Care Management Recognition Awards – Palliative Care
Best Practice Submission Template
Oakland Physician Network Services_ Sylvan Lake Family Practice PLC, _Best Practice _Palliative Care_2019

Contact Information

Submitter Name: Beverly Walters RN, BSN
Submitter Title: Clinical Care Manager, OPNS End of Life Planning Committee Chairman
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Physician Organization Name: Oakland Physician Network Services
Practice Name: Sylvan Lake Family Practice, PLC
Practice Address: 2111 Orchard Lake Rd., Sylvan Lake, Michigan 48320
# of Physicians in Practice: 2
Description of care team: 2 Family Practice Physicians (Kirti Sanghvi MD, Prakash Sanghvi MD) and RN Care Manager (Christine Bartolac RN, BSN, MSHA) embedded in the practice two days/week

Executive Summary (5-8 bullet points, must include summary of results):

- OPNS is focused on developing end of life care planning practices in their physician offices. This initiative is managed by the End of Life Planning (ELP) Committee, a collaborative venture of OPNS, St Joseph Mercy Oakland and community home care/hospice representatives. The Committee sponsors educational opportunities (physician Town Hall CME programs, office staff workshops and OPNS subsidized *Respecting Choices®* facilitator training) and provides tools and resources that impower our practices to provide timely ACP and palliative care services.

- OPNS care managers work in team relations with their physicians and ancillary staff. At Sylvan Lake Family Practice, the doctors initiate ACP conversations and referral for palliative care in coordination with the CM, Christine, who helps develop the patient's plan of care and coordinates referrals to community agencies. She also identifies patients for ACP from her case load and Transition of Care telephone calls. Office staff promote ACP, provide educational materials and schedule individual counseling. An Advance Directive form is provided at all discussions and completion assistance is offered. Patients are encouraged to schedule in-depth follow-up ACP discussions with the doctors or care manager.

- This practice promotes ACP discussions with posters and brochures in the office. The physicians and CM identify patients for ACP or Palliative Care who are over 65, usually at the Annual Wellness Exam, or from patients being seen for management of chronic conditions, declining health or recent hospitalizations. Some patients self-refer themselves for these services as the result of office publicity.

- Sylvan Lake Family Practice has developed successful end of life planning processes that includes:
  - Collaboration between the CM, physicians and office staff in promoting and providing ACP counseling and palliative services
  - Increased office staff awareness and engagement in end of life planning processes
  - Care Manager led and billed ACP conversations from August 2018 – March 2019 totaling **139 patients (79 conversations** in the first quarter of 2019)
  - Increased patient satisfaction and peace of mind reported as the result of available end of life planning opportunities.
  - Increased compensation from appropriate billing of codes S0257 and 99497/99498 for ACP services rendered.

Category of Submission: Palliative Care

Title of Submission: End of Life Planning – a Rewarding Team Process

When did the intervention start and end? (1 – 2 sentences)?

The care manager initiated ACP conversations in August 2018 after discussion with the practice providers on the need for end of life planning with their predominately geriatric and chronically ill patient base. This intervention is ongoing and now includes identification of patients for Palliative Care.

Goals of the Program/Intervention: (1-2 sentences)

Goals of the office's Palliative Care program are to engage patients, especially the geriatric and chronically ill population, in ACP discussions and, where needed, earlier palliative care services.

Who developed the Program/Intervention, and how? (2-4 sentences)

Through its ELP Committee and Informatics Department, OPNS provided tools, resources and educational/training opportunities that enables Sylvan Lake Family Practice physicians and CM to identify more eligible patients and develop ACP/Palliative Care workflow activities that meet their needs.

Description of the Program/Intervention (2-3 paragraphs):

The care manager is an integral part of Sylvan Lake's ACP program. ACP conversations are usually initiated by the providers and referred to the care manager for further education and/or assistance in completing Advance Directive forms. Additionally, the CM generates ACP conversations with patients in her case load, especially those with frequent hospitalizations or declining health. She prefers to include family members in ACP conversations and will often initiate discussions when patients are accompanied to office visits by family members. She also counsels patients who request it as a result of office publicity.

The CM often begins discussions with: "Dr Sanghvi asked me to speak with you about ACP. Do you know what that is?" Information follows with an explanation of ACP, its importance and a review of the Advance Directive form. If the patient has a chronic condition or declining health, the CM will expand her education to include information on the patient's disease state and usual illness trajectory or refer to the doctor for more in-depth information. Other engagement statements from the ACP Toolkit script are utilized when patients are not referred by the doctors. Patients frequently voice appreciation for the information provided.

