Defining the Problem and Opportunity

Expanding eConsent: Advance Care Planning in the 21st Century

Defining the Problem and Opportunity

Moderator: Carol Robinson, DNP, RN

Rebecca Sudore, MD
University of California, San Francisco
Associate Professor of Medicine

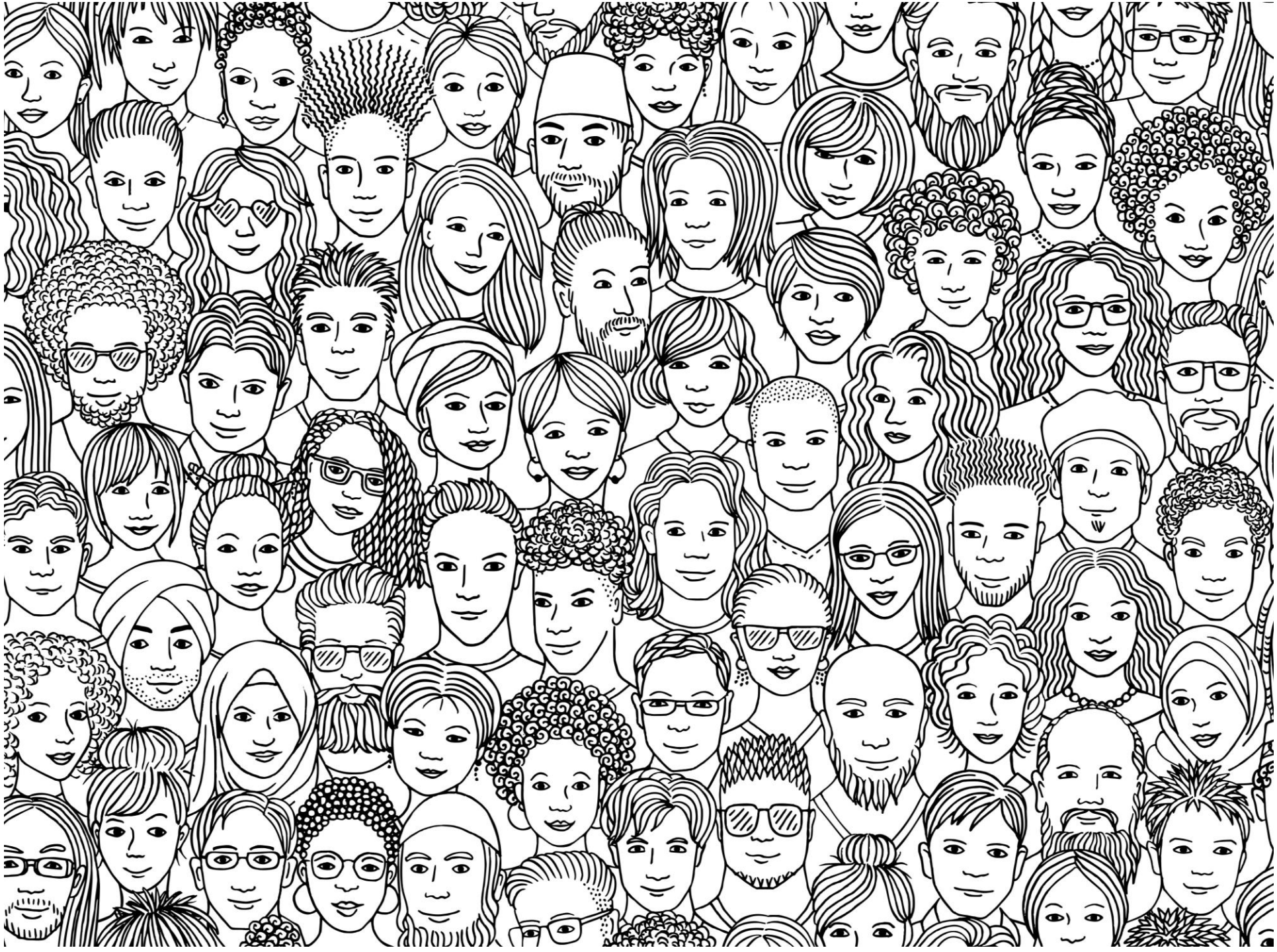
Lenel James
Blue Cross Blue Shield Association
Business Lead – Health Information Exchange and Innovation

Julie Wallace
National Patient Advocate Foundation
Volunteer Lead

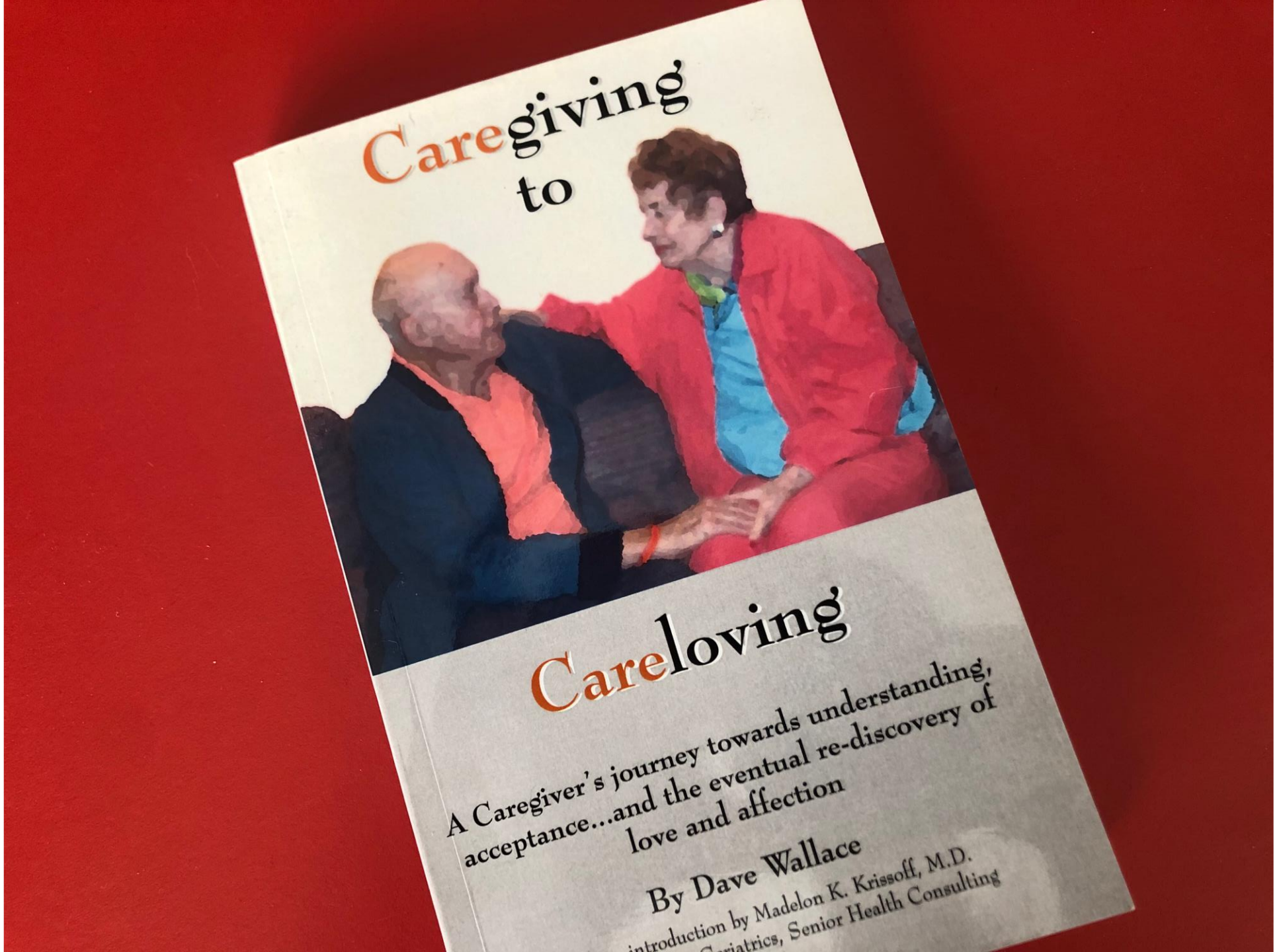
Shari Ling, MD
Centers for Medicare and Medicaid Services
Deputy Chief Medical Officer

David Wang, MD
Scripps Health
Systems Director of Palliative Care

Julie Wallace
National Patient Advocate Foundation
Volunteer Lead




OAKLEY


Caregiving
to
Careloving
A Caregiver's journey towards understanding, acceptance...and the eventual re-discovery of love and affection
By Dave Wallace
Introduction by Madelon K. Krissoff, M.D.
Geriatrics, Senior Health Consulting

