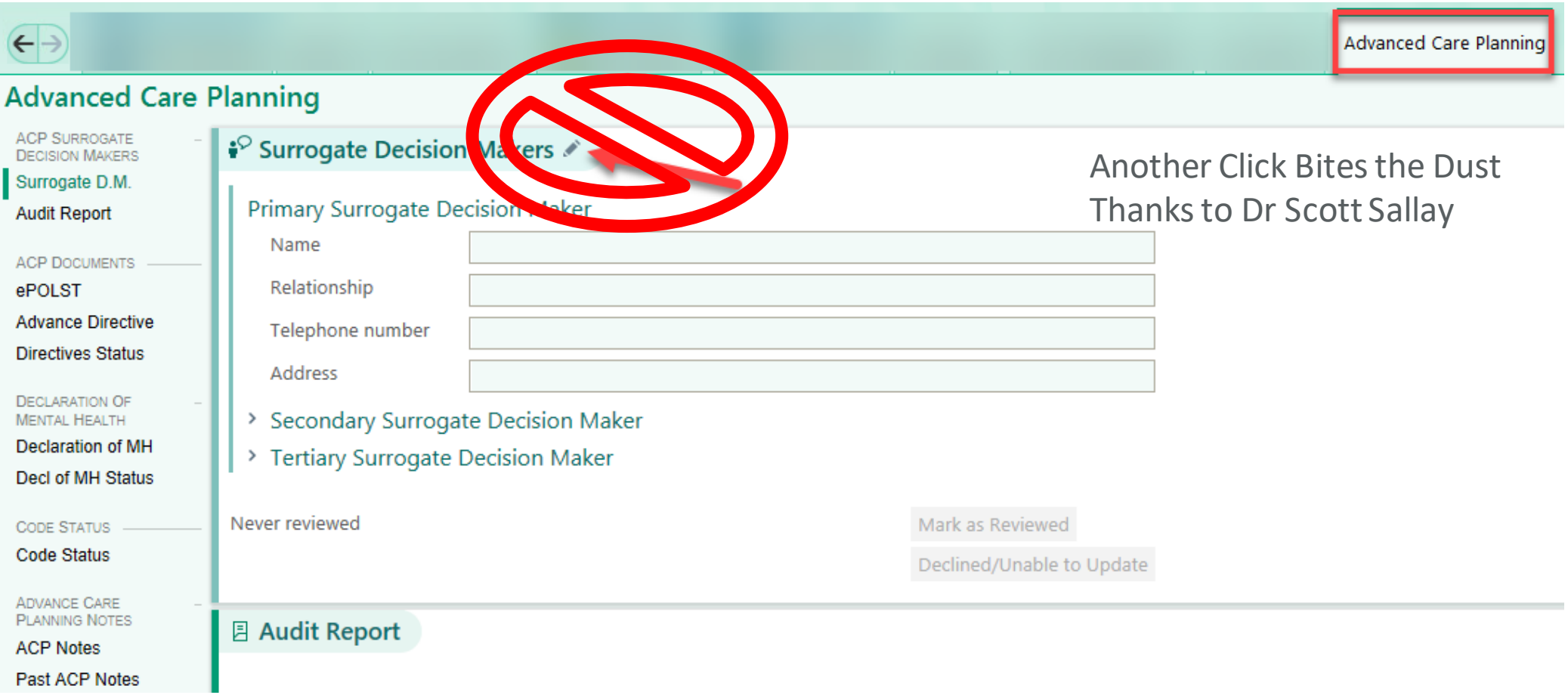
ACP/SDM Quality Metrics for CMS/BPCIA

- 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 (4TH percentile) with a financial loss in BPCIA program
  - Mismatch of system work and CMS quality metric

