Advance Care Planning

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February 17, 2017
Maryland ACP Chapter
Scientific Meeting

Objectives

- Have a framework to approach advance care planning discussions
- Learn the basic coverage under Medicare for these services
- Provide communication checklist so you can better understand your patients' goals and values

Disclosures

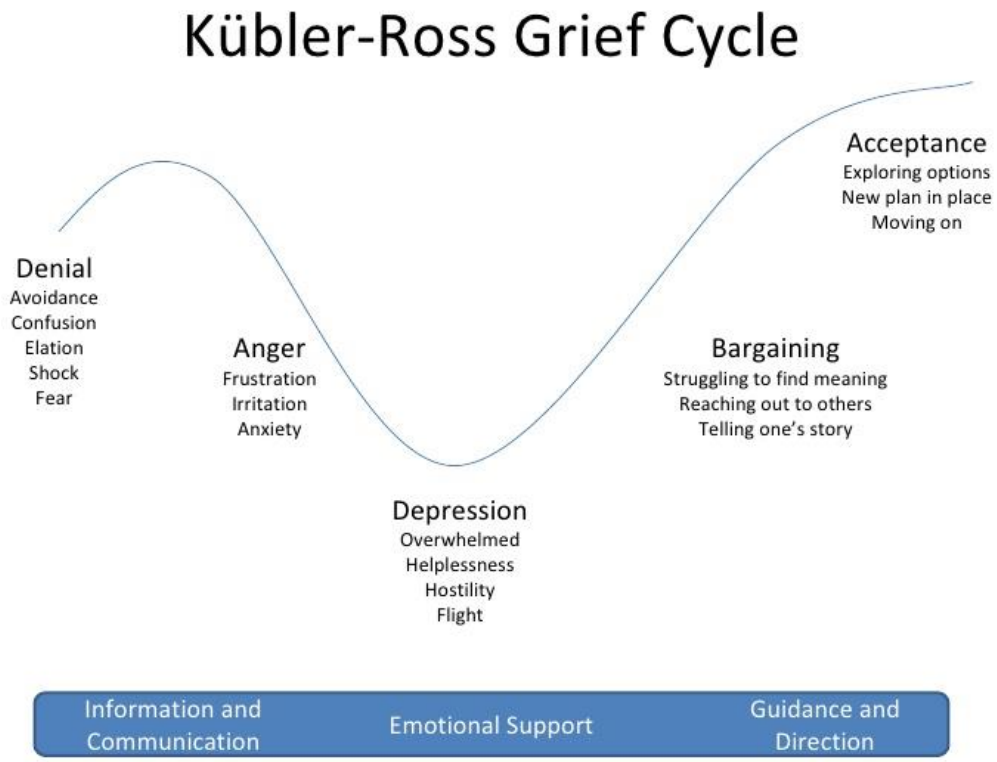
- Mary Newman- None
- Rab Razzak- None

Who is she?

Death Panels 2009

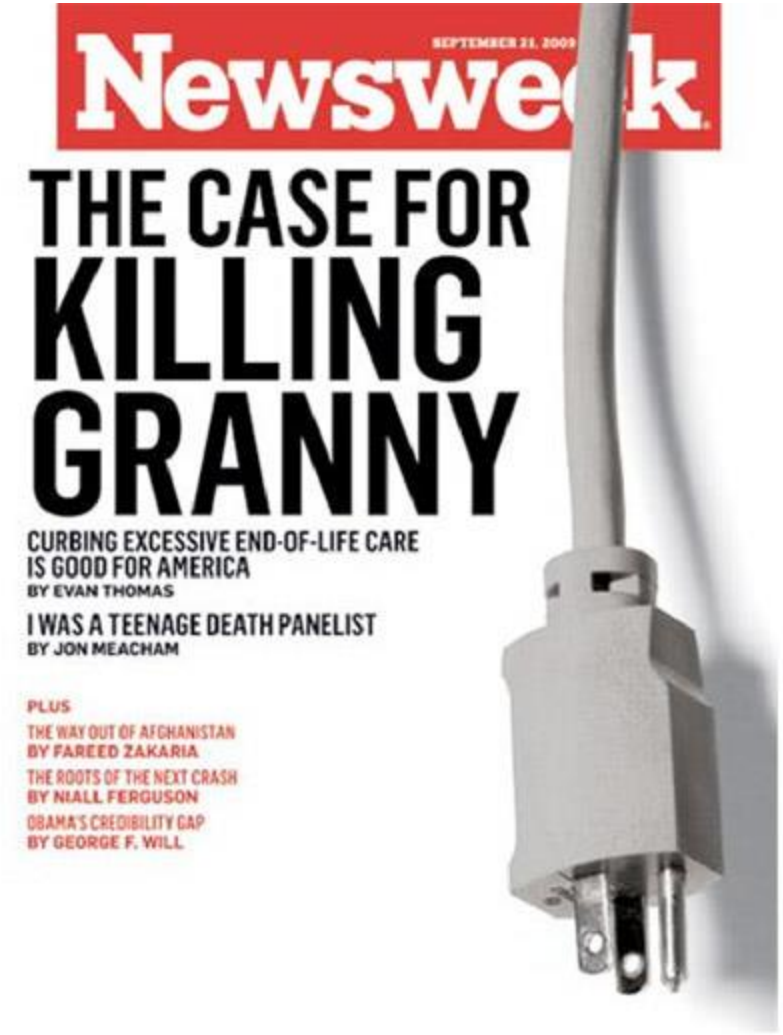
Historical Notes & Advocacy

- Elizabeth Kubler Ross On Death and Dying (1969)
- Hospice Movement
- Advance Directives
- Health Care Proxy



Historical Notes & Advocacy

- Death Panels 2009
- Advocacy from health care community and patient advocacy groups
- January 1, 2016 CMS begins payment for Advance Care Planning in Physician Fee Schedule



Anna Davis

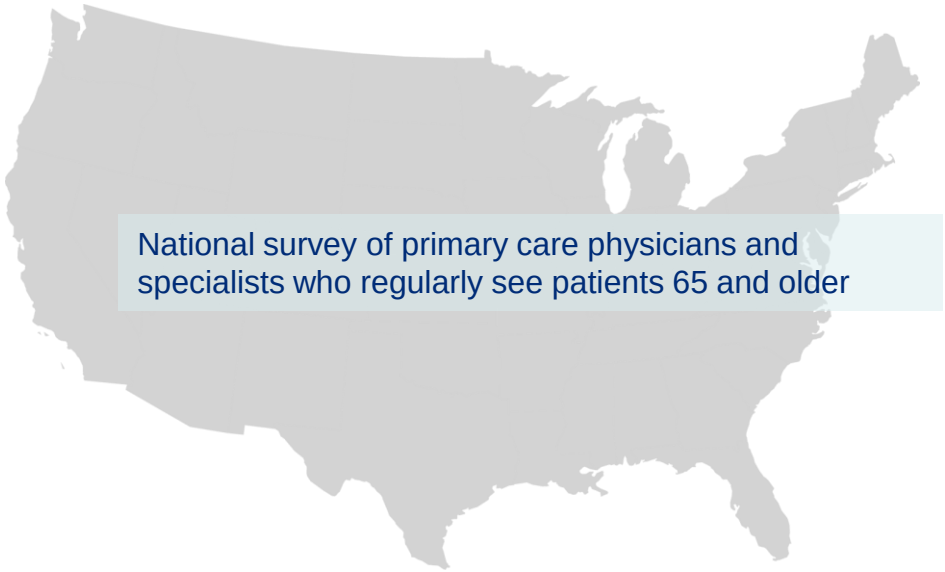
- 85 year old widowed nutritionist
- Very deaf, nearly blind, lives alone
- Recent recognition that she also has moderate dementia
- Aortic valve disease, hypertension, recent thoracic compression fracture

Anna Davis

- 2 adult children, one is a physician, the other a nurse
- You come in Monday morning and learn from CRISP she has been admitted after a fall, has a traumatic brain injury and intubated
- You wonder “Is this what she or anyone wanted?”