Rebecca Sudore, MD
University of California, San Francisco
Associate Professor of Medicine

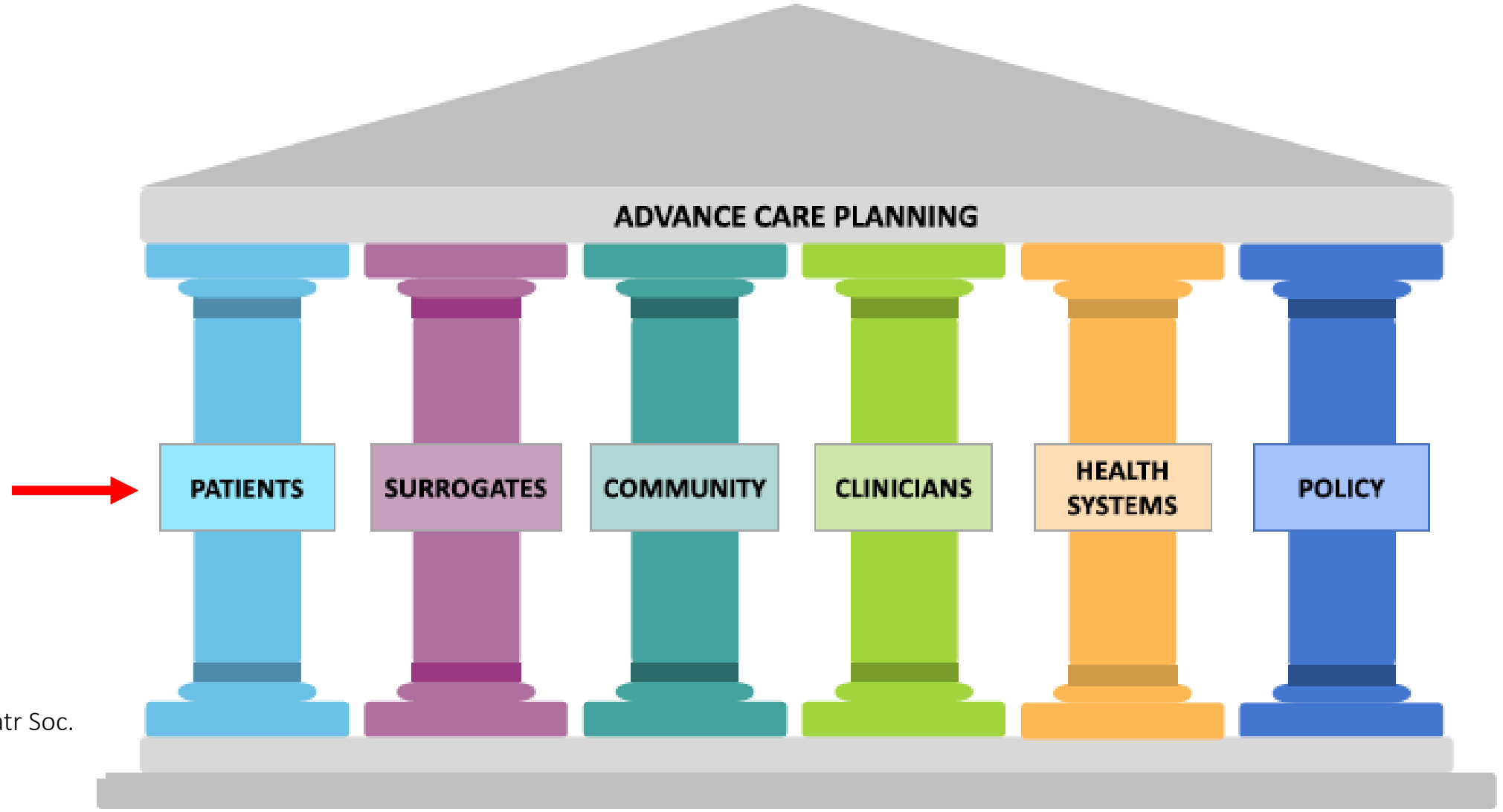
PREPARE™
For Your Care

Rebecca Sudore, MD
Professor of Medicine, Division of Geriatrics
University of California, San Francisco

Consent & Advance Care Planning: The Patient Perspective

UCSF

Consent & Advance Care Planning: Complex Interplay of Many Stakeholders



McMahan, Sudore:, *J Am* Geriatr Soc. Sept. 2020

Why is ACP Important?

- Improves patient satisfaction with care and quality of life
- Less unwanted medical care aligned with wishes
- Less stress for the surrogate decision maker

Detering KM et al. *BMJ*. 2010; Silveira MJ, et al. *N Engl J Med*. 2010;362(13):1211-1218; Houben CH, et al. *J Am Med Dir Assoc.* 2014; Bischoff et al. *J Am* Geriatr Soc. 2013; Bond WF, et al. *J Palliat Med.* 2018

ACP Realities

- ACP rates: ~ 33% for the past 10 years
- Lower among minority populations, only ~ 15-20%
- Only ~ 10-20% discussed wishes with medical provider
- Among ICU decedents, ~ 20% no ACP before death

Silveira et al. *N Engl J Med*. 2010; Yadav et al. Health Aff (Millwood). 2017; Harrison et al. *JAMA Intern Med*, 2016; Block BL, et al. *JAMA Intern Med.* 2020

Challenges & Opportunities

- Outdated Models
- Health Literacy
- Language Diversity
- Cultural Diversity & Disparities
- Digital Literacy
- Legal Challenges
- COVID-19 Challenges

Outdated Models of Consent and Advance Care Planning (ACP)

- **Old Consent model:** Read and sign

- **Old ACP Model:** One-time advance directive, DNR order, or checkbox

Sudore et al., Delphi Panel Consensus Definition. JPSM 2017

2020 Systematic Review Enhanced Informed Consent

- Patient consent comprehension:
  - 43% with written interventions
  - 56% with audiovisual interventions
  - 67% with multicomponent interventions
  - 100% with teach-back interventions (**New Model**)

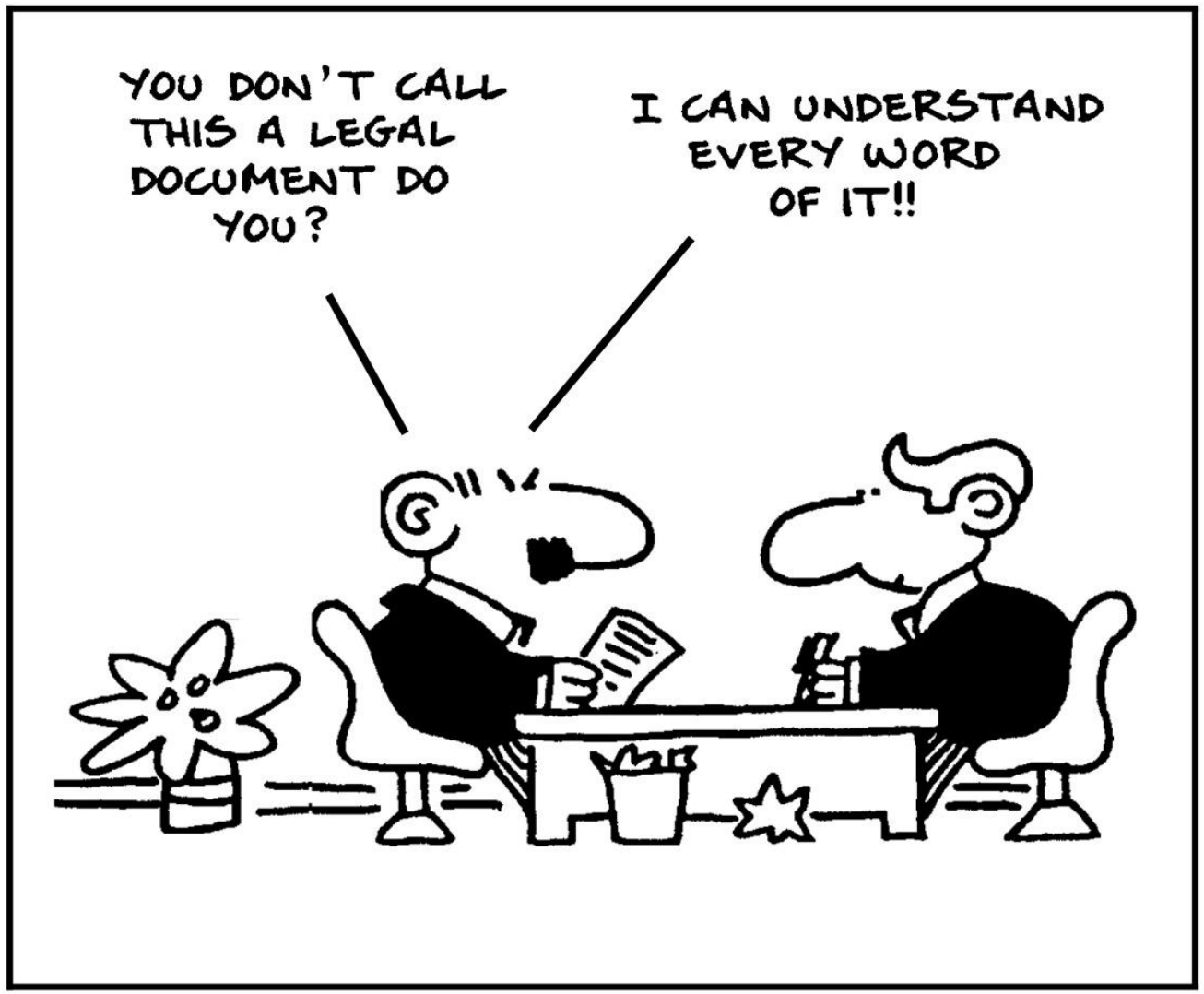
Glasser, et. al. Med Decision Making. 2020

