My Life Matters! Honoring the Voice of the Intellectually and Developmentally Disabled and Other Marginalized Patients (TH332)

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Objectives

- Examine the role of implicit bias and its influence on medical treatment and quality of life perspectives of marginalized patient populations, including the Intellectually and Developmentally Disabled (IDD).
- Construct a robust social history for IDD patients using four key elements.
- Describe three communication strategies used to help engage IDD patients in health discussions.

Our country is currently engaged in vital conversations about stereotyping and implicit bias. In attempts to root out our collective prejudices, we now appreciate the necessity to talk about the underlying thoughts, beliefs, and values that inform our everyday actions and behaviors. Though many of us are drawn to the work of hospice and palliative care to practice compassion and advocate for patients' values, we may not realize how implicit bias influences our practice. The Intellectually and Developmentally Disabled (IDD) population has a history of social injustice and wrongful medical treatment that accentuates the harm of implicit biases. The IDD population is a particularly vulnerable group that deserves our attention and requires astute considerations by palliative care or hospice providers in order to effectively meet their needs. Highlighting this marginalized population allows us to identify the subtler iterations of bias with other patient populations as well. During this presentation, we will use a case discussion to facilitate the identification of implicit bias and strategies for overcoming it. This case highlights the common landscape of social adversity for this population and how it effects their access to healthcare and providers' perceptions on their quality of life. We will explore the components of a rich social history for IDD patients and how it can inform values and goals of care that are free of judgment. We will offer communication strategies and tools to help include these patients in conversations about their healthcare, alongside their legal guardians or healthcare decision makers. We will discuss challenges in decision-making when patient participation is not possible and offer ways to support healthcare decision makers. Through this presentation, participants will gain better insight into working with IDD patients and be able to identify and mitigate biases when working with other marginalized patient populations.

Walking the Tightrope: Palliative Care and Organ Donation (TH333)

Paul DeSandre, DO, Grady Hospital and Emory University School of Medicine, Atlanta, GA. Joanne Kuntz, MD FACEP FAAHPM, Emory University School of Medicine, Atlanta, GA. Leslie Hunter-Johnson, APRN, Sunrise Hospital and Medical Center, Las Vegas, NV. Jason Lesandrini, MA PhD(c), Wellstar Health System, Atlanta, GA. Myrick Shinall, MD PhD MDIV, Vanderbilt University Medical Center, Nashville, TN.

Objectives

- Identify the value for Palliative Care teams to include organ donation consideration with end-of-life decision-making.
- Discuss novel approaches to the integration of Palliative Care teams in the organ donation processes in both academic and community hospital settings.
- Examine the ethical challenges faced by Palliative Care teams in providing adequate information regarding the potential for organ donation with the duty to advocate for the values of our patients and families.

Palliative Care teams often assist patients and families in the full range of end-of-life decision-making. Organ donation is generally omitted from these conversations unless explicitly brought up by the family. It is often through organ donation decision-making that one can turn an otherwise tragic situation into one of meaning and legacy. Palliative Care teams offer a unique opportunity to assure holistic end-of-life care decision-making, including organ donation, regardless of the clinical circumstance. Using a panel of five clinicians (three physicians, one advance practice nurse, and one clinical bioethicist) from a variety of backgrounds and clinical practice environments, we will explore the tenuous balance of considering organ donation in end-of-life care discussions and process integration. Case examples and novel models of Palliative Care and organ donation integration will be presented as we examine the related ethical challenges facing Palliative Care teams. Participants will be given the opportunity to have questions addressed directly by the panelists.

Yes, and…Lessons Borrowed from Improvisational Theater to Teach Primary Palliative Medicine Skills (TH334)

Gitanjli Arora, MD, Children's Hospital Los Angeles, Los Angeles, CA. Isaac Chua, MD, Dana-Farber Cancer Institute, Boston, MA. Rachel Rusch, MSW MA, Children's Hospital Los Angeles, Los Angeles, CA.

Objectives

- Describe concepts and themes from Improvisational theater to strengthen clinicians'

communication skills with patients, families, and colleagues.
- Apply techniques from Improvisational theater to teach primary palliative communication skills with a specific emphasis on self-awareness and listening in order to engage in shared medical decision making.

