PARTNERSHIP HEALTHPLAN of CALIFORNIA

Appendix IVB: Advance Care Planning – Medical Record Components

The following is a list of components we look for when determining whether an ACP discussion documented in a medical record qualifies for the ACP incentive:

Basic Information

- Patient's name, date of birth, and CIN
- Whether written materials on **advance directive and POLST** was given to patient to review, and whether an Advance Directive and/or POLST is completed or updated
- Clinician's name and organization
- Date of discussion

Patient general preferences around end of life

- At this time, patient wishes all treatments to be done that have any amount of potential life lengthening effect, regardless of pain or discomfort
- At this time, patient would like to balance the potential benefits with the side effects of treatment options on a case by case basis.
- At this time, patient would like only treatments that will alleviate pain, anxiety and discomfort, even if this shortens life somewhat

If patient is unable to make decisions, and unable to discuss details of care with health care decision maker, use this course of action:

- All treatments given if my attending physician determines possible benefit.
- Comfort care (includes no tube feeds)
- Comfort care plus a short term trial of tube feed
- All treatments given except
  __Chest compressions
  __Cardiac shock
  __Intubation (breathing tube)
  __Tube feeds
  __Intravenous treatments: __If heart stops __antibiotics __other:_____
  __ Blood transfusion (List reason:_____)
  __ Other specific limitations of care expressed:_____

Details of discussion: _____

_____

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Appendix IVA: Advance Care Planning – Physician/Clinician Attestation

Discussions by doctors, nurses, physician assistants, and other clinicians about Advance Care Planning with PHC **Medi-Cal** or **Medi-Medi** members ages 65 and older or who have significant health problems limiting their life expectancy may qualify for a financial bonus under PHC's Quality Improvement Program (QIP). You may submit one attestation per member per fiscal year, up to a maximum of 100 attestations. To be eligible for the incentive, please do the following:

1. Discuss end-of-life choices with your patient
2. Document the ACP discussion in the patient's medical record
3. Complete this attestation form

ACP discussions must take place **between July 1, 2015, and June 30, 2016**. All attestations submitted are reviewed by PHC. Upon approval, the attestation will qualify for the incentive. Attestation forms should be submitted no later than **July 31, 2016** via email at QIP@partnershiphp.org or fax at 707-863-4316.

Patient Name	***Date of Birth***	***CIN #***
Reason for ACP discussion *(check one):* ☐ 65 or older ☐ Under 65, with potential life-limiting illness or concomitant disease process specified below (Please see Specifications for examples): _____		

I, _____(Clinician Name), practicing at _____(Organization), hereby attest that the patient listed above had their choices around advance illness care discussed on _____/_____/_____ (Date of Service). If someone other than me facilitated the conversation about ACP in our office, that person is trained and competent at conducting these discussions and the conversation was reviewed and confirmed by me with the patient. This ACP discussion is documented in the Patient's medical record, which I agree to being audited by PHC, and includes the following activities:

A. *Advance Directive (AD)* *One of the three boxes below must be checked for this form to be considered complete (Click here for AD sample)

☐ Patient completed AD or committed to filling one out after ACP discussion
☐ Patient had previously completed his/her AD and reaffirmed they do not wish to make any changes
☐ Patient declined to complete AD. Information given: pamphlet/handout about Advance Directives

B. *POLST* *One of the three boxes below must be checked for this form to be considered complete (Click here for the English California POLST Form)

☐ POLST inappropriate for patient
☐ POLST appropriate and signed
☐ POLST appropriate but declined

Clinician Signature: _____ Date: _____