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Advance Care Planning: How to Have the Conversation You Want With Your Patients


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More patients are receiving intensive care in their last days of life, even though studies show that most don't want it. Family physicians are uniquely positioned to make sure patients' wishes are recorded and respected.

ABOUT THE AUTHOR
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My patient's name was Tom, and I had been his primary care physician for almost 20 years. He was in his 80s and a "retired" farmer, which meant he worked 40 hours a week instead of 80. He came in for a Medicare annual wellness visit (AWV) one day, and I told him I was embarrassed that in all our time together I had never talked with him about advance care planning.

I said that although he was healthy I needed to ask if he had any documents that detailed what life-saving or life-sustaining measures he would want taken — or not taken — if his health dramatically changed. Would he want to be intubated or have CPR if his heartbeat or breathing stopped?

Tom, a very taciturn man, looked at me and replied, "If you bring me back from the dead, I will haunt you."

We filled out a form that day to specify Tom's advance care planning wishes, including a do-not-resuscitate (DNR) order.

Advance care planning (ACP) is one of the most important ways you can help honor your patients' wishes. Studies show that most patients would rather die at home than in a hospital or nursing home,[1] and if asked to put their wishes in writing, 9 out of 10 say they want limited care or only comfort care at the end of their lives.[2] But a quarter of Medicare beneficiaries still die in acute care hospitals, and the percentage of patients who receive intensive care, or undergo multiple transitions of care, during the final 30 days of life has increased.[3] Most of us have known patients who did not have advance directives and spent their final days in intensive care units undergoing multiple, costly interventions they did not want and enduring unnecessary stress and discomfort for themselves and their loved ones.

To change this, the Centers for Medicare & Medicaid Services (CMS) in 2016 began paying for ACP, and some private insurers have followed suit (see "Coding, billing, and documentation for advance care planning," page 20).

Any physician or other qualified health care professional can bill for ACP if they explain and discuss advance directives face-to-face with patients, their family members, or surrogates. The codes also cover the time needed to complete forms.

Physicians and patients were discussing advance directives long before CMS offered payment for it, but many patients still do not have the conversation, or if they do, it's not until the very end of life.[4] This is unfortunate, because earlier ACP discussions can prevent aggressive treatments that negatively affect patients and their caregivers.[5]

THE NECESSARY SKILLS FOR ACP

Why don't we have these conversations? Patients may not start them because they think it's too early to discuss the end of life. Physicians may not start them because we don't think it's the right time either, or we don't feel comfortable or confident enough.

One way to overcome this discomfort is to stop calling it an "end-of-life" discussion and start calling it advance care planning instead. This not only avoids the finality that may frighten both patients and doctors, but also recognizes that we are helping patients consider their values and what is important to them, whether they are healthy or living with serious illness.

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Another way to build confidence is to practice what you would say in these situations by role-playing. Practice with another primary care physician by walking through a clinical scenario, such as a 52-year-old engineer with pancreatic cancer and his doctor talking about what's to come.

Some physicians may wonder if they are the best person to have the ACP discussion. For example, if the patient has cancer, shouldn't the oncologist do it? The answer is yes, of course, but that doesn't preclude the primary care physician from being part of the conversation. Everyone on the patient's health care team should be asking what the patient wants. The oncologist

KEY POINTS

- Advance care planning (ACP) is an ongoing conversation about your patients' wishes for the end of their lives. Their advance directives can be discussed and revised as many times as necessary.
- Discussions about the end of life can be uncomfortable for patient and physician, but the earlier they begin, the better. If you wait until the patient is near death, when the situation is often chaotic and stressful, they can be even more difficult.
- ACP can be billed using CPT code 99497 for the first 16 to 30 minutes and 99498 for each additional 16 to 30 minutes.

understands the prognosis, survival rates, and complications of various therapies, but the family physician looks at how the condition or treatment fits into the bigger picture and how other aspects of the patient's health are helping or complicating the situation. We can also consider the patient's support system, because we likely treat some or all of the patient's family. Family physicians are ideally suited for ACP because it builds on the long-term relationships we already have with our patients.