Improvisation is a well-defined technique in the theater arts and can have direct application to patient care. While the word improvisation (improve) implies spontaneity and impulsivity, theatrical improvisation consists of an underlying skill set that allows actors to quickly build trust and communication with each another while simultaneously building the narrative of the scene. Through an exploration of themes and interactive skill building, this workshop will apply the framework of improv theater to teaching primary palliative communication skills, with a specific emphasis on self-awareness and listening to engage in shared medical decision making. The session will include a discussion of improv concepts and ground rules, considerations and case examples of the application of improv concepts to palliative medicine, and small group improv exercises of relationships and situations commonly encountered in palliative medicine. For novice palliative practitioners, this session will provide an opportunity to apply improv theater methods to improve one's own communication skills and will illustrate how medical educators can use improv theater pedagogy. For intermediate and advanced palliative practitioners, this session will provide skills and tools for applying improv theater methods to teach primary palliative communication skills.

The XYZs of Billing and Clinical Revenue: Going Way Beyond the ABC's (TH335)

Christopher Jones, MD MBA HMDC FAAHPM, Perelman SOM at the University of Pennsylvania, Philadelphia, PA. Phillip Rodgers, MD FAAHPM, University of Michigan, Ann Arbor, MI.

Objectives
- Describe five commonly used groups of billing codes applicable to palliative care teams' clinical work.
- List the 3 components of a relative value unit (RVU) and compare the relative differences between commonly used codes.
- Consider the clinical components of a billable encounter to choose the correct billing code or codes to compliantly maximize revenue.

Once niche services that flew well under the fiscal radar, many Palliative Care (PC) programs now have 7-figure budgets and a dozen or more clinicians. As programs cost more, sponsoring institutions' expectations for clinical revenue grow, leaving PC team members working longer hours to see more patients and close yawning budgetary gaps. Most PC providers have become accustomed to basic billing and coding principles, but significant revenue opportunities exist among rapidly expanding breadth of professional fee codes, even for seasoned clinicians and program leaders.
How do programs tap these opportunities? In this concurrent session, two PC physicians responsible for the financial health of their teams and a nationally-recognized billing-and-coding expert will elevate clinicians with a fundamental knowledge of billing and clinical revenue to the next level. We will open with a brief review of the billing codes now available to PC providers − Evaluation and Management (E/M), Advance Care Planning, Face-to-Face and Non-Face-to-Face Prolonged Service Codes, and Chronic and Complex Chronic Care Management Codes. Relative Value Units (RVUs) for these codes will be unpacked, explained and compared as well. The session will then transition to lively case-based learning with extensive audience interaction. Inpatient, outpatient, and home care clinical scenarios will be described and dissected and, when different codes or combinations of billing codes could be compliantly chosen, RVU differences will be highlighted to show which billing codes might be selected to optimize revenue. Attention will also be paid to using complexity- and time-based codes (alone and in combination), documentation, and billing for team based care.
The time has ended when PC programs' costs were nothing more than an organization's financial rounding error. It is incumbent on program leaders and seasoned clinicians to understand clinical billing at a deep level, to maximize revenue that will sustain and grow their teams.

Routinizing Goals of Care Conversations—Improving Patient Outcomes and Satisfaction (TH336)

Matthew Gonzales, MD, Providence St. Joseph Health, Torrance, CA. Yvonne Corbeil, RN, Providence St. Joseph Health, Torrance, CA. Nusha Safabakhsh, MS MBA, Providence Health and Services, Torrance, CA. Jennifer Kozakowski, MN MPH, Providence St. Joseph Health, Torrance, CA. Ira Byock, MD FAAHPM, Providence Institute for Human Caring, Torrance, CA.

Objectives
- Discuss how quadruple aim goals can be achieved by embedding palliative care knowledge, attitudes, and skills within routine patient care.
- Identify educational and operational components of a goals of care conversation initiative.
- Outline key informatics and analytic principles that allow for automated storage and retrieval of goals of care conversations from an EHR to