

Critically Addressing Advance Care Planning

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Biography



Judith Sands, RN, MSL, BSN, CPHRM, CPHQ, CCM, LHRM, ARM has over 30 years of experience as a healthcare professional and is a recognized authority in the areas of quality, risk management, and patient safety. She earned a Bachelor of Science in Nursing from the University of Florida and her Master of Science in Leadership from Nova Southeastern University. Judith is a registered nurse, holding state and national certifications in case, quality, and risk management. Judith has been a speaker at various local and national conferences. Her current focus is on ensuring patient safety, care coordination, and bringing dignity to end of life care.

RN – Registered Nurse (North Carolina Multistate)

MSL – Master of Science, Leadership

BSN – Bachelor of Science, Nursing

CPHRM – Certified Professional, Healthcare Risk Management

CPHQ – Certified Professional, Healthcare Quality

CCM – Certified Care Manager

LHRM – Licensed Healthcare Risk Manager

ARM – Associate Risk Manager



Answering Mom's Question





Objectives

At the conclusion of the presentation the participant will be able to articulate the significance of and approaches to address:

- End-of-Life “Costs”
- Patient & Family Engagement in Advanced Care Planning (ACP)
- Operational Responsibilities
- Educational & Promotional Responsibilities to the Member
- Quality Metrics



End-of-Life “Costs” - Stats

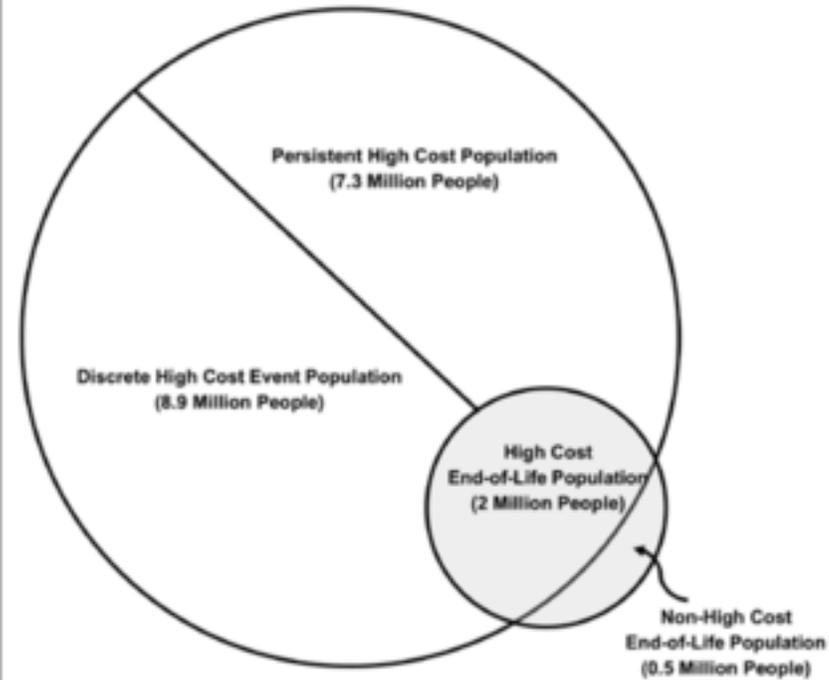
Advancements in medical health technologies prolong life in many life-threatening situations, raising new challenges surrounding decision-making for end-of-life care.

High cost of dying

- 25% of U.S. deaths occur in long-term care setting, projected to rise to 40% by the year 2040
- 25% of Medicare’s annual spending is used by the 5% of patients during the last 12 months of their lives
- Medicare costs from patients last year of life ranging from 13% to 25%

End-of-Life “Costs” - High Cost of Dying

FIGURE 1.
2011 United States Estimated Top 5% High Cost Users (18.2 Million): Persons with Persistent High Costs, Discrete High Cost Events, and End-of-Life



Note. Aldridge and Kelley (2015) estimated total population and health care costs from the 2011 Medical Expenditure Panel Survey with adjustments from the national expenditure data to include the nursing home population. They obtained the distribution for total costs for the end-of-life population from the Health and Retirement Survey data linked to Medicare claims, adjusted the estimates to include non-Medicare payers, and then adjusted to 2011 dollars using the Bureau of Labor Statistics Consumer Price Index. Source. Aldridge MD, Kelley AS [9].

