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All's Well That Ends Well: A Comprehensive Advance Care Planning Strategy

NCIOM Taskforce on Serious Illness

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About Us

Cone Health is one of the region's largest and most comprehensive not-for-profit health networks with more than 100 locations in Guilford, Forsyth, Rockingham, Alamance, Randolph, Caswell and surrounding counties, including six hospitals, three ambulatory care centers, three outpatient surgery centers, three urgent care centers, a retirement community, more than 100 physician practice sites and multiple centers of excellence.

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Outline of Discussion

Background
Alignment and Organizational Readiness

Financial Impact
Mortality Data and ROI based on retrospective analysis

Digital Platform
EHR Integration and optimization, National Registry

Strategic Targeting for ACP
Managing Risk, Predictive Modeling

Quality Communication
Education Initiatives

BACKGROUND

Where We Started.

- No universal, effective plan to access healthcare choice or official ACP documentation made prior to or during an acute admission.
- Dis-concordant care, inappropriate use of resources, moral distress in frontline providers and unnecessary suffering and conflict for patients and families

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- Educational gaps, poor quality communication by providers and staff regarding ACP
- Multiple failed attempts to improve this process

"Success usually comes to those who are too busy to be looking for it.."

- Henry David Thoreau

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Possible Formal Directive Papers

2
Informal Documentation Types

Formal	Use and Limitations
North Carolina Advance Directive/ Living Will- Short Form	Must be Witnessed and Notarized, limited accessibility and reliability
North Carolina Durable Healthcare Power of Attorney	Must be Witnessed and Notarized, limited accessibility and reliability
Five Wishes Forms	Must be Witnessed and Notarized, less commonly used form
Medical Orders for Scope of Treatment (MOST)	Requires Patient and Provider Signature, must be updated yearly
Portable DNR/ "Golden-Rod"	Provider only signature, poor accessibility, document must be visible to EMS, only prevents CPR
Informal	**Use and Limitations**
Institutional Code Status Orders (DNR, PARTIAL CODE, FULL CODE)	Orders REQUIRED on every admission, limited understanding by patient and provider, default full code. DNR order alone tells us very little about patient wishes. NOT SAFE FOR USE. (See Appendix A.)
Goals of Care Documentation Shared Decision Making of Medical Choices in Advanced Illness (situation specific- ex. hemodialysis, short term intubation, blood transfusions, chemotherapy, nutrition. Antibiotics, surgery)	• Gives important information about patient during care transitions and provider handoffs. • Allows for ongoing conversations about medically reasonable interventions and options. • Inconsistent documentation and poor accessibility to documentation ex. buried in a clinic note • Outcomes often depend on provider communication skills and approach.

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14+ Possible Places to Look

Tool/Data Entry Field	Assessment of Use and Functionality
ACP Navigator	Minimal Use System-wide
Legal Guardian	This is being confused with HCPOA-should only be reserved in cases where there is a confirmed court appointed guardian and patient lacks capacity for own decision making.
Healthcare Agents	Feature not active in CHL ACP Navigator (recommend)
Patient Capacity	Feature not active in CHL ACP Navigator (recommend)
MOST Form YES/NO Question	YES/NO and link to document, could build in e-MOST to reflect preferences and trigger yearly review- Vynca will make this much easier and user friendly and available to those not on Epic.
Code Status Order History	List of all institutional code status orders available, does not link to documentation with details indicating consent.
ACP Notes within any note type	Provider progress note may reflect conversation and review of ACP directives but not accessible without detailed chart review.
ACP Navigator Goals of Care Note	Available in the ACP navigator and across settings, not being utilized because it requires documentation in another note and new process. Discussion of template in progress. (*See Appendix B for Atrium Health Tool)
My Chart ACP Activity and Patient Entered Questionnaire	Demo seen several months ago, great engagement tool for conversation and PCP appointment trigger-- feature is not active , will require consideration and thoughts on workflow and use issues. Vynca working on My Chart interface to pull and validate patient self uploaded documents.
NC ACP Registry Embedded Hyperlink	Would remove, not being utilized
ACP Billing Codes	Providers do not understand Medicare conditions. Reluctant to use.
Problem List Documentation	Work around, being used in CHCC to meet requirement of conversation. ED does not see problem list.
Media Tab AD Filter	Scanning is an unsettled issue: Must be sure to overwrite old versions, Hard copy only for transfer, If scanned, electronic form technically valid only for current admission
Banner Features	Providers unaware they can obtain information by clicking on Code Status in Banner, Color change insignificant impact.