- Are we prepared to have these discussions in the hospital or office?

Conversation Stopper: What's Preventing Physicians from Talking With Their Patients About End-of-Life and Advance Care Planning



National survey of primary care physicians and specialists who regularly see patients 65 and older

The survey includes:

N = 736 total physicians
N = 470 primary care providers/internists
N = 266 specialists
- N = 85 oncologists
- N = 87 pulmonologists
- N = 94 cardiologists

N = 202 California physicians

Margin of sampling error:

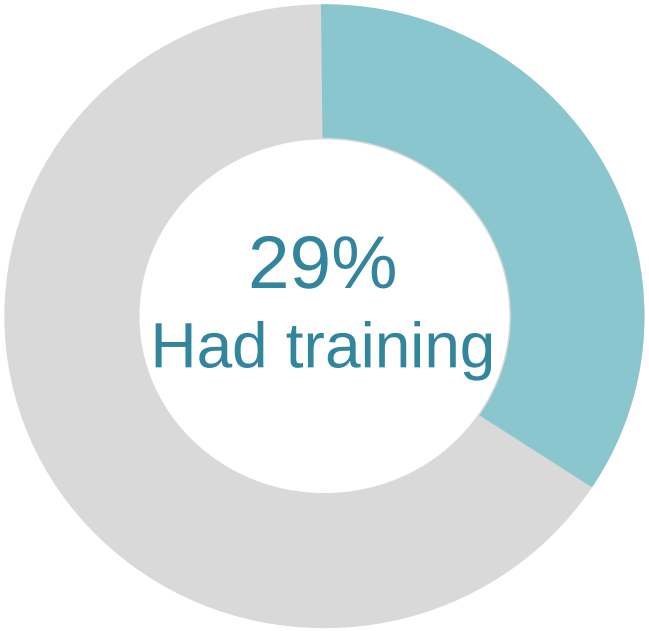
- For total = ± 3.6 percentage points.
- For internist/primary care provider = ± 4.5
- For specialist = ± 6.0
- For California physicians = ± 6.9

Conducted by telephone from February 18 to March 7, 2016.

Courtesy: The John A. Hartford Foundation, Cambia Health, and California Health Care Foundation

Less than a third has had training on the issue.

Have you had any training specifically on talking with patients and families about end-of-life care, or not?

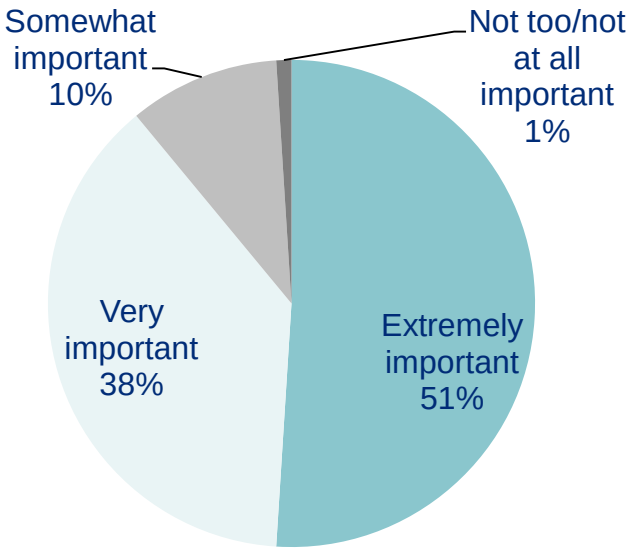


Respondents most likely to have had training include younger physicians and those with a racially and ethnically diverse patient population. Two-thirds of physicians seeing patients nearly everyday who are near end of life do not have specific training on these conversations.

