Advance Care Planning

Communicating End of Life Decisions

Karen Linnear Smith, MD, FAAFP
Disclaimer

• The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

• The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.
Dr. Karen Smith is the owner of a solo family practice clinic in Raeford, North Carolina providing acute, chronic, and preventative services from birth to end of life. She became involved in all levels of the North Carolina Academy of Family Physicians (NCAFP) and was president in 2005. Roles at the American Academy of Family Physicians (AAFP), include participant and past chair of the Commission on Quality and Practice, and currently serves on Governmental Affairs. Other affiliations include North Carolina Medical Society, and for over thirteen years a member of the Division of Medical Assistance Advisory Board and the North Carolina Institute of Medicine.
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/
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/
• www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

For questions and feedback, contact: Barbie Hays, Coding and Compliance Strategist, BHays@aafp.org or Karen Breitkreutz, RN BSN, Delivery System Strategist, kbreitkreutz@aafp.org