ACP education is documented in the patient's medical record and includes length of conversation, agreement of patient to participate, family members present, and information discussed. Christine keeps personal records of ACP conversations in her Care Manager Log and uses this and the medical record to track completion of Advance Directive documents. She follows up with patients at the next office visit to encourage Directive completion. Appropriate ACP care management or CPT codes are billed at the end of each day. PO reports and office financial analytics are generated to track program outcomes and success.

How were patients identified for the program/intervention? (1-2 paragraphs)

Patients are introduced to ACP by the physicians at the Annual Wellness Exam or during office visits for complex chronic conditions and/or declining health. In addition, the CM identifies patients at all payer levels through her case load and Transition of Care telephone calls. Some patients are self- referred as the result of office publicity (wall posters, ACP information brochures) and ancillary staff interaction.

Patients are identified for additional Palliative Care management by the physicians and referred to the CM for a collaborative team approach that includes education, comfort care support and if needed, referral to a community palliative care program such as those provided by *St Joseph Mercy Home Care/Hospice or Residential* home care services . Christine would often coordinate this level of care.

How was success measured? Process based or out-come based? (2-3 paragraphs)

The CM measures success of her involvement in the practice's ACP program on an out-come basis by personally tracking and calculating the 1) number of patients receiving ACP education and 2) the number of executed

Advance Directives returned to the practice. This data is stored in the Care Manager's activity log, reported quarterly to OPNS and tracked through claims reports.

On a process basis the practice feels success when their ACP education or palliative care efforts meet with patient satisfaction. Patients and family express appreciation for these services that relieve uncertainty and foster peace of mind.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

Palliative Care Program results:

- Care Manager ACP Statistics - August 2018 – March 2019 **(See Addendum A)**
  - 4th Quarter 2018 - **60 Care Manager** ACP Conversations Initiated and billed
  - 1st Quarter 2019 – **79 Care Manager ACP** Conversations Initiated and billed
  - Total: **139 Care Manager** ACP Conversations Initiated and billed 8/1/2018 – 3/31/2019

- Total number of ACP 99497 CPT codes billed to multiple insurance companies (1/1/2019 – 3/31/2019) = **66 patient conversations**
  Insurance plan claims:
  - **Medicare = 49 claims**
  - **Medicare + Blue Advantage = 25 claims**
  - **Priority Health = 1 claim**

- The CM has established working relationships with area Palliative Care/Hospice programs and coordinates care for patients needing these services

Tools, processes or resources developed to aid in the development of the program/intervention (1-2 paragraphs):

OPNS ELP Committee developed an Advance Directive form and ACP Toolkit containing tools and resources used by this practice to promote and enhance their ACP program. **(See Addendum B – Advance Care Planning Toolkit Contents)**

The CM and office staff are provided education and guidance with ACP/Palliative Care processes at monthly Care Manager Work Group meetings and through OPNS Medical Management and End of Life Planning Committee educational programs and oversight support.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs):

Prior to August 2018 and the beginning of Care Management at Sylvan Lake Family Practice there was no ACP or palliative care program. Now, because of the CM's promotion of end of life planning, the entire practice from the physicians to clerical staff are aware of the importance of ACP and attuned to helping patients plan for their future. Palliative Care referrals are made in collaboration with the care manager to improve coordination of care. As a result of these interventions, patients experience peace of mind and the staff is gratified and proud of their accomplishments.

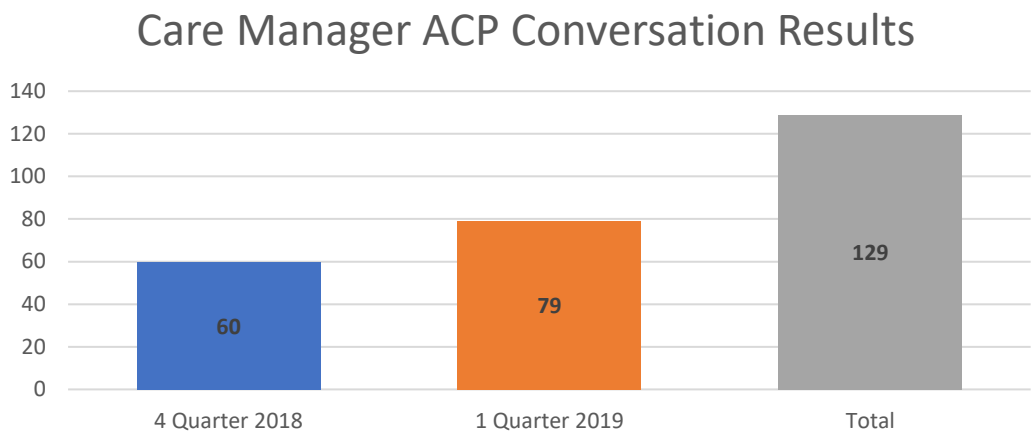
How will your organization use the funds if your submission wins? (1 paragraph):

Funding would be used to expand the Provider Delivered Care Management program by enabling OPNS to hire and support additional care managers and provide the *Respecting Choices®* ACP facilitator training and other Palliative Care related educational programs. In addition, it would help to develop a consistent tracking process at the local office and PO level of ACP and Palliative Care services rendered.