Natalie C. Ernecoff, and Sally C. Stearns North
Carolina Medical Journal 2018;79:43-45

2018 by North Carolina Institute of Medicine

End-of-Life “Costs” - Financial

- 25% of Medicare spending occurs in the last year of life, unchanged in 30 years
- 8.5% of total health spending is in the 12 months of life
- \$80,000 - Mean per capita spending in the last 12 months of life
- Hospital spending in the last 12 months of life, greater percentage than in the last 3 years of life
- Some terminal illnesses generate short periods of concentrated expenditure, many are the culmination of chronic conditions





The Value of ACP Programs

- End-of-life care & ACP are critical to risk-based reimbursement models
- Systematic implementation of ACP programs, resulted in 43% reduction in hospitalizations, reduced ICU admission and LOS
- Five-star patient satisfaction ratings increase from 34% to 51% with ACP discussions
- Patients get the care that is consistent with their goals and preferences
- Population of 65 yrs. and older is projected to double between 2000 and 2030 (US), 66% will suffer from multiple, chronic illnesses
- 92% of people would consider palliative care for loved ones with serious disease
- Demand for ACP to skyrocket over the next 10-15 years



ACP & the Bottom Line

- Reimbursement for ACP will continue to increase
- CMS began reimbursing for voluntary ACP (1/1/16)
- Payers including CMS requiring some quantification around ACP
- ACP is a critical reimbursement piece, and recognized as quality of care factor
- More than a half-million Medicare beneficiaries took advantage of ACP in 2016, which almost doubled early projections
- In the first half of 2016, CMS made \$35 million in ACP payments.
- ***20% of ACOs still have few or no end-of-life care processes in place!***

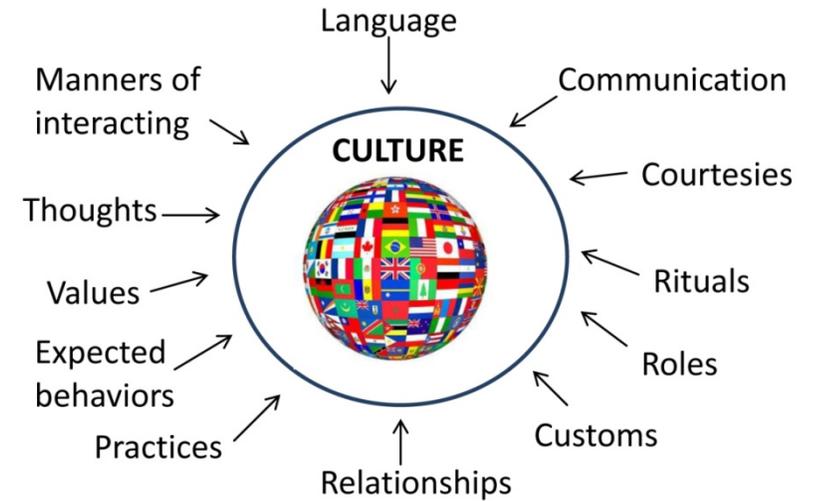
End-of-Life “Costs” - Emotional

- Change in roles
- Financial implications
- Emotions – Loved One
 - Anxiety
 - Anger
 - Guilt
 - Embarrassment
 - Sadness
- Emotions – Caregiver
 - Grief
 - Guilt & Regret
 - Anger
 - Feelings of Peace



Patient & Family Engagement in ACP – Culture

- Background
- Country of origin
- Rural V. industrial
- Sex /gender
- Race
- Religion
- Education /literacy
- Life experiences
- Travel
- Language
- Age
- Life experiences
- Moral values
- Wealth
- Patriarchal V. matriarchal
- Freedom of expression
- Access to information/technology



Patient & Family Engagement in ACP

Proactive - Initiating & Following up on the ACP Discussion

- Who really needs to get on the ACPD assistance list?
 - Value of being proactive
 - Expressing the need to honor
- Key Opportunities to Impact
 - Annual Wellness
 - Chronic Care Management
 - Advance Care Planning
 - Transitions of Care



