Advance Care Planning

Communicating End of Life Decisions

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Learning Objectives

- Review CMS Advanced Care Planning (ACP) requirements
- Recognize the need for end of life care discussions
- Identify resources to initiate ACP

What is ACP?

- CMS began reimbursing for ACP as a payable service for traditional Medicare beneficiaries in 2016
- Face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives

ACP Requirements
CPT Code 99497

- Includes the explanation and discussion of advance directives such as standard forms
- Provided by the physician or other qualified health care professional
- First 30 minutes face-to-face with the patient, family member(s), and/or surrogate
- Completion of an advance directive is only required “when performed.” It is not an overall requirement for billing ACP services.

ACP Requirements
CPT Code 99498

- Each additional 30 minutes face-to-face with the patient, family member(s), and/or surrogate
- Listed separately in addition to code for primary procedure

Why discuss ACP?

- Prevention of unnecessary physical and emotional stress for the patient and family
- Prevention of unintended healthcare costs
- Prevention of deterioration of Patient-Physician/Provider bond at end of life

Implications of not providing ACP

- End of Life talk with a unfamiliar provider of care at a vulnerable period of the lifecycle
- Pulled in at the end to disentangle distraught family and providers of care
- Escalating healthcare costs if we do nothing

Cost for End of Life Care

- In 2011, Medicare spending reached close to $554 billion
- Medicare spent 28 percent, or about $170 billion, on patients' last six months of life

Kaiser Health News, June, 4, 2013
https://khn.org/morning-breakout/end-of-life-care-17/


PASSION

The Primary Care Physician

- Best position to start the conversation
- Knowledge, trust, and compassion already established
- Office based team approach readily accessible
- Engaged audience by virtue of the visit

Care Team

- The family and significant others as identified by the patient
- Healthcare providers including physicians, hospital team, home health, long-term care staff, hospice

Strategy Alignment

- Educate staff about end of life terminology
- Identify team and project champion with roles and responsibilities
- Determine goals and measures

Developing the Plan

- Analyze ***your*** patient population and define who will benefit the most from the proposed intervention
- Determine steps to getting started

Simple Analytical Tools

- Establish a time line
- Determine need for data search, use of alerts, mechanism for tracking identified patients/families
- Tools to track may include
  - Electronic health record
  - Registry
  - Excel

Patient Engagement

- Introduce ACP early
- Resources may include brochures, online patient friendly pamphlets, electronic health record transmission of health information via the portal

Patient Engagement (cont.)

- How to begin the conversation with the patient
- Talking points that have been developed over time

Questions

Resources

- www.aafp.org/acp
- https://familydoctor.org/end-life-care/
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

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