National Share the Experience 2018
Improving Person-Centered Outcomes Through Collaboration
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THE CURRENCY OF ADVANCE CARE PLANNING: FROM PRACTICE TO PAYMENT

Presented by:
Lynda Tang, DO
Katie Pence, PAC
Disclosures

• None relevant

Agenda

• Background
• Methodology for integrating ACP discussion into primary care visits
• Criteria to satisfy billing for ACP discussion in a primary care visit
• Results of coding and payment
• Limitations and conclusions
Who We Are

VANCOUVER
Not B.C.

WASHINGTON
Not D.C.

Clark County
Not Nevada

Near Portland, OR
Not Maine

Background

• Honoring Choices PNW – First steps

• Few PCP visits include ACP due to insufficient time and lack of training\(^1\)

\(^1\) Am J Hosp Palliat Care 2017;34(5):423-429
**Ignite Paradigm Shift**

- Annual Wellness Visit
  - Affordable Healthcare Act
- CMS ACP Codes: 99497, 99498
- Currency for dialogue with primary care

**Primary Care Redesign: Embracing ACP**

- Primary care visit types as opportunity for ACP
  - Annual Physical Exam
    - 99391 – 99397
  - IPPE (Welcome to Medicare)
    - G0402
  - Initial AWV (Initial Annual Wellness Visit)
    - G0438
  - Subsequent AWV (Subsequent Annual Wellness Visit)
    - G0439
- “Annual Comprehensive Visit” = Wellness + Physical Exam
Socialization

- Small Test of Change
- Primary care summit
- EHR Integration
  - Templates
  - Smart phrases

EHR Integration

```
I. VOLUNTARY DISCUSSION
This is a voluntary discussion with:
A. [Name of Family Member]
B. Other family members or surrogates

II. COMPLEXITY
1. Do they currently have Advance Directives?
   - [ACPADV: Yes-No as default 22389: "No"]
2. Document types:

   - [ACPADV: Yes-No 22380: "Yes"]
   - [ACPADV: Yes-No 22381: "Yes"]

Is the DPOAHC form completed and witnessed? [ACPADV: Yes-No 22380: "Yes"]

Original given to patient. Copy has been taken and sent to medical records [ACPADV: Yes-No 22380: "Yes"]

III. TIME SPENT
   - [ACPADV: Time spent 22380]
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Training PCPs on ACP integration

- Workshops
  - Primary Care AHPs
  - 90 mins
- Department Meetings
  - IM, FM
  - EPIC Demo

Results

<table>
<thead>
<tr>
<th>Data collected from 9/2017 – 8/2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Primary Care Providers</td>
<td>69</td>
</tr>
<tr>
<td>Number of ACVs</td>
<td>6182</td>
</tr>
<tr>
<td>Number of ACVs with ACP billing</td>
<td>833</td>
</tr>
<tr>
<td>Average charge for 99497</td>
<td>$256</td>
</tr>
<tr>
<td>Average reimbursement for 99497</td>
<td>$99</td>
</tr>
<tr>
<td>Approximate revenue gained from 99497</td>
<td>$82500</td>
</tr>
<tr>
<td>Potential revenue available from 99497</td>
<td>$612000</td>
</tr>
</tbody>
</table>
Discussion / Limitations

- Non billed ACP discussions occurring in ACVs?
- Chart review for content/quality of ACP discussion?
- Do ACP discussions increase the rate of documented advance directives?
- Methodology scalable to other departments?

Future

- Missed opportunities and financial incentive
- Primary care re-design
  - Administration support
  - Medical home model and value based care
  - Include ACP in all visits
- HC-PNW 2020 goal: 75% of population will have an AD at time of treatment
Conclusions

• Primary care visits are excellent settings for ACP discussions
• Systems integration is vital for success
• Socialization and training can prime and motivate clinicians on the importance of adding ACP discussions into visits
• ACP discussions are a large untapped revenue source

Questions

• Lynda Tang
  – LTANG@tvc.org
• Katie Pence
  – KPENCE@tvc.org