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Situational Approach to ACP - Operationalizing

- **Lead by example** - “Have you thought about your desires and wishes...”
- **The News** - “I heard/read an interesting article about end-of-life, it got me thinking about his for myself, and for you.”
- **Clinical Visit** – The neutral approach asking the status of ACP documents
- **The Control Angle** - “If you want control over what happens to you at the end of your life, it’s important that we get your wishes written down”
- **Connect with Family** – Find the receptive family member
- **Use Movies** – The Bucket List, Steel Magnolias, Still Alice
- **Resources & Programs**

ACP Educational Resources

- Novant Health's Choices & Champions <https://www.novanthealth.org/home/patients--visitors/choices-and-champions.aspx>
- Five Wishes <https://fivewishes.org/>
- Death Over Dinner <https://deathoverdinner.org/>
- National Institute on Aging <https://www.nia.nih.gov/health/advance-care-planning-healthcare-directives>
- PREPARE <https://prepareforyourcare.org/prepare/0-1-1>
- Hello Game <https://commonpractice.com/>
- Coffee and Conversation <http://www.ihl.org/communities/blogs/coffee-and-conversation-how-to-encourage-advance-care-planning>

NC Advance Health Care Directive Registry



Secretary of State
Elaine F. Marshall

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[Secretary of State](#) » [Advance Health Care Directives](#)

Advance Health Care Directives

Welcome to the North Carolina Advance Health Care Directive Registry!

The NC General Assembly authorized the North Carolina Department of the Secretary of State to establish a registry where you may file your advance health care directives. Advance health care directives are legal documents that give written instructions about your health care if, in the future, you cannot speak for yourself.

Operational Responsibilities

Like Procedure Consents, ACP is a Process

The ACP Process is NOT “check the box” activity



ACP Means Asking Questions

Advance Care Planning Discussion

Advance Statement to include

- What is important to you?
- What do you want to happen?
- What do you not want to happen?
- Who would speak for you ?

The image shows a screenshot of a document titled "Thinking Ahead - Advance Care Planning". The document contains several sections of text and a table. The text discusses the importance of advance care planning and provides instructions for completing the form. The table has two columns: "Patient Name" and "Physician Name". Below the table, there are sections for "Physician Signature" and "Patient Signature".

| Patient Name | Physician Name |
|--------------|----------------|
| | |



Talking to Terminal Patients About EOL Care

- **Talk to patients sooner.** "Oncologists should initiate conversations about serious illness with patients who have a significant risk of dying in the foreseeable future" because "patients want, require and deserve to know what is coming"
- **Broaden the conversation.** Along with basic care preferences, oncologists should also talk to patients about their values and priorities in life
- **Make conversation notes accessible to the entire care team.** Information about these conversations "should be documented, accessible and flagged in the EMR to increase the accessibility to others involved in the patient's care"

<https://www.beckershospitalreview.com/patient-engagement/3-tips-for-talking-to-terminal-patients-about-end-of-life-care.html>

Annual Wellness - ACP is a Component

- Furnish, ACP services at the beneficiary's discretion
- Include discussion about:
 - Future care decisions that may need to be made
 - How the beneficiary can let others know about care preferences
 - Caregiver identification
 - Explanation of advance directives, which may involve the completion of standard forms

How do you capture the information?

Transitional Care Management (TCM) Codes

A FACE-TO-FACE VISIT

- Face-to-face visit within certain timeframes
 - ☒ CPT Code 99495 – TCM services with **moderate** medical decision complexity (face-to-face visit within 14 days of discharge)
 - ☒ CPT Code 99496 – TCM services with **high** medical decision complexity (face-to-face visit within 7 days of discharge)

The face-to-face visit is part of the TCM service, and should not be reported separately

Chronic Care Management (CCM) Codes

- Only one type of CCM is furnished per service period
- Code 99491 cannot be reported for the same calendar month as CPT codes 99487, 99489 or 99490
- Complex CCM (CPT codes 99487, 99489) cannot be reported for the same calendar month as any other CCM service code
- CPT codes 99487 & 99489 may be reported for the same calendar month