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21+ Relevant Encounter Types and Locations

Cone Health System	Community Encounters
Inpatient • Admission/Hospitalization • ED Visit • Elective Surgery • Elective Procedures • BH Admission/Evaluation **Ambulatory** • 1st Adult PCP Visit (Age 18- Wellness) • Time of Diagnosis of Serious Illness • Medicare Wellness Visit • Yearly Review After the Age of 65	**Post Acute Care** • SNF • EMS • Home Health • Hospice and Community Based PC • LTACH • ALF/LTC/Medical Foster Homes **Community Services** • Local Attorneys • Senior Centers • Social Services • Congregational Programs • Colleges and Universities • PACE Program

12+ Provider and Staff Types possible involved with ACP

Primary Care Physicians, PAs, NPs	Nurses Inpatient (All)
Subspecialty Physicians and APPs	Medical Records Staff, Front Office Staff
Social Workers (THN, Cone Inpatient, Ambulatory)	Care Management (THN, IP, AMB)
Chaplains (IP, CHCC)	Pre-Operative/ Procedural Areas (RN, CRNA's)
ED TRIAGE/EMS	Ambulatory RN, CMA, Mental Health Tech
HIM/Clinical Informatics	Rapid Response Team

Call to Action

What We Did.

Demonstrated Significant Financial Impact of ACP

Failure to obtain and transmit an accurate ACP is a medical error.

Demonstrated Significant Financial Impact of ACP

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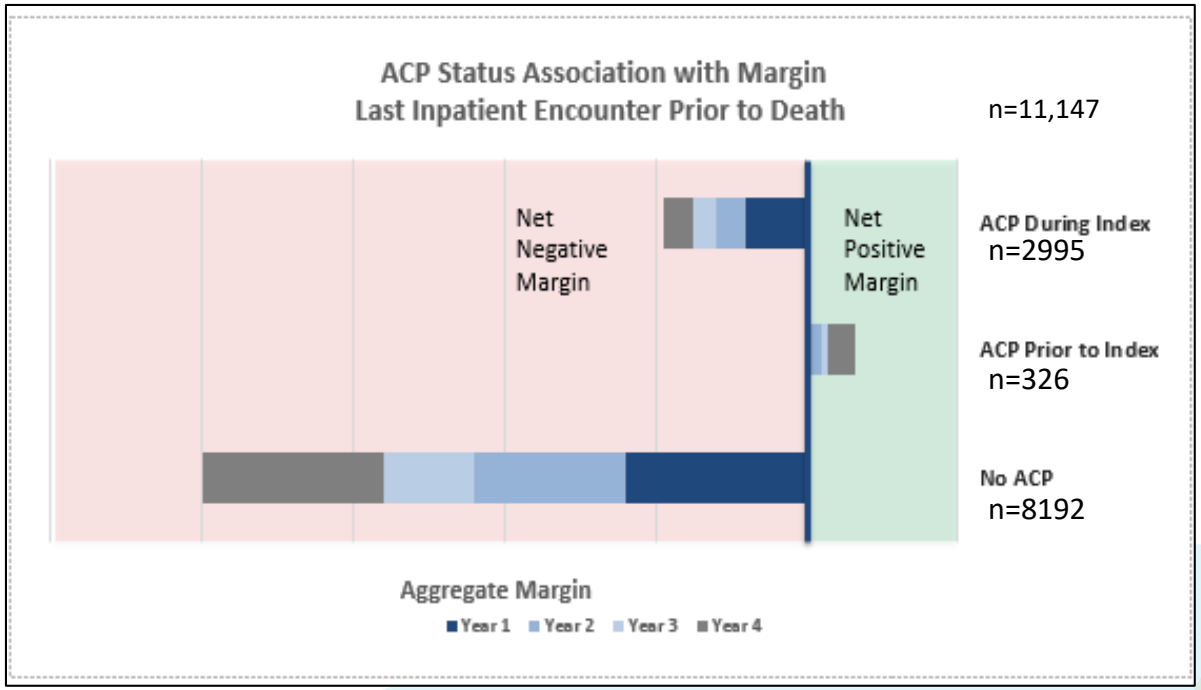
Financial Impact

Advance Care Planning



If we could move just 10% of patients into [ACP Prior to Admission] in the current environment it would result in positive margin for the whole population.

$2.0M GAIN

$1.4M LOSS

Alignment and Engagement

We have alignment across the entire system, including CHMG, THN and other key partners to support this project and transform ACP at Cone Health and in our community.

Health System

Alignment with System-wide metrics including 30 day mortality, Readmissions and Quality/Safety.

Medical Group

Alignment of physician incentives and upstream approach to ACP in ambulatory settings

ACO-Health Plan

Capital partner in transformational care and population health, Manages at risk contracts with insurers to improve quality and reduce costs

Community Partners

Pilot site for Duke Endowment funded project to transform advance care planning with a focus on using digital media to engage the public and community organizations.

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Advance Care Planning Initiative and System-wide Strategy

Standardize Best Practice

Incentivize for ACP completion and best practice work, provide decision and practice support tools.

Seamless HIT Platform

Reach both EPIC based and non-Epic based providers. Vynca Solution. Optimization of ACP Navigator.

Strategic Targeting

Developed Predictive Modeling tool to predict 12m mortality. Patients at highest risk identified for ACP. Milestone driven ACP encounters.

Education/Support for High Quality Communication

GME didactics and clinical experience, CAPC communication module incentives. Conversation support in HER.

Analytics

Support Predictive Modeling. Ongoing analysis of interventions and outcomes and identify new opportunities.

Culture Change and Community Connection

Mind My Health key partner in supporting community efforts.

Advance care planning is a cornerstone of palliative care, population health and serious illness management. Cone Health, along with many other health systems, has struggled to overcome the challenges of accessibility, reliability and portability associated with advance care planning documentation and in overcoming the difficult societal and cultural barriers of having these often difficult conversations. This strategy is the way forward.

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Digital Platform

Seamless HIT to enable high quality documentation of health choices and end of life wishes

- **Investment in Vynca Solution™ to fill significant gaps in EHR (EPIC) and for web-based community and provider portal**.
  - Complex logic and error checking features to avoid discordant choices when creating ACP documents.
  - Patient engagement and education tools for ACP, Multi-language functionality
  - Easy one-click access to all ACP documents in a single location.
  - Automatic display of most recent, legally valid ACP document.
  - Clearly labeled voided ACP documents and aggregation of all historical forms in a single location.
  - ACP documents are electronically accessible to providers outside of your organization.
  - Multiple points of clinical integration: Hospital, Ambulatory, SNF, Home Health, EMS
- **Optimization of EPIC Advance Care Planning Navigator**
  - Care Alignment Tool
  - Revision of Institutional Code Status Orders to align better with MOST form
    - DNR-Comfort Care, DNR- Full Scope Treatment w/or w/o Intubation
    - Full Code –by consent, Full Code –by default, address within 24 hours
- **Support for ACP encounter coding and billing practice**
- **Community Facing Portals** (Mind My Health, Vynca, My Chart)

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Achieving High Value ACP Intervention

Optimal Timing and Strategic Selection of Individuals

- **Cone Health Predictive Modeling tool for 1 year mortality**
  - Advanced proprietary technology that applies a risk score for 1 year mortality
  - Patients who trigger the model are triaged for needs and if applicable PCP is contacted for palliative care services consult or patient is scheduled for advance care planning office visit. Acute care patients or patients in ED are seen by the inpatient palliative team within 24 hours.
- All upstream ACP timed with appropriate life events and milestones for creation, updates and revisions.
- Analytics has demonstrated that certain patients (heart failure, advanced age…) who have an ACP in place prior to their last admission before death have lower readmissions and are less likely to die in the hospital.

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Education and Support for Quality Conversations

The only thing worse than no conversation is a bad conversation.

- GME Education Provided
- Formal Nursing and Support Staff ACP Education
- CAPC Communication Modules, mandatory for hospitalists
- Patient Education though EMMI and Consumer Portals
- Educational Events
- Digital Decision Support and Conversation Guide

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Future Ideal State

All's Well That Ends Well

- The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.
- The ultimate measure of success will be when ACP is accepted and expected by all people who seek healthcare in our system and not something just nice to have or tucked away and forgotten.

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Contact Us

Speaker: Elizabeth L. Golding, DO
Medical Director, Palliative Care Services

Address
1200 N. Elm Street, Ste. 300
Greensboro, NC 27410

Contact Info
Email: elizabeth.golding@conehealth.com

Telephone
Office Phone: +1 (336)832-2840