	Yes	No
Total	29%	68%
Patients <25% diverse	23%	74%
Patients 25%+ diverse	33%	64%
Sees patients 65+ almost everyday+	32%	65%
Sees patients 65+ several times/wk or less	26%	71%
Under age 50	38%	59%
Over age 50	24%	73%

Courtesy: The John A. Hartford Foundation, Cambia Health, and California Health Care Foundation

Virtually all say conversations about advance care planning are important – half say extremely important.

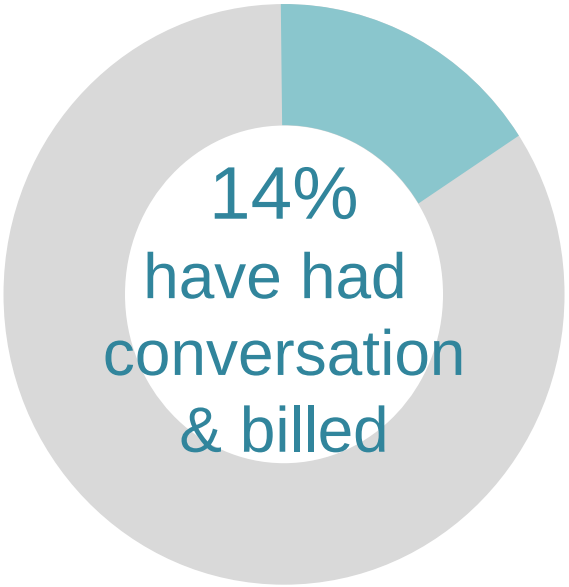


Respondents are more likely to say it is extremely important for health care providers to have these conversation with their patients if they have had training (59% vs. 47% of those with no training) or if they have a formal system in place (61% vs. 47% of those without a formal system).

Courtesy: The John A. Hartford Foundation, Cambia Health, and California Health Care Foundation

However, most say they have not had a conversation about advance care planning and billed Medicare for it this year.

Have you had this conversation and billed Medicare for it this year?
(Respondents who bill Medicare fee-for-service n = 626)

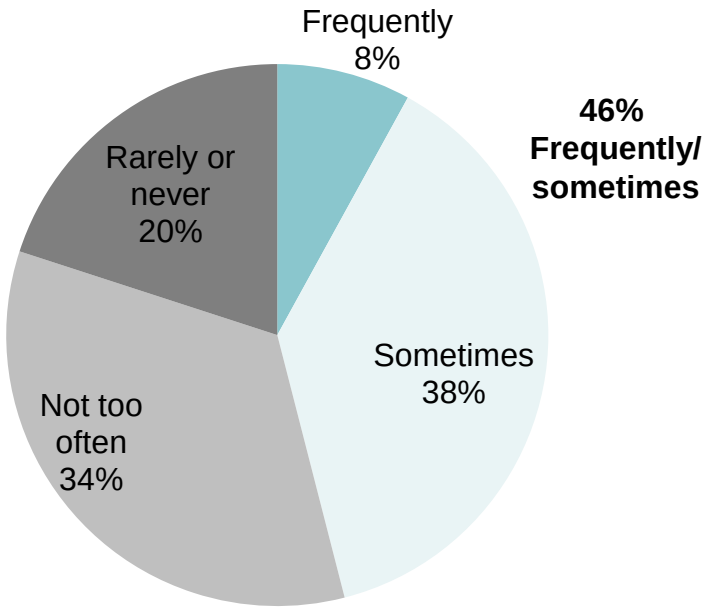


	Yes	No
Total	14%	85%
Sees patients 65+ almost everyday+	15%	84%
Sees patients 65+ several times/wk or less	6%	92%
Had end-of-life (EOL) training	19%	80%
No EOL training	12%	87%
System in place for assessing EOL wishes	25%	75%
No system in place	9%	90%

Courtesy: The John A. Hartford Foundation, Cambia Health, and California Health Care Foundation

Almost half say they frequently or sometimes feel unsure of what to say during conversations about end-of-life care.

During conversations about end-of-life care, how often do you feel unsure of what to say? Would you say:



Physicians who have had end-of-life training are more likely to say they rarely or not to often feel unsure about what to say (60% compared to 52% of those without training).

Physicians more likely to experience uncertainty around what to say in these conversations include racially/ethnically diverse physicians, women, and younger respondents.

Courtesy: The John A. Hartford Foundation, Cambia Health, and California Health Care Foundation

Advance Directives

- make health care wishes known if unable to communicate
- allows one to
  - appoint a power of attorney for health care (a health care agent).
  - state instructions for future health care decisions.

What kind of instructions?

- place of death
- MD preference
- accepting or refusing life-sustaining treatment
- quality of life considerations
- organ/tissue donation instructions

What makes a document legal?

- signature and date
- the signatures of 2 witnesses (or notary)
- at a skilled nursing facility, the signature of the patient advocate or ombudsman

Advance Care Planning

I'd like to talk with you about possible health care decisions in the future. This is something I do with *all my* patients so I can be sure that I know and can follow your wishes. Have you ever completed an Advance Directive?

Planning the Visit

- Who needs to be present
  - Patient
  - Decision maker
- What documents do we need
  - Advance Directive latest version
  - Durable Power of Attorney
  - MOLST or POLST form
- What educational materials may be helpful

Documentation

- Who was present
- Medical issues
- Decision makers and advisors
- Goals of patient
- Prognosis
- Decisions made and decisions to consider
- Education
- Follow up plans

Sample Note

- There are no required elements at this time
- The note should be clear and reflect the information needed for ongoing decision making
- The note should allow covering physicians team members to make decisions consistent with the plan

Coding

- **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 professional; *first 30 minutes*, face-to-face with the patient, family member(s) and/or surrogate.

Coding

- **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 professional; *each additional 30 minutes.* (List separately in addition to code for primary procedure.)

Coding

- May be billed with Annual Wellness Visit with no copay. Use modifier 33
- May be billed with E&M visit on the same day. Use modifier 25 for ACP
- No exclusion for Chronic Care Management or Transitional Care Management
- Local Carrier Policies apply

Advance Care Planning

What do you understand about your health situation?

Advance Care Planning

If you were unable to make your own medical decisions, who would like to make them for you? Have you spoken to this person?

Advance Care Planning

Have you discussed your wishes with your family?

Takeaways

When patients sound uncertain about advance care planning

- slow down
- invest a moment in setting up your explanation
- attend to your patient's uncertainty

Takeaways

When you talk about surrogate decision makers, setting up an A or B choice makes it easier

Takeaways

You can frame advance care planning as “hope for the best and plan for something we’re hoping doesn’t happen”.

Takeaways

Try asking about a ‘what if’ situation to locate advance care planning in the future and distinguish it from now.