Advance Care Planning (ACP) Codes 1/1/16

- CPT Code 99497 - ACP 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
- CPT Code 99498 - each additional 30 minutes (List separately in addition to code for primary procedure)
- There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period
- ACP services are **voluntary**, beneficiaries should be given a clear opportunity to decline to receive ACP services

Completion of an advance directive is not a requirement for billing

Implications

- Critically examine the ACP program
- Reduce costs while improving the quality of care
- Initiate/improve management of patients with serious or advanced illness
- Improve effective use of palliative care and hospice benefits



Legislative Front

- State and Federal policies will mature. The Coalition to Transform Advanced Illness Care (C-TAC), a nonprofit alliance that advocates for patient-centered policies
- The coalition recommended:
 - How best to incorporate advanced illness care best practices into MACRA
 - Championing the Patient Choice and Quality Care Act (PCQCA) of 2017 (S. 1334)
 - Allows social workers to bill Medicare for ACP
 - Medicare Choices Empowerment and Protection Act of 2017 H.R. 3181, which would give a one-time \$75 payment to patients who participate in ACP



Patient Choice and Quality Care Act of 2017

- IOM: We need to modernize America's end-of-life system
<https://www.advisory.com/daily-briefing/2014/09/18/iom-on-end-of-life-care> <https://www.congress.gov/bill/115th-congress/senate-bill/1334>
Patient Choice and Quality Care Act of 2017
 - Bill requires CMS to create a new Medicare model for advanced illness and care management, enables certain Medicare beneficiaries with serious, chronic progressive, or advanced illnesses, to voluntarily engage in a planning process to obtain specialized care consistent with their health care goals. One participant in this model must be a hospice program
 - Model requires an interdisciplinary team to provide beneficiaries and their caregivers with information and services on disease trajectory, treatment options, and available care
 - Information on ACP must be included in the Medicare & You Handbook



Medicare Choices Empowerment and Protection Act

- Medicare Choices Empowerment and Protection Act
<https://www.congress.gov/bill/115th-congress/house-bill/3181>
 - This bill amends title XVIII (Medicare) of the Social Security Act to establish an Advance Directive Certification Program. CMS shall grant accreditation to advance directive vendors that meet specified accreditation criteria
 - CMS shall establish procedures for an eligible beneficiary to register the adoption of a certified advance directive under the program
 - Beneficiary registration in the program shall be optional, but each eligible beneficiary who adopts and registers a certified advance directive shall receive a one-time incentive payment
 - CMS shall provide for related education and outreach

Quality Metrics

- National Committee for Quality Assurance (NCQA), includes ACP in its Healthcare Effectiveness Data and Information Set (HEDIS®) expectations within the Care for Older Adults (COA) measure
- Care for Older Adults (COA) The percentage of adults 66 years and older who had each of the following during the measurement year
 - Each reported separately
 - Advance care planning
 - Medication review
 - Functional status assessment
 - Pain assessment

How do you?

- *Operationalize*
- *Collect data & report*
- *Conduct PI/PM activities*

Navigating Home Care – WCPSS Adult Education

Dates: Tuesdays – June 4, 11, 18 & 25

Time: 6:30-9:30 PM

Location: Sanderson High School

Register:

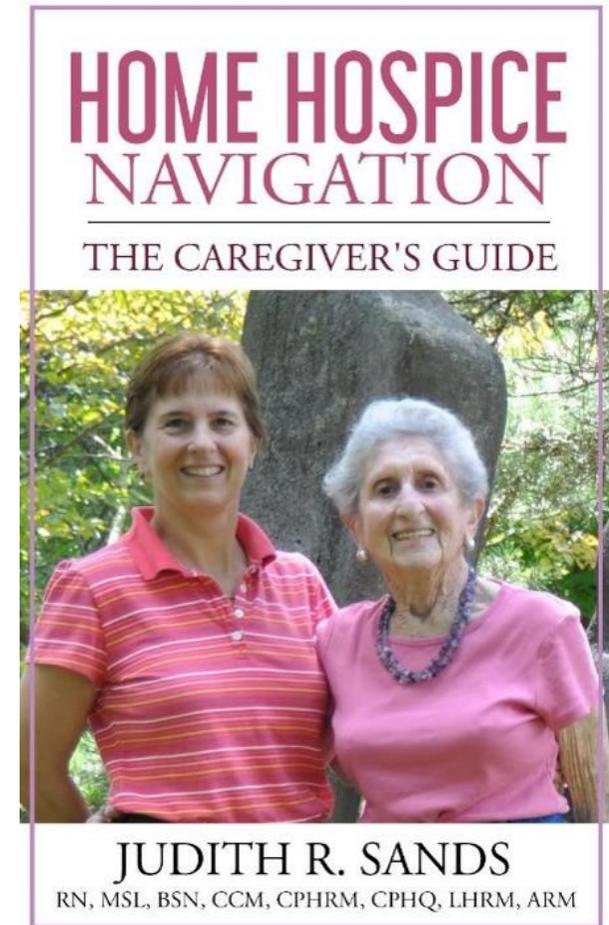
<http://judithsands.com/registration/>



Home Hospice Navigation: The Caregiver's Guide

- The only independently produced resource specifically written for the home hospice caregiver
- Grant money is accessible to make the book available to the targeted population
- *Please:*
 -  **Home Hospice Navigation** – Facebook page
 - Sign up for Blog posts
 - Write a review on Amazon or Good Reads
 - Share with a friend

Contact: Judith@JudithSands.com
JudithSands.com



Questions & Answers

What would you like to ask?



Resources

- Accountable Care Guide For Hospice and Palliative Care (NC resource)
<http://www.ncmedsoc.org/wp-content/uploads/2014/04/ACO-Guide-Palliative-care-042214-reduced-file.pdf>
- ACO Quality Metrics Documentation: Advanced Care Planning EPIC tip sheet
<http://intranet.njpcp.com/wp-content/uploads/2018/12/ACO-ACP-TipSheet-004.pdf>
- 2018 MIPS Measure #047: Care Plan
<http://healthmonix.com/mips-quality-measure/2018-mips-quality-measure-047/>
- Vitas & ACOs <https://www.vitas.com/for-healthcare-professionals/partner-organizations/accountable-care-organizations>



Resources

- Advance Care Plan (NQF #0326) National Quality Strategy Domain: Communication and Coordination (2/19)
<https://innovation.cms.gov/Files/fact-sheet/bpciadvanced-fs-nqf0326.pdf>
- 3 tips for talking to terminal patients about end-of-life care
https://www.beckershospitalreview.com/patient-engagement/3-tips-for-talking-to-terminal-patients-about-end-of-life-care.html?origin=quality&utm_source=quality

Resources

- Advance Care Planning Documentation in Electronic Health Records: Current Challenges and Recommendations for Change
<https://www.liebertpub.com/doi/abs/10.1089/jpm.2017.0451?journalCode=jpm> Decision Aids for Advance Care Planning: An Overview of the State of the Science. Mary Butler, PhD, MBA; Edward Ratner, MD; Ellen McCreehy, MPH; Nathan Shippee, PhD; and Robert L. Kane, MD. Ann Intern Med. 2014;161(6):408-418. Provides an overview of the science and value of different planning aids.
- Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV) - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/MM9271.pdf>

Resources

- Costs at the End of Life Perspectives for North Carolina
<http://www.ncmedicaljournal.com/content/79/1/43.full.pdf>
- Changes In End-Of-Life Care In The Medicare Shared Savings Program
<https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0491> This suggests that ACOs have not yet substantially altered end-of-life care patterns and that additional incentives, time, or both may be needed. Alternatively, curbing wasteful end-of-life care might not be a viable source of substantial savings under population-based payment models. 10/18.

Codes & Information – The “Bible”

- **Transition of Care Management Codes and Info:**

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>

- **Chronic Care Management Codes and Info:**

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment for CCM Services FAQ.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment%20for%20CCM%20Services%20FAQ.pdf)

- **Advance Care Planning Codes and Info:**

<https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf>