Advance Care Planning
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Introduction

We discuss and plan:
• Birth of a child
• Graduations
• Going to college
• Weddings

Rarely do we have conversations or plan for how we want to be cared for at the end of our lives...
Advance Care Planning
Why Do It?

- Provides information on what the patient wants as they face a terminal diagnosis or approach the end of their life
- Improves decision making
- Reduces stress, anxiety and depression of the patient and their family
- Provides the patient greater control
- The patient is more likely to get the care and treatment they would have wanted
- Patients want to discuss end of life issues with their doctor
Yes It’s Hard to Do…

- Start early, focus on goals and have ongoing conversations
- Empower the patient
- Develop a systematic approach to use consistently
- Use your team
THERE'S NO BETTER TIME THAN NOW.
Steps

1. Introduction
   ◦ Make sure other significant people are present.
   ◦ Explain why you are raising the topic (related to a diagnosis, change in prognosis, recent hospitalization, that ACP is standard for all your patients).
   ◦ Use the discussion as a way to emphasis support of the patient.
Steps

2. Set the Stage
   ◦ Reassure the patient that death is not imminent (if true) but avoid false reassurance.
   ◦ Make sure the patient understands the course of his or her illness and prognosis.
   ◦ Explain any treatments that are discussed in terms of the patients' experience and probable outcomes.
Steps

3. Elicit Preferences
   ◦ The discussion should move back and forth between preferences for specific treatments and the patient's values. The patient should understand the implications of specific decisions and the physician will understand the patient's values. Identify what situations the patient would find unacceptable.
   ◦ Discuss probabilities in medical treatment.
   ◦ Give a clear description of what you will do to meet the patient's goals regardless of the choices they make.
4. Identify a Proxy

- Identify who will speak for the patient if they are unable to convey preferences.
- Stress the need to make sure their agent knows about their preferences and will support them.
5. Documentation
   ◦ Document the conversation. Clearly state the context of the conversation, goals discussed and any decisions made or still pending.
   ◦ Complete the Advance Directive (Declaration & DPOAHC) and/or POLST as appropriate.

6. Closing the Conversation
   ◦ Express your appreciation for their willingness to talk about the topic.
   ◦ Emphasis non-abandonment.
   ◦ Stress this is an ongoing conversation.
General Tips

• Ask for questions
• Remind patients they don’t need to make immediate decisions and they can change their minds
• Ensure shared understanding of the conversation by asking “Why” when patients ask for certain treatments or express their goals
• Restate your understanding so that you got it right
• Remember to talk about the positive things you can do to help the patient accomplish their goals
• Avoid vague terms or define them
Standard Work Options

- Introduce ACP with all new patients or at the beginning stages of treatment
- Provide **Conversation Ready Tool Kit** or similar tool and advance directive packet for patient to take home and complete with loved ones
- Schedule an appointment to review and discuss patient preferences and surrogate decision maker (Encourage DPOAHC especially if choice would not be the legal next of kin)
- Complete Advance Directive (Declaration and DPOAHC) (need witnesses or notary) and/or POLST (requires provider signature)
- Originals to patient after scanning into EMR. Patient should provide copies to family and all of his/her health care providers.
ACP Billing

Effective date: January 1, 2016

- **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 patient, family member(s) and/or surrogate

- **99498** Each additional 30 minutes (list separately in addition to code for primary procedure)

- ACP services are voluntary; beneficiaries should be given an opportunity to decline
- Some people may need ACP multiple times in a year if they are chronically ill and their circumstances change
ACP Billing

- If billing multiple times for a given beneficiary, CMS expects to see a documented change in the beneficiary’s health status and/or wishes regarding his or her care
- May be billed by hospitals
- No specific diagnosis is required for ACP codes to be billed
- No place of services limitations
Advance Directives

- Living Wills /Declarations
- Durable Power of Attorney For Health Care

II. Physician Order for Life-Sustaining Treatment (POLST)
What are Advance Directives?

Advance Directives are documents which state a person’s choices about medical treatment and name someone to make medical decisions when the person is unable to make choices for themselves.
What are Living Wills?

- A Living Will (officially called a “Declaration” in Nevada) generally states the kind of medical care a person wants or does not want if they become irreversibly incapacitated and unable to make decision for themselves.
- Most states have Living Wills but the forms may vary.
- Generally the document states preferences on life sustaining treatment including resuscitation, artificial nutrition and hydration.
What is a Durable Power of Attorney for Health Care (DPAHC)?

- A DPAHC is a legal document that names another person to be an individual’s “agent” or “proxy” to make medical decisions when a person is unable to make them for themselves.
- The person designated has a duty to act consistent with the desires stated in the document.
- Individuals continue to make all medical decisions for themselves as long as they are capable and can give informed consent.
- Patients can identify first and second alternatives.
General Instructions

• Patients' should be told to give copies to the agent if named, family and all patients health care providers and facilities.

• Declarations (living wills) must be witnessed by two adults. DPOAHC can be notarized or signed by two witnesses who can not be the attending or treating MD, an employee of the treating MD, hospital or health care facility. It also can’t be the agent and one witness must be unrelated to the patient.

• Advance directives can be verbally revoked.

• Most states honor other states advance directives.
What is a Provider Order for Life Sustaining Treatment (POLST)?

• The POLST is a pink form that helps communicate to healthcare providers orders for life sustaining treatment.
• The orders can address decisions related to such issues as resuscitation, the goals for medical intentions and tube feedings.
• Must be completed and signed by a healthcare provider and the patient, agent, guardian, parents for minors or next of kin.
• POLST includes information on any Advance Directives completed.
• Provides a practical way to assemble patient preference information on a one page (two sided) form.
• POLST orders are to be followed by any healthcare provider in any setting including the scene of a medical emergency.
Questions