Let’s Talk: Palliative Care and Advance Care Planning

Greg A. Sachs, MD, FACP
Susan Hickman, PhD
Shilpee Sinha MBBS, FACP
Explain the core principals and scope of palliative care
Differentiate hospice and palliative care
Describe Indiana’s advance care planning tools
Discuss strategies for engaging in advance care planning conversations and how to use new Medicare billing codes for reimbursement
Origin of the term “Palliative”

- Dr. Balfour Mount coined the term palliative care
- Latin root is the word *pallium* which is in reference to an outer garment that covered or cloaked a person
- Suggestion that palliative care can effectively cloak the symptoms of a serious illness
“Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.”
World Health Organization – Palliative Care Core Principles

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process and intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care using a team approach
- Offers a support system to help patients live as actively as possible until death and the family to cope during the patient's illness and in their own bereavement
- Is applicable at any phase of a chronic serious illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, mechanical circulatory devices, renal replacement therapy
Delivery Model for Palliative Care

Life Prolonging Care  →  Palliative Care  ←  Hospice Care

Death  Bereavement
Misconception Of Palliative Care
Who can Benefit from a Palliative Care Consult

- Potentially life threatening condition AND
- Primary criteria
  - Surprise question
  - Frequent admission
  - Symptoms that are difficult to control, physical or psychosocial
  - Complex care requirements
  - Decline in function, weight, ability to eat, failure to thrive
- Secondary Criteria
  - Awaiting/ deemed eligible for solid organ transplant
  - Patient/family /surrogate request for emotional, spiritual or relational disease or hospice or palliative care services
  - Potential candidate for interventions such as feeding tube/tracheostomy/LVAD/AICD/LTAC/Bone marrow transplant / RRT

Identifying patients in need of a Palliative Care Assessment in the hospital setting: A consensus report from the center to advance palliative care; David E. Weissman, MD and Diane E. Meier, MD
The Palliative Care team is a Multidisciplinary team

- Physician
- Advanced care provider (NP / CNS)
- RN
- Medical SW
- Chaplain

The specialty advantage that the team brings is twofold

- Enhanced Communication
- Symptom Management
Effective Communication Tools

**Ask-Tell-Ask**

**V.A.L.U.E.**

A 5-step mnemonic to improve ICU clinician communication with families

- **V** = Value comments made by the family
- **A** = Acknowledge family emotions
- **L** = Listen
- **U** = Understand the patient as a person
- **E** = Elicit family questions
Communication Skills: SPIKES

Six Step Strategy for Delivering Bad News:
1. S – Set up the interview
2. P – Assess the individual’s perception
3. I – Obtain the individual’s invitation
4. K – Give knowledge and information to the individual
5. E – Address the individual’s emotions with empathic responses
6. S – Strategy and summary

Breaking bad news: the S-P-I-K-E-S strategy; Robert A. Buckman, MD, PhD, Journal of Community Oncology March/April 2005
Symptoms

- **Pain** – grimacing, guarding against painful maneuver
- **Tiredness** – increased amount of time spent resting
- **Drowsiness** – decreased level of alertness
- **Nausea** – retching or vomiting
- **Appetite** – quantity of food intake
- **Shortness of breath** – increased respiratory rate or effort that appears to be causing distress to the patient
- **Depression** – tearfulness, flat affect, withdrawal from social interactions, irritability, decreased concentration and/or memory, disturbed sleep pattern
- **Anxiety** – agitation, flushing, restlessness, sweating, increased heart rate (intermittent), shortness of breath
- **Wellbeing** – how the patient appears overall
Models for Delivery of Palliative Care

Primary Palliative Care

Specialist level Palliative Care
Resources For Palliative Care

- [www.capc.org](http://www.capc.org)
- AAHPM
- Fast Facts
- [www.indianapost.org](http://www.indianapost.org)
- ELNEC
- [www.nhpco.org](http://www.nhpco.org)
End of Life Nursing Education Consortium

The ELNEC project gives nurses the knowledge and skills required to provide this specialized care and to positively impact the lives of patients and families facing serious illness or the end of life.

**ELNEC-Core content is divided into eight modules:**

1. Nursing Care at the End of Life
2. Pain Management
3. Symptom Management
4. Ethical/Legal Issues
5. Cultural Considerations in End-of-Life Care
6. Communication
7. Loss, Grief, Bereavement
8. Preparation for and Care at the Time of Death
Difference Between Palliative Care and Hospice

**Palliative Care**
- Can be provided at any point in the disease trajectory regardless of prognosis
- Objective exemplary symptom control alongside even curative intent therapy
- Covered by regular insurance that a patient carries
- Uses an interdisciplinary model of care
- It is the broad umbrella and hospice is specialized towards the last 6 months of life
- In the current setting more established in the hospital with limited availability in the outpatient setting, gradually growing

**Hospice**
- Requires 2 physicians to certify that the patient has a life expectancy of 6 months or less IF the disease runs its natural course
- Requires the plan of care to shift to a comfort focus and curative intent treatments are discontinued
- Medicare defined program & benefit and has to be elected by patient or loved one IF meets eligibility criteria based on specified guidelines
- Largely delivered in the home
Both hospice and palliative care focus on aggressive comfort needs

Palliative care is **not** hospice but hospice is **palliative care**

Palliative care is appropriate at any time of illness

Hospice care is appropriate for patients with a life expectancy of 6 months or less and curative treatment care is stopped

Insurance coverage differs between hospice and palliative care

- Hospice is the only Medicare benefit that includes pharmaceuticals, medical equipment, 24/7 access to care, Nursing, chaplaincy, Social services, bereavement services as defined by the agency. Other insurance plans generally follow Medicare program regulations

The 2 golden rules of hospice

- Patient needs to MEET criteria
- Patient must CHOOSE hospice
Thank you! Questions?
Advance Care Planning…

- is a process
- is not a “one size fits all” discussion
- must be individualized to patient readiness and stage of health
- requires advance care planning facilitation skills to address stage of planning
- benefits from a team approach
Tools to Document Outcome of Advance Care Planning (ACP)

Basic Advance Directives

- Appoint a Surrogate/Proxy/Legal Representative
  - Health Care Representative
  - Health Care Power of Attorney

Statement of Preferences

- Indiana Living Will
- Indiana Life-Prolonging Procedures Declaration
The POST Paradigm

POST = Physician Orders for Scope of Treatment
- Converts treatment preferences into actionable medical orders
- Advanced chronic progressive disease and frailty; terminal illness
- Preferences to have or decline treatments
- Transfers across treatment settings with patient
- Recognizable, standardized form
**Indiana Physician Orders for Scope of Treatment (POST)**

**INFORMATIONAL RESUMPS Approximation (CPR):** Patients have no pulse AND is breathing OR has pulse and is NOT breathing.
- **Pass** Resuscitation (CPR): **Do Not Attempt Resuscitation (DNR)
- **Release** in D by physician on request.

**MEDICAL INTERVENTIONS:** If patient has pulse AND is breathing OR has pulse and is NOT breathing.

- **Comfort Measures** (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management, relieve pain, and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.
- **Limited Additional Interventions** (Allow Natural Death): Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.
- **Full Intervention** (Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

**ANTIBIOTICS:** Use antibotics consistent with treatment goals.

**Artificially Administered Nutrition:** Always offer food and fluid by mouth if feasible.

**Documentation of Discussion:** Orders discussed with check one:
- **Patient** (patient has capacity)
- **Legal Guardian / Parent / Minor**
- **Healthcare Power of Attorney**

**Signature of Patient or Legally Appointed Representative:** Signature required at least one of the following: patient or legal guardian. In the absence of the patient or legal guardian, other persons must sign on the patient’s behalf.

**Signature of Physician:** Signature must be placed on the patient’s official medical records and must be signed by the physician who has written the orders. The signature must be witnessed by an independent person.

**Information for Physician about Physician Orders for Scope of Treatment (POST):**

The Indiana Physician Orders for Scope of Treatment (POST) form is voluntary. POST is based on the patient's goals of care and record treatment is made. When initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. Full intervention orders require the patient's written consent. Forms that need to be made available to health care professionals and patients. If the patient is incapacitated, someone other than the patient can speak on your behalf if you cannot speak for yourself. You can identify a healthcare representative in the box below if you have not directly done so. The POST form includes information about the patient's medical condition and preferences.

**Contact Information for Sections E and F:**

**Directions for Healthcare Professionals:**

- POST orders should reflect current treatment preferences of the patient.
- If the patient lacks capacity, the form may be completed by legally appointed guardian, healthcare representative, healthcare power of attorney, or parent of minor. The authority of the named Healthcare Representative is bound by Indiana statute.
- An order to withhold or withdraw treatment must be made in Section C of this form.
- The POST form is the personal property of the patient. Use of original form is encouraged, however photocopies, electronic copies and transmissions are valid.

**Using Physician Orders for Scope of Care (POST):**

- People who are in need of emergency medical care because of a sudden accident or injury are the scope of the patient's health care.
Stages of Advance Care Planning Over the Lifetime of Adults

**First Steps**
Create POAHC and consider when a serious neurological injury would change goals of treatment

**Next Steps**
Determine what goals of treatment should be followed if complications result in “bad” outcomes

**Last Steps**
Establish a specific plan of care expressed in medical orders using the POST paradigm
Patients eligible for a POST form

Qualified Persons are adults or minors who have at least one of the following:

- Advanced chronic progressive illness
- Advanced chronic progressive frailty
- Terminal condition
- Unlikely to benefit from CPR
Section A: CPR Orders

When does Section A apply?

- When patient has no pulse and is not breathing
Section B: Medical Interventions

When does section B apply?
- When the patient still has a PULSE and is/is not breathing

Medical Interventions: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

- Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

- Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

- Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.
Section C: Antibiotics

Antibiotics for Comfort

- Examples: Urinary tract infection; wound infection
- Literature suggests antibiotics are NOT needed to ensure comfort in a patient with pneumonia

Consistent with treatment goals — see Section B

- Stabilize condition
- Cure and prolong life if possible

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<th>Check One</th>
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<td>ANTIMICROBIALS:</td>
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<td>Use antibiotics for infection only if comfort cannot be achieved fully through other means.</td>
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<td>Use antibiotics consistent with treatment goals.</td>
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Section D: Artificial Nutrition

- Discuss risks and benefits of feeding tubes
- For trial periods, discuss the goals of the trial and when you will re-evaluate
Documentation of Discussion and Patient Signature

- Patient/Representative Signature is required

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**DOCUMENTATION OF DISCUSSION:** Orders discussed with (check one):

- [ ] Patient (patient has capacity)
- [ ] Legal Guardian / Parent of Minor
- [ ] Health Care Representative
- [ ] Health Care Power of Attorney

**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE**

My signature below indicates that my physician discussed with me the above orders and the selected orders correctly represent my wishes. If signature is other than patient’s, add contact information for representative on reverse side.

Signature (required by statute) | Print Name (required by statute) | Date (required by statute) (mm/dd/yyyy)
Section F: Physician Signature

- Physician Signature is required along with date, phone number, and license number
- Cannot be signed by NP or PA

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<tr>
<th>Print Signing Physician Name <em>(required by statute)</em></th>
<th>Physician Office Telephone Number <em>(required by statute)</em></th>
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**Signature of Physician**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

**Physician Signature** *(required by statute)*

**Date** *(required by statute)* *(mm/dd/yyyy)*

Office Use Only
Preparing a POST form

- Can be prepared by a physician or his/her designee (e.g., nurse, social worker)
- Requires treating physician signature to execute
- Also requires signature of patient or representative
- Send original with patient; make copy for medical record
Honoring POST Orders

- Required to comply with the POST unless the provider believes in good faith that:
  - POST is not validly completed;
  - POST has been revoked;
  - The patient or legally appointed representative has requested alternative treatment;
  - It would be medically inappropriate to provide the intervention on the POST;
  - Has religious or moral beliefs that conflict with the POST
    - Must attempt transfer to another health care provider if this is the case
Advance care planning is a process that should be revisited over time.

Traditional advance directives are helpful but not enough.

The Indiana POST can be used to document the treatment preferences of seriously ill patients.
Thank you! Questions?
And you can bill for it! Discuss the mechanics of billing for these conversations.

It’s easier than you might think. Resources for starting and holding ACP conversations.

Which patients need advance care planning? Why choose – do it with all of your patients (well, at least your older adult patients)!
Barriers to Planning

- It will frighten patients
- I haven’t been trained
- I don’t have the time
- It’s not valued (I don’t get paid for it)
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Overcoming Barriers

- 90% want discussion
- Training available
- Time still an issue
- But at least it will be paid for if we make the time
Medicare Started Paying for ACP Discussions Jan. 1, 2016

Who?
- All willing Medicare beneficiaries (voluntary)
- OR their surrogates
- AND the provider (or “other qualified health professional” - no incident to questions PLEASE)

What?
- ACP, goals, EOL care plans
- With or without execution of forms or orders

Where? Any setting, ideally office/clinic, nursing home or patient home.
Medicare Started Paying for ACP Discussions Jan. 1, 2016

When?
- As part of Medicare Annual Wellness Visit
- As part of a regular visit (E/M billed)
- As a separate visit just for ACP
- Even as part of TCM, CCM, surgical bundle

Why? Right thing to do – and it’s reimbursed ($)

How? Two new CPT codes:
- 99497 – 1st 30 minutes
- 99498 – each additional 30 minutes thereafter
The Billing Codes

- 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.
- 99498 – . . . each additional 30 minutes.
- Medicare convention on timed billing beyond midpoints
  - 0-15 minutes = 0; 16-45 = 30, bill 99497; at least 46 to bill 99498
  - Standard patient co-pay
- If billed as part of Annual Wellness Visit:
  - Modifier – 33; no co-pay (consistent with AWV overall)
Resources for Conversations:
https://agingwithdignity.org/five-wishes/about-five-wishes
http://theconversationproject.org/starter-kit/intro/
https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
https://www.acpdecisions.org/products/
https://www.acpdecisions.org/evidence

Video Tools
A comprehensive library of video decision aids.
Work of Dr. Rebecca Sudore

You will see stories of people who are making all kinds of decisions.

Some of these people are healthy and some are ill.
Some decisions are about medicine or surgery.
Some decisions are about the care they would want if they were very ill.

These stories are only examples. Your experience may be different.

Click the NEXT button to move on.
Patients want to have these conversations!
Should happen with all older adults and anyone with serious illness
Resources are available to assist patients, families, and clinicians in holding these conversations
Medicare will pay for these conversations
Additional Resources


- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Thank you! Questions?