> Be ready for the emotions that the patient, family members, and maybe even you will have to work through.

We can also help our patients know what questions to ask physicians in other specialties. I frequently tell patients to ask oncologists or cardiologists what they would recommend for their own family members in a similar situation. It's a more comfortable, less dramatic way of getting to the information they want than asking, "Am I going to die?" or "Is this chemotherapy terrible?"

TIMING OF ACP CONVERSATIONS

Starting an ACP conversation is a commitment. You have to be ready to sit with that patient for as long as necessary to discover and record the patient's wishes, or

CODING, BILLING, AND DOCUMENTATION FOR ADVANCE CARE PLANNING

Some aspects of advance care planning (ACP), such as helping patients fill out forms, can be handled by staff working under the treating physician's direction. But, according to the Centers for Medicare & Medicaid Services, ACP is "primarily the provenance of patients and physicians," and the agency expects the billing physician or nurse practitioner "to manage, participate, and meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision."[1]

CPT code	Description	Work RVUs[2]	Payment[2]
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 the patient, family member(s), and/or surrogate.	**1.5**	**$86.49**
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 care professional; each additional 30 minutes (list separately in addition to code for primary procedure).	**1.4**	**$76.04**

Deductibles and coinsurance

- No deductible or coinsurance applies if ACP is provided on the same day as a covered AWV (G0438 or G0439) and modifier 33, "Preventive service," is appended to the ACP code.
- Medicare Part-B deductible and coinsurance apply if ACP is provided during a regular office visit.
- ACP may be offered (and billed for) multiple times per year if the conversation is indicated and documented.

Documentation

- Record that the conversation was voluntary,
- Summarize what was discussed,
- Explain advance directives,
- Record the length of the conversation,
- Record who was present.

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1. Frequently asked questions about billing the physician fee schedule for advance care planning services. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf. Published July 14, 2016. Accessed Sept. 13, 2019.

2. 2019 Medicare Physician Fee Schedule, non-facility national payment amount.

have the necessary skills to begin the conversation and then continue it at a future appointment.

The timing of the ACP conversation dictates a lot of how you should do it and what you should cover. It's best to start the conversation before the patient is critically ill, because the situation is less chaotic and the patient is less stressed. I find that I have three kinds of ACP conversations with patients:

Early. This conversation usually involves a younger patient with few, if any, health problems. I often have this conversation during a patient's AWV, because it's a good time to reassess the patient's entire health picture. The goal of this ACP conversation is to get patients thinking about what will be important to them when their health changes, possibly many years in the future.

I typically give them handouts that explain advance directives and how to discuss them with their families. If the patient has already completed ACP documents, such as a durable power of attorney for health, I ask if they are still current (for example, if the patient has recently gotten angry with her daughter, she may now want to turn those decisions over to her brother).

The key points of your discussion with the patient must be included in the medical record. This satisfies CMS billing requirements, but more importantly it ensures that if you are not available when a patient's condition deteriorates, your colleagues and staff can use the record to find the patient's ACP information. One best practice is to designate a specific place in your electronic health record for advance directives and have pointers to the specific visits in which these discussions took place.

Middle. This conversation occurs when I consider a patient's health on shaky ground. It is more serious and in-depth. I sometimes find that including ACP in transitional care management visits for patients who have been admitted to the hospital works well. Those patients may have just experienced the types of treatment they could experience again near the end of their lives and can reflect on which treatments they would be OK with having again and which they would want to avoid.