Advance Care Planning (ACP) – the Ultimate Informed Consent

- **New Model:** ACP is a **process** that supports adults at any age or stage of health in **understanding and sharing** their personal values, life goals, and preferences regarding medical care.

Sudore et al., Delphi Panel Consensus Definition. JPSM 2017

Health Literacy



Health Literacy Considerations

- Average reading level in the US = 8th grade
  - Medicaid and elderly = 5th grade
- Advance directives & consent written >12th grade level
- Limited literacy = poor understanding

CALIFORNIA
ADVANCE HEALTH CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures and programs of medication; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation;
(e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Consent: The Common Rule

- “It has long been recognized that under the current rules, consent forms have been growing longer and can be difficult to understand.

- They too often appear to be designed more for protecting the legal interests of institutions than for helping someone make a decision...”

Menikoff, et. al. The Common Rule, Updated. NEJM, 2017

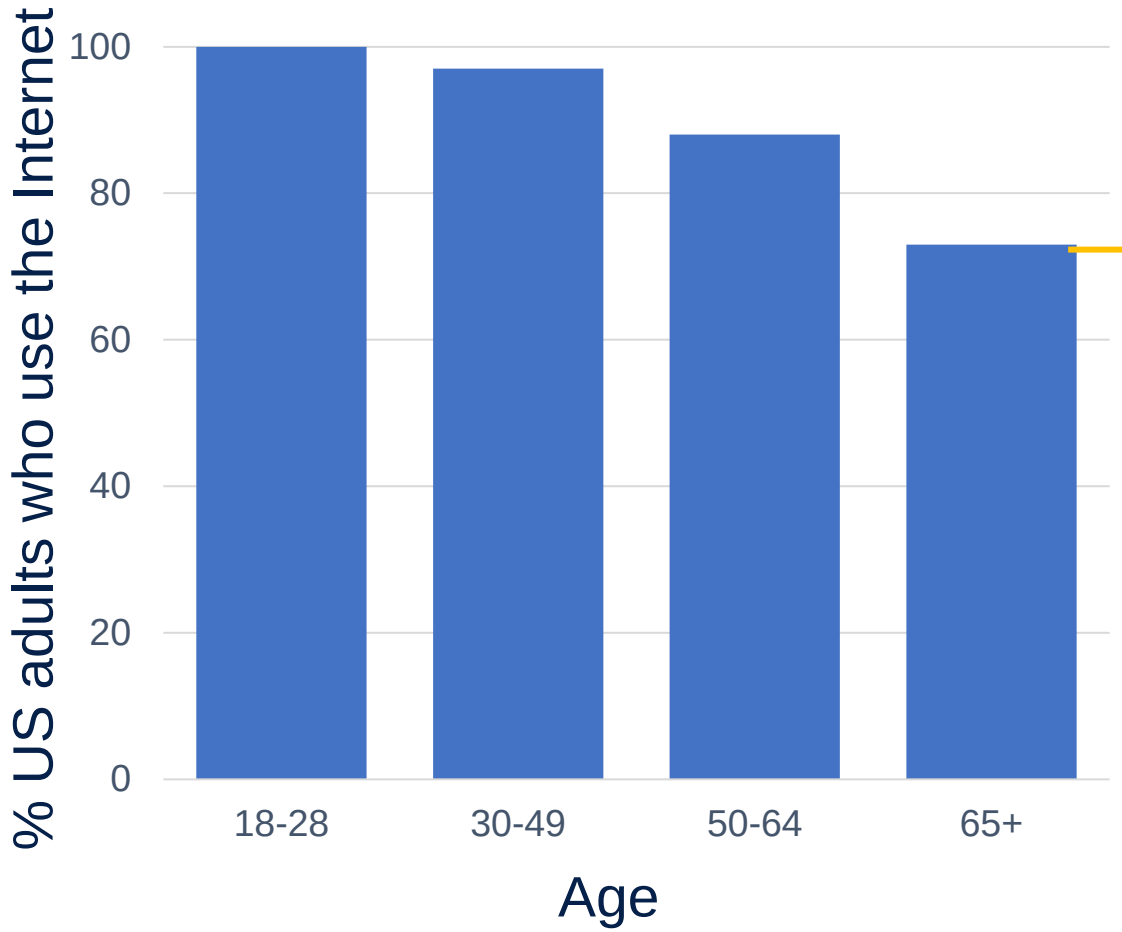
Language Diversity

- 61 million (~20%) speak language other than English at home
  - 40 million Spanish, 3.4 million Chinese
- Non-native English speakers & diverse langua
  poor understanding

Cultural Diversity & Disparities

- Non-Western views on autonomy & decision making
  - ~20% do not want to make own medical decisions
- Experiential racism & mistrust

Digital Literacy

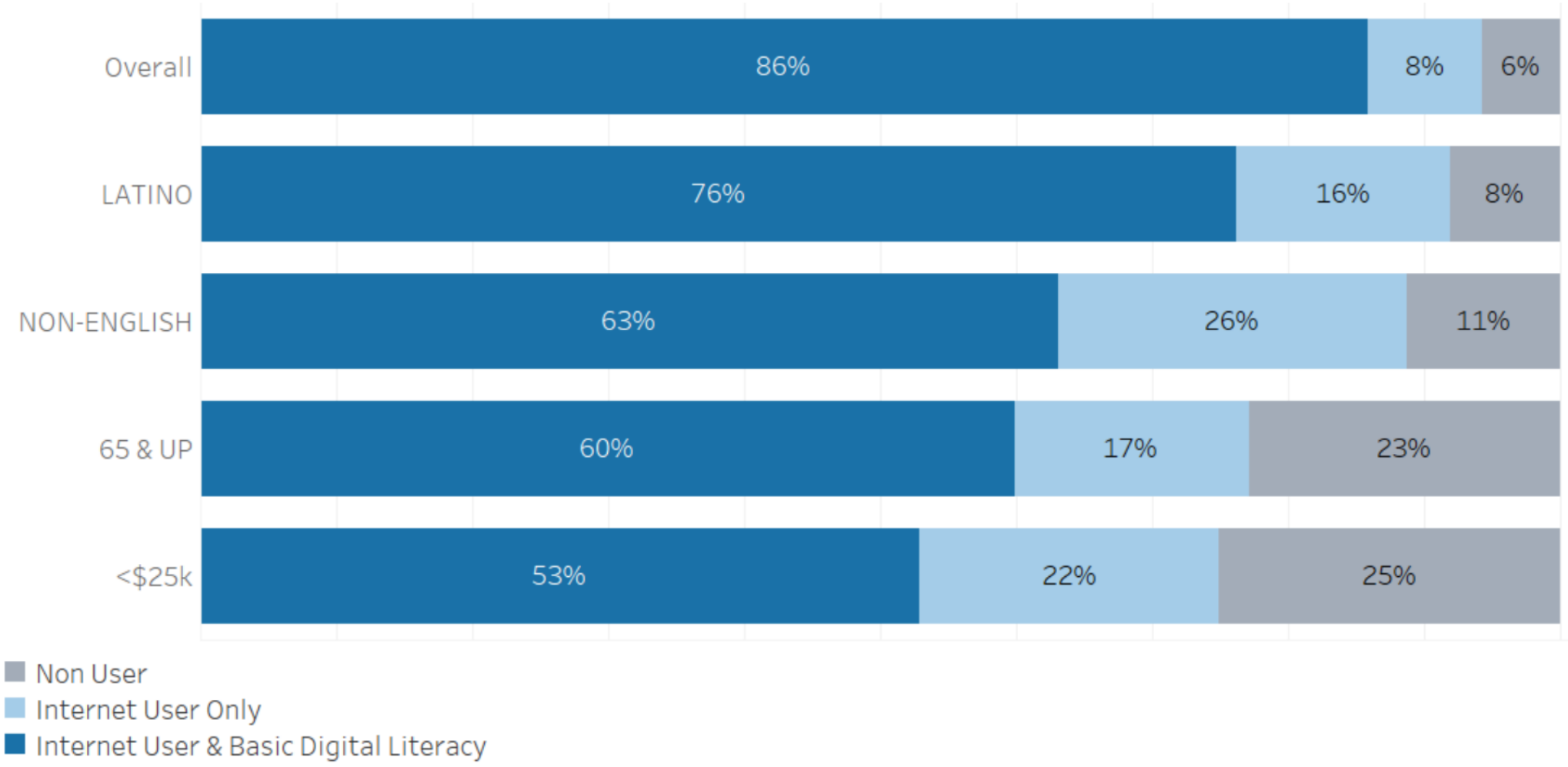


73% of older adults use the Internet

Yet only 60% are able to send an email, fill out an online form

Source: Pew Research Center, Internet/Broadband Fact Sheet. June 2019.

Digital Literacy: Disparities



Source: SF Office of Digital Equity.

Slide developed by Sarah Nouri, MD

Digital Divide: Patient Portals

- Only 50% of patients 50-80 yrs access patient portals
  - -84% check labs
  - -37% schedule an apt
  - -26% get advice

University of Michigan's National Poll on Healthy Aging

Slide developed by Sarah Nouri, MD

The Digital Divide: Video Visits

- ☑ Access → Not own enabled devices
- ☑ Digital literacy → Not knowing how to use devices
- ☑ Usability → Hearing, speaking, seeing; cognitive impairment

38% of older adults are not ready for video visits

Latinx: 70%
Black: 60%
Low SES: 67%
Poor health: 77%

Lam et al. JAMA Intern Med. 2020;180(10):1389-1391.

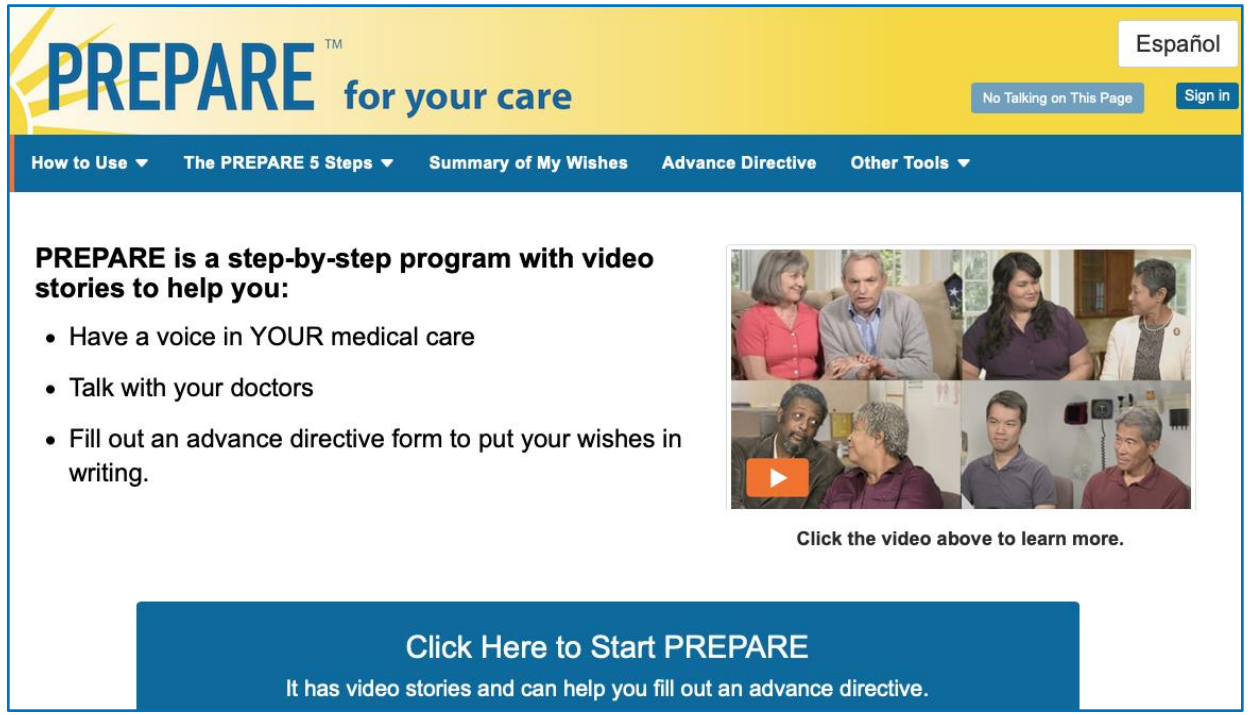
Slide developed by Sarah Nouri, MD

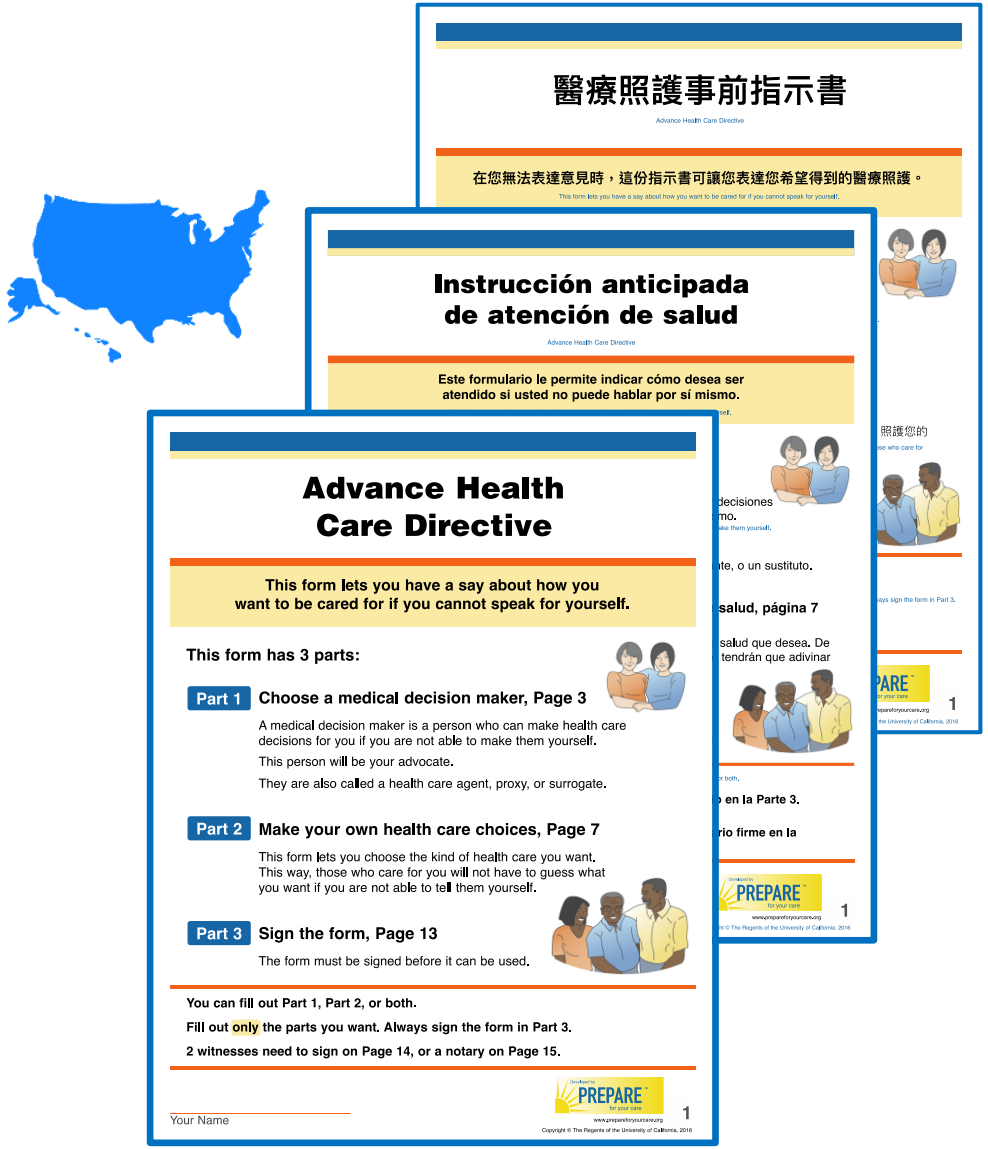
Legal Challenges

- Each states has their own AD laws

- Execution barriers
  - Not allow oral directives
  - Require witness sigs
  - and/or a notary

Addressing Challenges

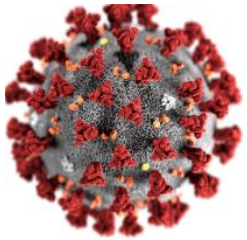




Sudore, et al. JAMA Intern Med 2018: https://pubmed.ncbi.nlm.nih.gov/30383086/

Publication on eHealth Design coming soon

COVID Challenges



- Social distancing and socially isolated adults unable to get witness signatures
- Most states do not allow virtual notaries
- Many systems not set up for clinician signatures for POLST forms

Challenges & Opportunities

- Outdated Models
- Health Literacy
- Language Diversity
- Cultural Diversity & Disparities
- Digital Literacy
- Legal & Technical Challenges
- COVID-19 Challenges

ebecca.sudore@ucsf.edu

@prepareforcare

https://prepareforyourcare.org

Shari Ling, MD

Centers for Medicare and Medicaid Services

Deputy Chief Medical Officer

Expanding eConsent: Advance Care Planning In The 21st Century

Shari Ling, MD

Deputy Chief Medical Officer

Centers for Medicare & Medicaid Services

February 24, 2021

Disclaimer & Financial Disclosure

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

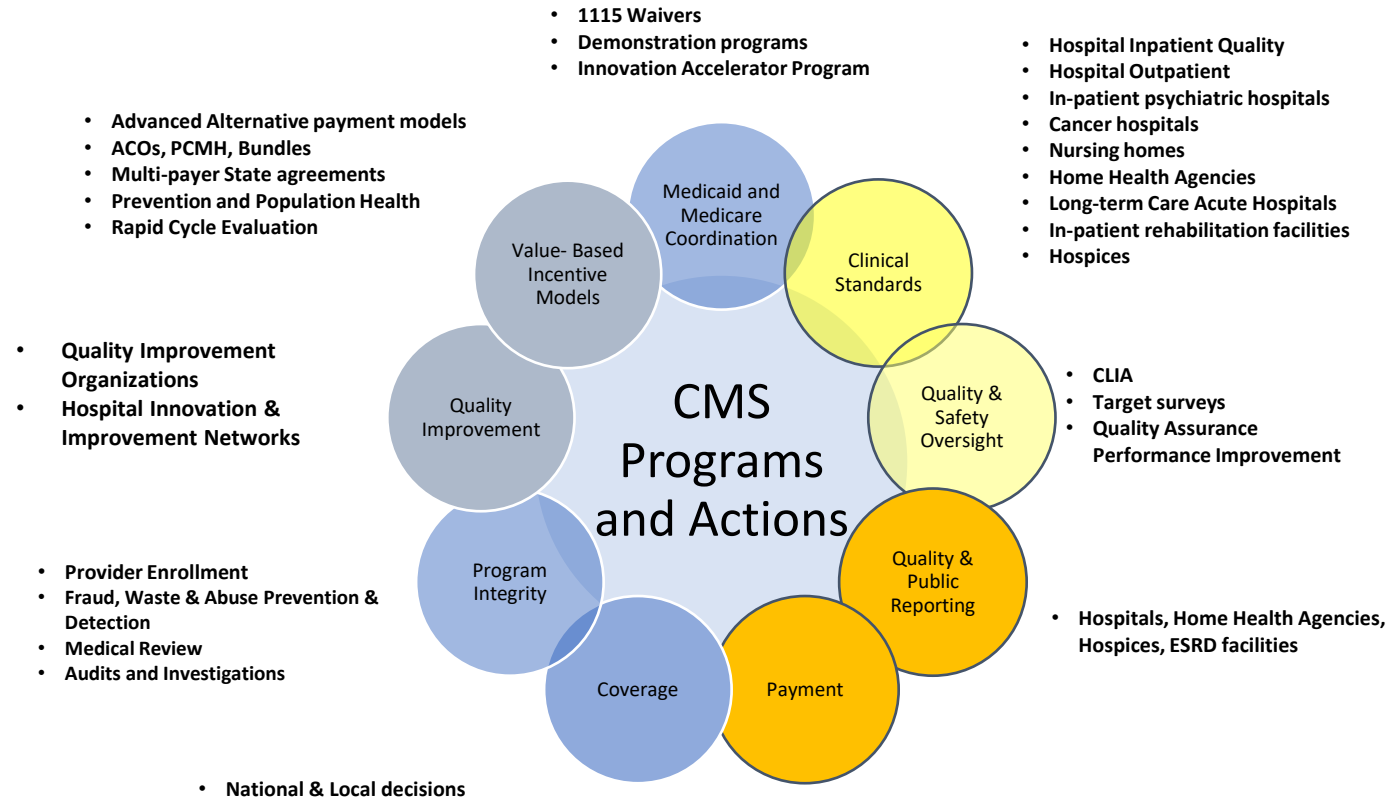
The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

No financial conflicts to disclose

Size and Scope of CMS Responsibilities

- CMS is the largest purchaser of health care in the world
- CMS covers 140 million people through Medicare, Medicaid, the Children's Health Insurance Program - roughly 1 in every 3 Americans
- Medicare spending was $750B in 2018 and is expected to experience the fastest spending growth across public and private spending (7.6 percent per year over 2019-28), largely as a result of having high projected enrollment driven by demographics
- The Medicare program alone pays out over $1.5 billion in benefit payments per day
- Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually

CMS Authorities & Programs



Advance Care planning

- Medicare Part B (Medical Insurance) covers voluntary advance care planning as part of your yearly “Wellness” visit. Medicare may also cover this service as part of your medical treatment.

- “Qualified” providers defined under Medicare Part B can report ACP codes for payment – Physicians (MD/DO), Nurse Practitioners and Physician Assistants, Clinical Nurse Specialists

- Other team members via applicable ‘incident to’ requirements ➔ All other providers (social work, psychology, chaplains) may not report codes independently

ACP Billing & Payment

Hospitals, physicians or non-physician practitioners (NPP) may bill ACP services if the practice scope and Medicare benefit category include the services

CPT Codes	Billing Code Descriptors
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

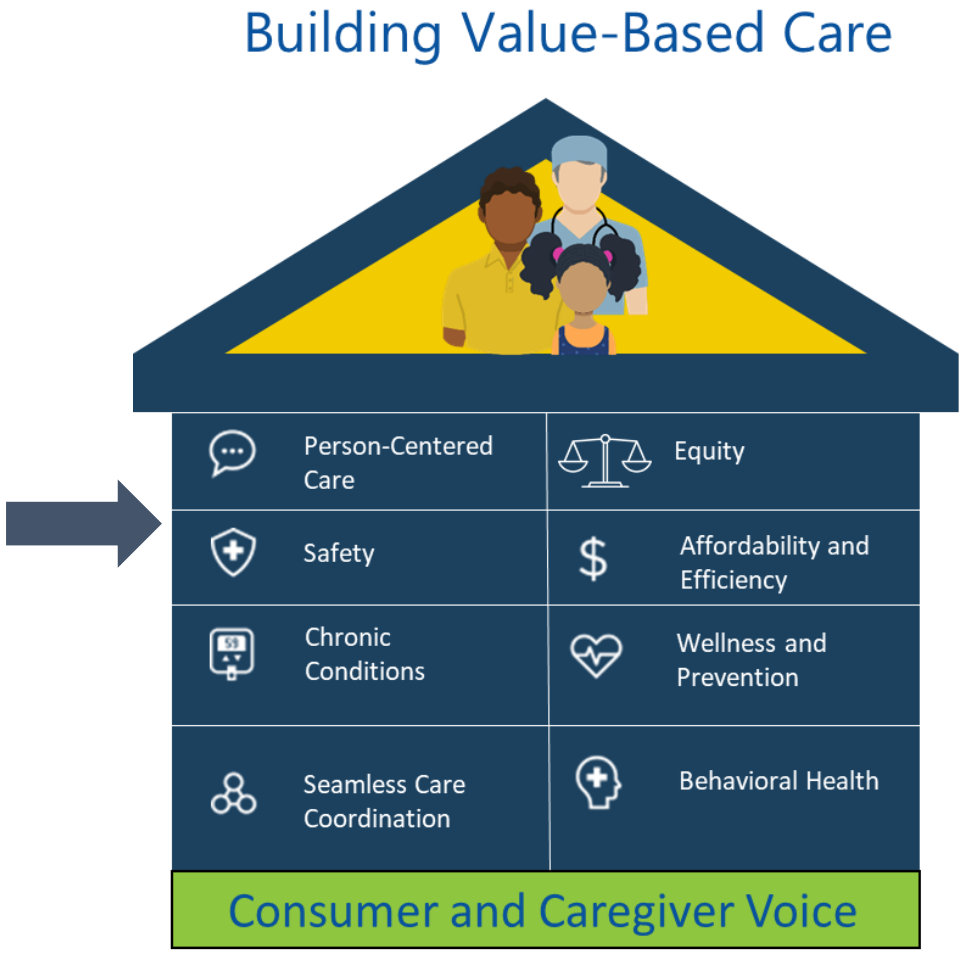
NOTE: There are no limits on the number of times you can report ACP for a given patient in a given time period.