Takeaways

The real goals of advance care planning are to

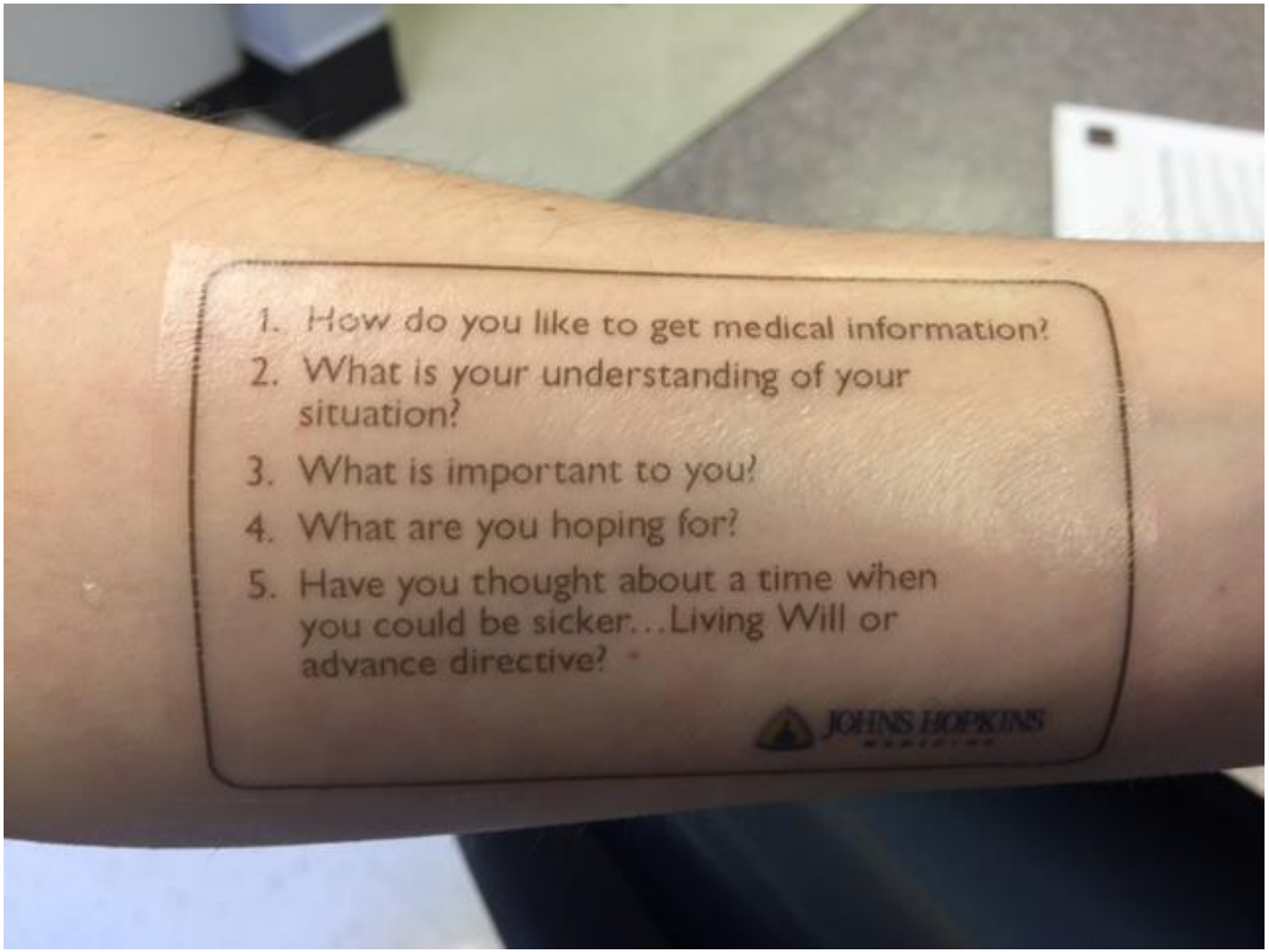
(1) begin understanding the patient's values, and

(2) begin thinking with the patient about the future in a non-threatening way.

MOLST

1	**CPR (RESUSCITATION) STATUS:** EMS providers must follow the *Maryland Medical Protocols for EMS Providers.* _____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function. [If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.] **No CPR, Option A, Comprehensive Efforts to Prevent Arrest:** Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. _____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation. _____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate. _____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.
2	**ARTIFICIAL VENTILATION** 2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated. 2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial. Time limit_____ 2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated. Time limit_____ 2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

JHM PC Tattoo



Communication

UNDERSTANDING

JAMA Int Med 2014; Supplement E1-10

Communication

JOHNS HOPKINS MEDICINE

INFORMATION

&

PROGNOSIS

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JOY

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GOALS

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TRADE-OFFS

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FAMILY

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Websites for ACP

- www.caringinfo.org
- www.mydirectives.com
- www.mygiftofgrace.com
- www.joincake.com
- www.coalitionccc.org
- www.vitaltalk.org

AD videos

https://vimeo.com/36052824

-NHDD

https://www.youtube.com/watch?v=OaQ8Z9XFK8E

- NIH Senior Health

https://www.youtube.com/watch?v=_J-hWOUR0EU

- Mayo Clinic

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