One way to determine if it's time to have this discussion during a routine office visit is to ask yourself if you would be surprised if the patient died in the next year. If the answer is "no," then it's time to talk. The goal is to first make sure patients understand their medical conditions. Are they on the same page as you with the answer to that "surprised" question? Then, gain an understanding of what is important to the patients and their families. An easy way to start the conversation is to ask if they have any documents already prepared, if they have talked to anyone else about advance directives, and if they would be comfortable sharing how they feel. You can also use resources like the Serious Illness Conversation Guide (see "Resources," page 22).

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Some patients are not ready to have the conversation right away. I often tell them that in medicine our default is to do everything, and if that's what they want, then we're good. If that's not what they want, then I tell them it's very important that they talk to me, talk to their families, and get their wishes written down. Many patients will want to think about it, and I often send them to websites like MyDirectives (https://www.mydirectives.com) to get more information, and give them forms to fill out. In my state, Kansas, you don't need an attorney to fill out advance directives, but laws vary from state to state. The important part is you've got to start the conversation and follow through with it. It's OK to be uncomfortable with the fact that your patient may be dying, and it's OK to share that with the patient if it helps launch the conversation.

Late. This is both the most frequent type of ACP conversation and the least

RESOURCES

Serious Illness Conversation Guide. A guide for clinicians: https://www.ariadnelabs.org/wp-content/uploads/sites/2/2015/08/Serious-Illness-Conversation-Guide-5.22.15.pdf

The Conversation Project. Starter kits for families interested in advance care planning: https://www.theconversationproject.org

Prepare for Your Care. Educational videos for patients and their families: https://prepareforyourcare.org/welcome

Advance Care Planning Fact Sheet. A resource from the Centers for Medicare & Medicaid Services and the Medicare Learning Network: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

A Physician's Guide to Talking About End-of-Life Care. An article from the *Journal of General Internal Medicine*: https://link.springer.com/article/10.1046%2Fj.1525-1497.2000.07228.x

National Hospice and Palliative Care Organization. Advance directive legal forms by state available for download: https://www.nhpco.org/patients-and-caregivers/advance-care-planning/advance-directives/downloading-your-states-advance-directive/

National Institute on Aging. Articles on advance care planning, including for people with Alzheimer's disease: https://www.nia.nih.gov/health/caregiving/advance-care-planning

ideal because it means you've waited until the patient's life is measured in weeks or even days, and the discussion often must be done in one session. It is best to include the patient's family at this stage, which adds both complexity and time. In this case, I let patients know this situation is real and that I need to know now what they want and what the goals are for their care.

This can be a very difficult conversation if you don't already have a personal relationship with the patient. But you must make time for it and be ready for the emotions that the patient, family members, and maybe even you will have to work through. Remember that this is something family physicians are very good at — understanding a patient's values.

SERVING THE PATIENT AT THE END

I have become more comfortable having ACP conversations as I've seen them bring meaning to my patient care. No patients have refused to talk about it when I introduced the subject, and I find that once started, the conversation is never over. It just picks back up during our future interactions.

Sometimes people surprise you. I was convinced that one of my nursing home patients, Caroline, would want to cling to life using every possible intervention, but a conversation with her during an AWV led to a DNR order after she expressed very different preferences and goals. Her death eight months later at the nursing home, surrounded by her family, was exactly what she wanted, and I knew that because of the time invested. These conversations are critical to providing great primary care, and they're one of the most important ways to serve our patients. FPM

1. Barnato AE, Herndon MB, Anthony DL, et al. Are regional variations in end-of-life care intensity explained by patient preferences? *Med Care*. 2007;45(5):386-393.

2. Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med*. 2010;362(13):1211-1218.

3. Teno JM, Gozalo PL, Bynum JP, et al. Change in end-of-life care for Medicare beneficiaries: site of death, place of care, and health care transitions in 2000, 2005, and 2009. *JAMA*. 2013;309(5):470-477.

4. Mack JW, Cronin A, Taback N, et al. End-of-life care discussions among patients with advanced cancer: a cohort study. *Ann Intern Med*. 2012;156(3):204-210.

5. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. 2008;300(14):1665-1673.

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