Quality Measure

- Quality ID #47 (NQF 0326): Advance Care Plan –
  - National Quality Strategy Domain: Communication and Care Coordination
  - Meaningful Measure Area: Care is Personalized and Aligned with Patient's Goals
- The ACP measure is in the Administrative Quality Measures Set and applies to all inpatient and outpatient Clinical Episodes included in the BPCI Advanced Model
- Inclusion of the ACP measure is especially important in the BPCI Advanced Model because many beneficiaries that trigger an episode are hospitalized for life threatening conditions and/or undergoing major medical procedures.

UPDATED: Meaningful Measures 2.0

Goals of MM 2.0
Utilize only quality measures of highest value and impact focused on key quality domains
Align measures across value-based programs and across partners, including CMS, federal, and private entities
Prioritize outcome and patient reported measures
Transform measures to fully digital by 2025, and incorporate all-payer data
Develop and implement measures that reflect social and economic determinants



Thank you

Shari Ling

Shari.ling@cms.hhs.gov

Resources

- 42 Code of Federal Regulations, Part 489, Subpart I (Advance Directives policy)
- 2016 Hospital Outpatient Prospective Payment Systems Final Rule (OPPS policy for ACP services) Pages 70469–70470
- 2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy for ACP services) Pages 70955–70959
- Advance Care Planning (information for Medicare patients)
- Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services, Section 280.5.1
- Medicare Claims Processing Manual Chapter 18, Preventive and Screening Services, Section 140.8
- MWV
- National Hospice and Palliative Care Organization (download your state's advance directives)

Lenel James

Blue Cross Blue Shield Association

Business Lead – Health Information Exchange and Innovation

Expanding eConsent, Defining the Problem and Opportunity – A Payer Perspective

February 24, 2021

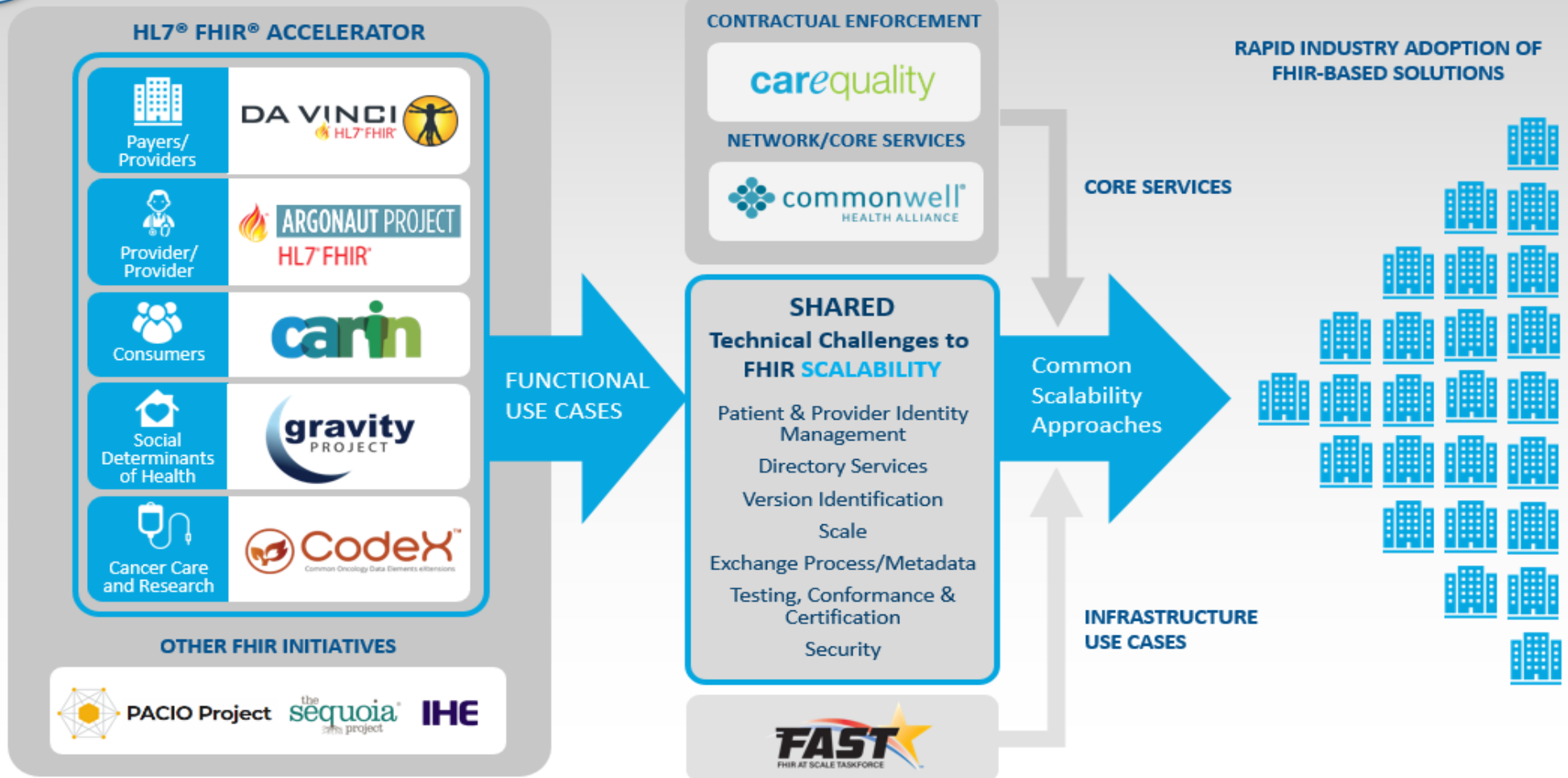
Lenel James, Business Lead, Health Information Exchange & Innovation