Addendum A – OPNS Palliative Care Best Practice Summary

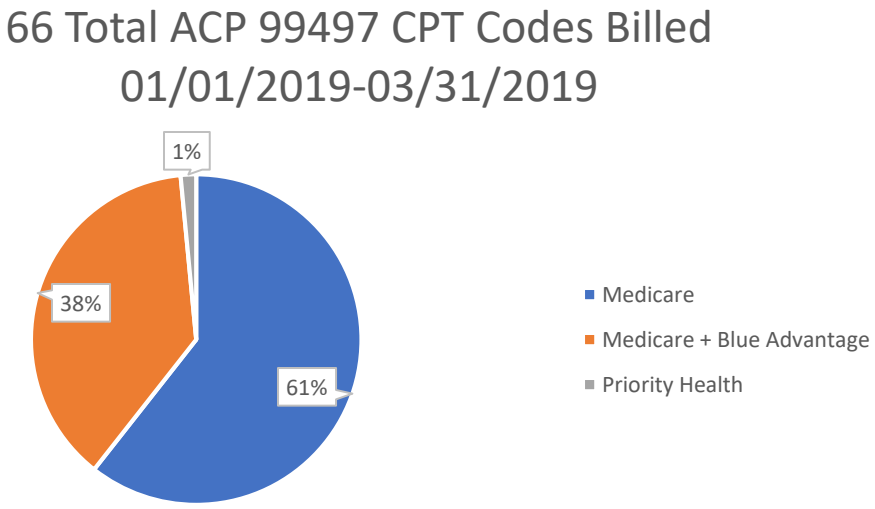
Care Manager ACP Conversation Results:

- Total number of care manager facilitated ACP conversations (8/1/2018 – 3/31/2019) = **129** patient conversations
  - 4th Quarter 2018 - **60** patient conversations
  - 1st Quarter 2019 - **79** patient conversations



Practitioners and Care Manager Combined ACP Program Results 1st Quarter 2019:

- Total number of ACP 99497 CPT codes billed to insurance companies (1/1/2019 – 3/31/2019) = **66** patient conversations
- Insurance plan claims for CPT code 99497:
  - Medicare **= 40** claims
  - Medicare + Blue Advantage = **25** claims
  - Priority Health = **1** claim



Addendum B – OPNS Palliative Care Best Practice Summary

Advance Care Planning Toolkit Contents:

Introduction letter by OPNS Chief Medical Officer, Dr. Imad Mansoor

Specific documents include:

- ***Glossary of Terms***
  -in front pocket
- ***What is Advance Care Planning?*** **Brochure**
  -intended to provide information to patients regarding ACP
  -can be used as source of information for PU staff
- **Advance Care Planning Process Information**
  -outlines ideas for ACP process implementation including staff roles and tracking and follow-up
  -itemizes documents contained in the ACP toolkit
  -discussion script providing an example of how you might discuss a patient's needs and concerns
- **ACP Billing and Coding Tip Sheet**
  -provides information on ACP CPT Codes including coding requirements
  -provides coding information for care management
- **Choosing a Patient Advocate**
  -provides information on selecting a patient advocate
  -outlines the responsibilities of a patient advocate
- **Resources for ACP**
  -can be shared with office staff as well as with patients
  -Informational brochures from Honoring Healthcare Choices
- **Advance Directive Forms – Pediatrics**
  -Everyone is receiving a Pediatric Starter Kit from the Institute for Healthcare Improvement
  -*My Wishes* (Pediatrics)
  -*Voicing My Choices* (Adolescents & Young Adults)
- **Advance Directive Forms – Adults**
  -OPNS (adapted from Making Choices Michigan)
  -*Five Wishes*
  -*MI-POLST*
- **Wallet Card – Making Choice Michigan**
  -can be completed by patient who has completed an advance directive
  -card is kept in "wallet" as a reminder or in case of emergency
- **ACP poster**
  -in back pocket of the toolkit
  -to be posted in conspicuous place of the office
- **MQIC Guidelines on Advance Care Planning**
  -in back pocket