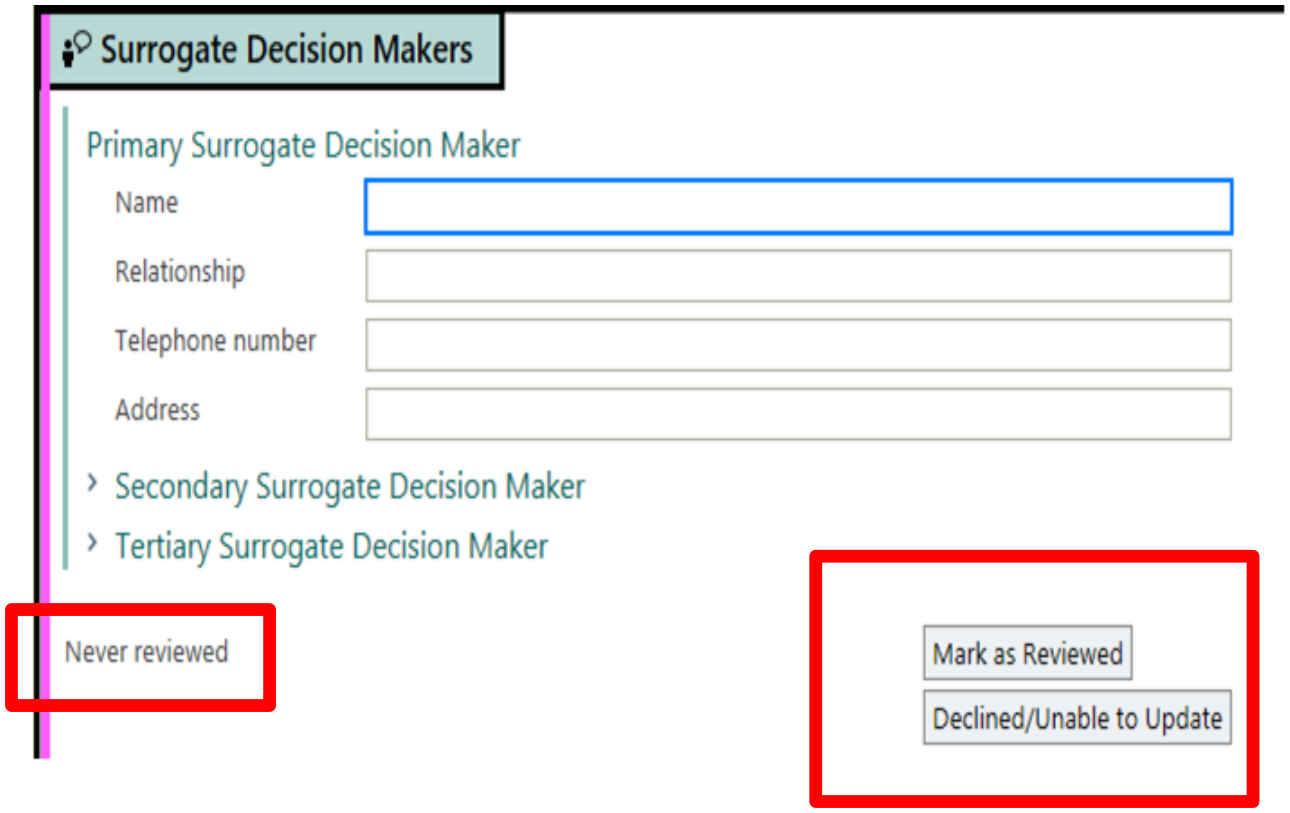
CPT Billing Code	Description
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	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).

CPT II Tracking Code	Description
1123F	Advance care planning discussed and documented – advance care plan or surrogate decision-maker was documented in the medical record.
1124F	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.

Surrogate Decision Maker Mark as Reviewed



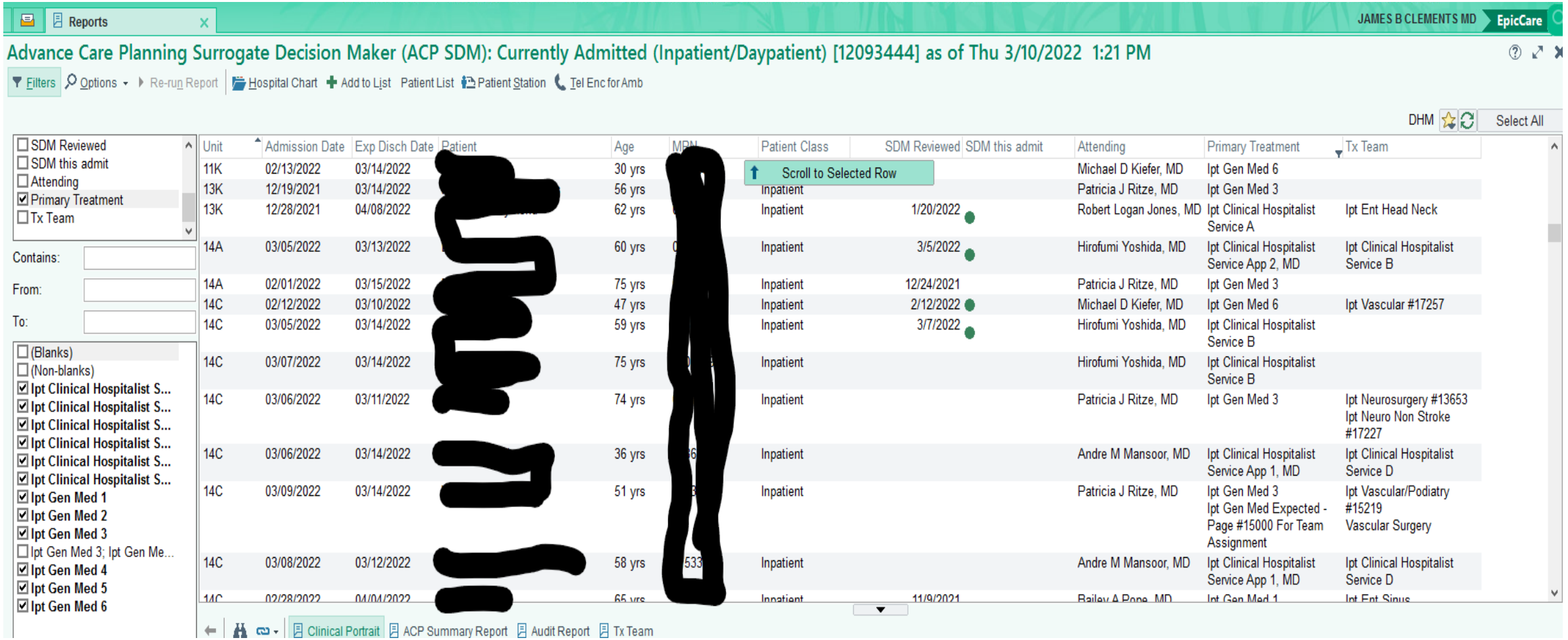
Intervention: Deployed 1/11/22



- 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

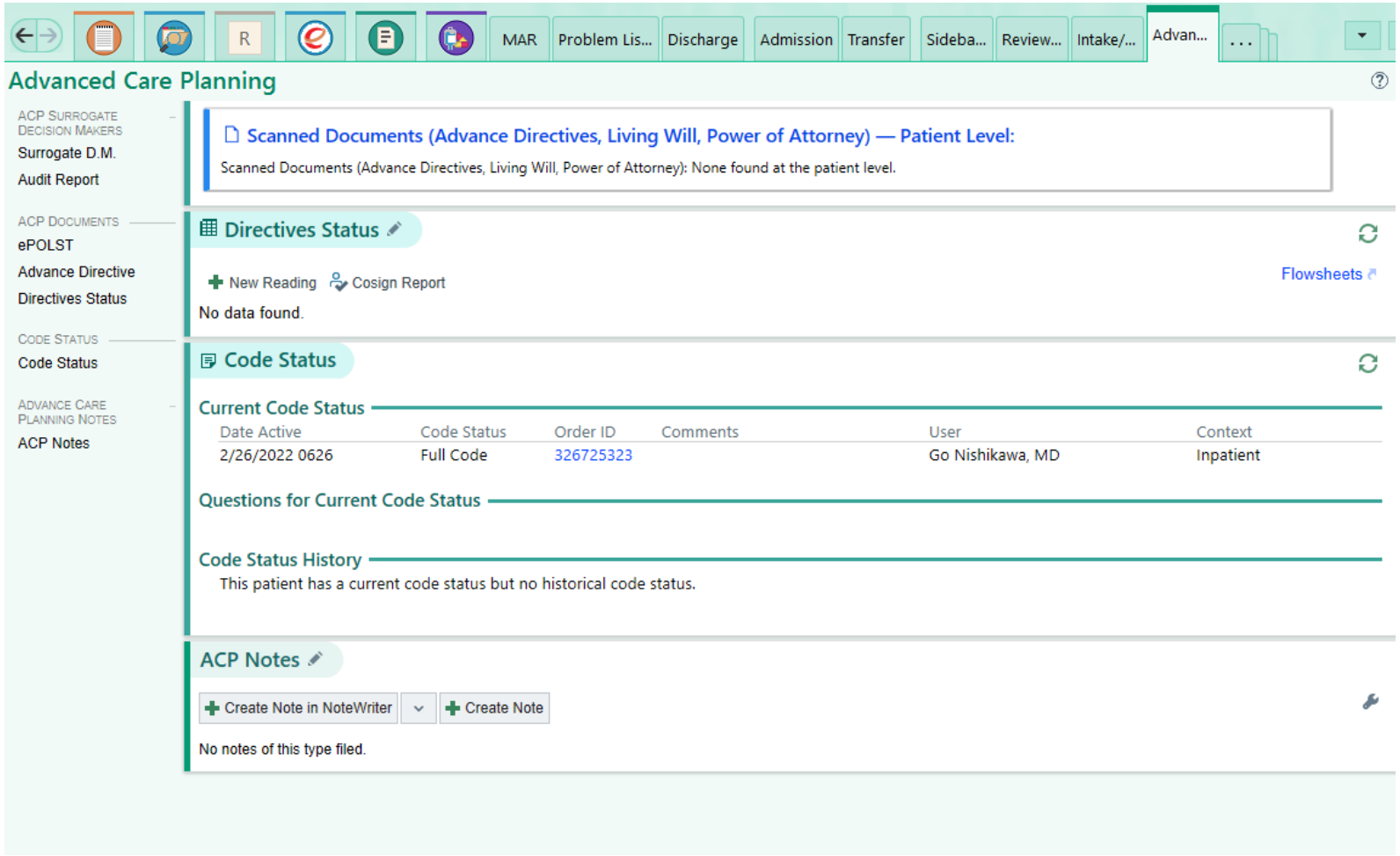
Continuum of Advance Care Planning

Izumi S, Fromme EK. A Model to Promote Clinicians' Understanding of the Continuum of Advance Care Planning. *Journal of Palliative Medicine. March 2017; 20(3):220-221.*

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

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:
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webbja@ohsu.ed

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