BlueCross BlueShield Association

Agenda

- Industry Activities
- Regulatory Perspective
- Related Standards

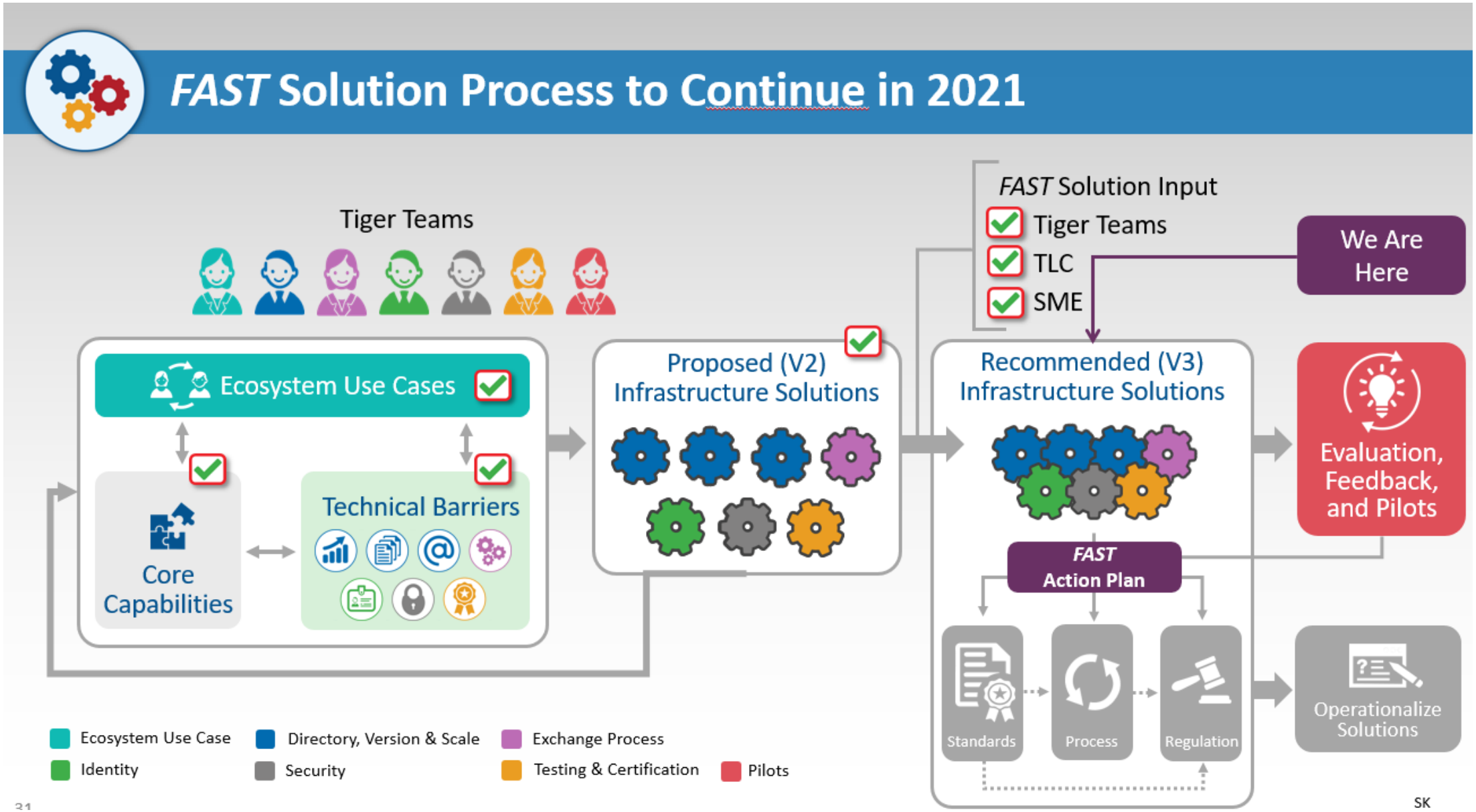
Collaborative Efforts Towards FHIR Adoption



SK

https://oncprojectracking.healthit.gov/wiki/pages/viewpage.action?pageId=43614268

FAST Solution Process to Continue in 2021



SK

https://oncprojectracking.healthit.gov/wiki/pages/viewpage.action?pageId=43614268

Use Case Maturity

Standard Phase	Future	Build	Ballot	Published/ing
Connectathon	<1		2-4	5+
Live	<1		1-3	>4
Progress				

Quality Improvement

- Data Exchange for Quality Measures
- Gaps in Care & Information

Coverage/Burden Reduction

- Coverage Requirements Discovery
- Documentation Templates and Rules
- Prior-Authorization Support

Member Access

- Clinical Data Exchange
- Payer Data Exchange
- Directory
- Formulary
- Coverage Decision Exchange
- Price Cost Transparency

Process Improvement

- Risk Based Contract Member Identification
- Risk Based Coding

Clinical Data Exchange

- Payer Data Exchange
- Clinical Data Exchange
- Notifications
- Patient Data Exchange
- Performing Laboratory Reporting

Proposed CMS Rules

Aligned with final ONC or CMS rule

https://confluence.hl7.org/display/DVP/Da+Vinci+Welcome

Da Vinci 2021 Multi-Stakeholder Membership

PROVIDERS

AMA Medical Group
Cedars-Sinai
HCA Healthcare
Sutter Health
MultiCare Connected Care
OrthoVirginia
OHSU
Providence St. Joseph Health
*RUSH
Texas Health Resources
UC Davis Health
UNC Health Care
Weill Cornell Medicine

EHRs

athenahealth
*Cerner
*Epic
healow | Insights
*veradigm

DEPLOYMENT

Availity
MiHIN
CHANGE HEALTHCARE
Cognizant

PAYERS

*Anthem
*BlueCross BlueShield of Alabama
*BlueCross BlueShield Association
*Blue Cross of Idaho
Blue Cross Blue Shield Blue Care Network of Michigan
of Tennessee
*CAMBIA
*Cigna
CENTENE Corporation
*CMS
CVS Health
GUIDEWELL
*HCSC
*Humana
*Independence
*UnitedHealthcare

VENDORS

casenet
*cognosante
*edifecs
infor
InterSystems Health | Business | Government
juxly
mcg
*OPTUM
*surescripts
*ZeOmega

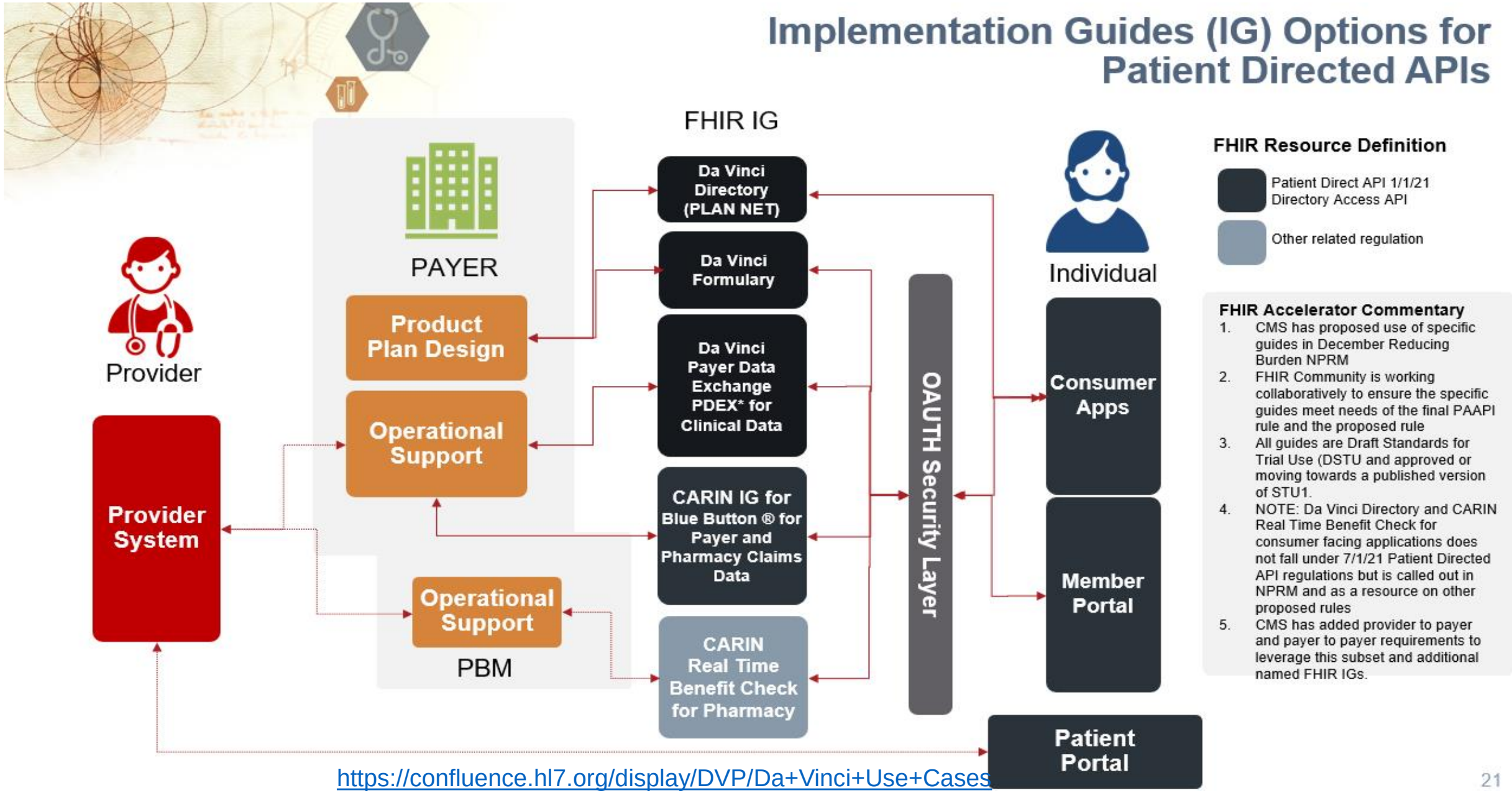
INDUSTRY PARTNERS

HIMSS
*HL7 International
NCQA Measuring quality. Improving health care.

*Indicates a founding member of the Da Vinci Project. Organization shown in primary Da Vinci role, Many members participate across categories.

For current membership: http://www.hl7.org/about/davinci/members.cfm

Implementation Guides (IG) Options for Patient Directed APIs



https://confluence.hl7.org/display/DVP/Da+Vinci+Use+Cases

Da Vinci Support of Regulation: Patient Access

Applies To

- CMS-regulated payers, specifically MA organizations
- Medicaid Fee-for-Service (FFS) programs
- Medicaid managed care plans
- CHIP FFS programs
- CHIP managed care entities and
- QHP issuers on the FFEs, excluding issuers offering only Stand-alone dental plans (SADPs) and QHP issuers offering coverage in the Federally-facilitated Small Business Health Options Program (FF-SHOP)

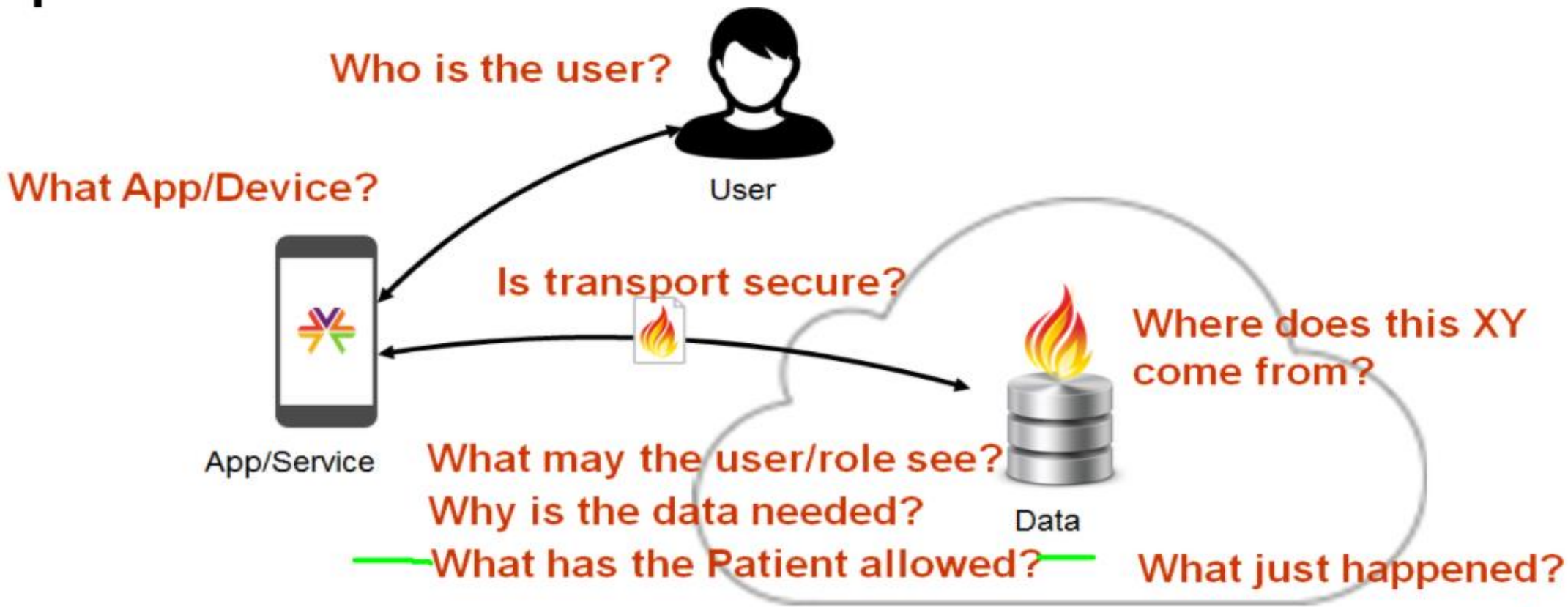
Implement and Maintain

- A secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice.

- Beginning January 1, 2021 (enforcement discretion for 6 months)
- QHP issuers on the FFEs, plan years beginning on or after January 1, 2021

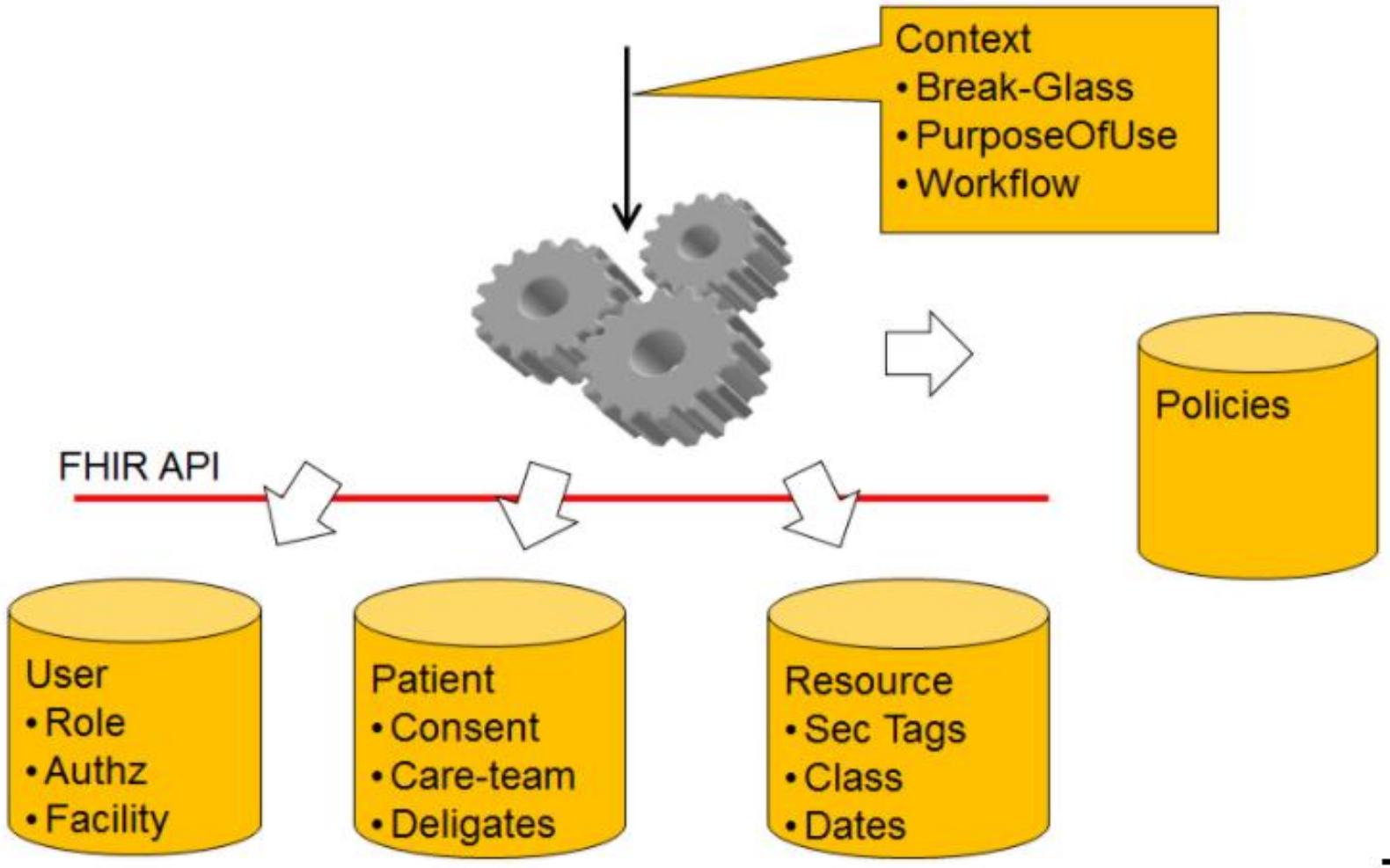
https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet

Security and Privacy needs



https://healthcaresecprivacy.blogspot.com/2020/08/fhir-security-and-privacy-tutorial.html

Access Control Engine



Consent control vectors

- Timeframe of validity of the consent - can expire
- Organization consent applies to - data custodian
- Who is being authorized (or denied)
- Regulation consent applies to
- Local Policy rules this consent build upon
- PurposeOfUse - only this kind of use is allowed
- Timeframe of data publication - only data in this period
- Security Tags - sensitivity classification of the data
- Type of clinical content - using clinical vocabulary use
- Who authored the data - only data authored by

Wrap Up

- Industry Challenge & Pace of Change
- Regulatory Implication
- Maturity and Complexity Of Implications

David Wang, MD
Scripps Health
Systems Director of Palliative Care