Advance Care Planning: Igniting “The Conversation” in our Hospital and our Community

Jackie Dinterman, MA, LBSW
Manager, Care Management
Frederick Regional Health System
Frederick Regional Health System

- Community hospital licensed for 240 beds; single hospital in the county
  - Approx. 250,000 residents in the county
  - Seniors are our fast growing population
- 2018 patient volumes:
  - ED with approx. 65,000 visits
  - Approximately 18,000 admissions (inc. Observation)
  - 21 bed adult inpatient behavioral health unit
- Routine outpatient services including; imaging, lab, rehab, immediate care, homecare and hospice
- Very close relationship with nursing facilities and assisted living/independent living facilities – monthly meeting for last 20 years to work on transitions between facilities
Why Now…The Importance

• Patient Self-Determination Act in 1991, healthcare organizations established advance directive (AD) policies and procedures. Compliance with the law was the goal. “Do you have an Advance Directive?”
  • Nationally, this AD approach has proven ineffective with low prevalence of actual, completed documents

• For many individuals the highest cost of medical care is delivered during the last 2-3 years of life.
  • Family members are making decisions for loved ones without ever having had an open discussion about end-of-life care
  • Placing providers and the healthcare team in the middle of ethical situations when our mission is to provide care
  • AD’s reduces costs of care in last two years of life on average by $79,000*

• The lack of Advance Directives and end of life discussions results in a high number of potentially avoidable hospitalizations
  • AD’s reduces unwanted hospitalizations at least once during last six months of life in 72% of the people*

Most Importantly....

An advance directive gives the patient control over their healthcare and quality of life.

It gives them choices!

And.......it’s the right thing to do to help our patients and our community ....
Where We Started:

- An average of 20% of patients had an Advance Directive upon admission to FMH
- An average of 8% of patients who didn’t have an Advance Directive, wanted more information
  - An average of 78% of those patients receive the requested information
  - Only 1% of patients completed their Advance Directive before discharge

We Can Do Better

- 100% of patients who request Advance Directive information will receive the information
- Increase the number of patients who have an Advance Directive completed at discharge to a SNF or start the conversation to 100%
April 16th
National Healthcare Decisions Day

• Collaborative effort of national, state and community organizations – many healthcare facilities are participating
• Opportunity to communicate and document future healthcare decisions
• Gives everyone “permission” to talk about decisions....

“Since today is national healthcare decisions day, I want to take this opportunity to talk with you about my decisions for healthcare if I am ever in a situation that I can not speak for myself like Terri Schiavo [or list someone else].”
Igniting the Conversation in Frederick

• Created the Advance Care Planning Committee:
  • Helping to keep people healthy, not just treat them when they are sick
  • Multidisciplinary
  • Full continuum of partners
  • Significant emphasis on community

• Goal of the Committee:
  • To provide education and awareness to Frederick County residents re. the importance of communicating personal wishes/preferences for end of life care
    • What is important to an individual; what defines quality and gives meaning
  • To provide tools and resources to individuals, caregivers, and healthcare providers to help encourage conversations
  • Improve the understanding of Palliative versus hospice care
  • 12 events per year

• Community Education and Outreach
  • Nursing homes/Assisted Livings/Independent Livings
  • Community Events
  • Civic Organizations
  • Media
AD Initiative Working Group

- Jackie Dinterman, Chair
- Rachel Mandel MD, VPMA and James Grissom, MD
- Sharon Smith, Hood College
- Melissa Lambdin, Marketing and Communications
- Kathy Troupe, NP, Heart Failure
- Judy Williams, Interpreting Services
- Carol Grissom, Glade Valley Nursing & Rehab
- Katie Rhinehart, Heartfields Assisted Living
- Patricia Ortiz-Sanmiguel, Hospice of Frederick Co.
- Jerree Atkins, IT
- Elisabeth McCall-Martin, Pain/Supportive Care
- Dolly Sullivan, Professional and Clinical Development
- Janet Harding, Cultural Awareness
- Melanie Bryan, Dept of Aging
- Peter Brehm, The Frederick Center
- Jodie Pritt, FMH/James Stockman Cancer Institute
- Rosario Campos, Asian American Center/Bridges
- Kathy Tyeryar, Goals of Care Navigator
- Nikki Moberly, Community, PFAC member
- Cookie Verdi, FMH Select!
- Kay Myers, Pastoral Care
- Chris Lovetro, Community Attorney

Mission:
1. Educate the community about the importance of Advance Directives
2. To provide tools and resources to individuals, caregivers, and healthcare providers to help encourage conversations
3. Increase the number of Advance Directives executed in the community and hospital
4. Raise awareness among providers about Advance Directives
5. Support the concept of the “Conversation Project”
The Conversation Project

Goal:

• To hold “kitchen table” style discussions with family and loved ones before a medical crisis occurs, so that what matters to you, when it comes to end-of-life care, is known.

• Avoid or decrease family disagreements, confusion and turmoil.
Suggestions and Materials for Employer Events
Suggestions and Materials for Health Care Events

Materials and Tools (translations, advance care planning resources, videos)

There are many wonderful advance care planning tools and resources available to people around the country. Below we’ve collected some of the materials we’ve created as well as those from partner organisations in different states. If you’ve found another helpful video or are interested in contributing to a new language translation, please keep us posted about what we can add.

Branding Guidelines
CMS Reimbursement One-Pager
Explaining Advance Care Planning in Different Ways
How to Talk to Your Doctor Guide Translations
Pediatric Starter Kit Translations
Starter Kit Summary Sheet
Starter Kit Template for Distributors
Starter Kit Translations
StoryCorps App
TCP Brochure
Videos and Recordings to Use in Presentations

Measurement (suggested measures, sample evaluation tools)

Publicity (press materials, social media strategies, TCP team info)
AD Initiative Outreach

- Initiative began February 2015
- National Healthcare Decision Day events
- “Bridges” program for LHE x 7 cohorts
- Nursing Homes, Assisted Livings, IL’s
- Colleges and Universities
- FMH Staff Lunch and Learns
- Friday Physician CME’s
- FMH 55+ Select
- Multiple Rotary Presentations
- Well Aware Magazine
- Women’s Giving Circle
- Frederick Community Health Fair, Elder Expo, Great Frederick Fair Senior Table
- Chaplain Intern Sessions
- Asbury United Methodist Church Community Block Party
- Frederick County PRIDE celebration
- Healthcare Symposium at Ceresville Mansion
- Department of Aging every 3 months – education and completing AD’s
AD Initiative Movement

• 31 events first year; Past 3 years to date: 164 events/education
• Approximately 13,450 people touched by outreach/events
• 100,000 households received Well Aware Magazine (6 articles in three years)
• Grant received for purchase of Red Magnetic Folder for storage of important papers as a giveaway
• Advance Directives in 10 different languages
• Anecdotal stories of people hearing about Advance Directives and the Conversation Project and wanting to fill one out
• Reaching out to more diverse populations
• Developed Ambassador and Facilitator programs
FMH Employees... Did You Know?

You and your spouse can each earn up to 10 wellness points per calendar year by engaging in Advance Care Planning and completing your Advance Directive.

To get started, fill out and submit the required points request form on the back of this flyer. Have you already completed your Advance Directive and/or placed it in your medical record at FMH? You can still earn points by completing the points request form and having your Advance Care Planning information verified.

Additional information, including a copy of the FMH Advance Directive, can be found at fmh.org/ACP. Call Michelle Ross, LGSW, FMH Advance Care Planning Social Worker at 240-651-4541 to schedule your appointment.
What is Advance Care Planning and why should I do it now?

Advance Care Planning is making decisions about the type of care you would like if you are ever unable to speak for yourself. Now is the time to have conversations and complete documents that identify your wishes, values, and beliefs. This caring act will relieve loved ones and healthcare providers of the stress and heartache of guessing what you would want.

What is an Advance Directive and why do I need one?

An Advance Directive is a legal document in which you can specify what actions should be taken for your health if you are no longer able to make decisions for yourself. It includes two parts: Selection of Healthcare Agent(s) and a Living Will.

PART 1: SELECTION OF HEALTHCARE AGENT

This section of the Advance Directive assigns a person(s) to assist the medical team to make healthcare decisions for you when you are unable to make decisions for yourself.

- Agent is able to consult with doctor, view medical records, and give consent for treatment
- Agent is bound to make decisions according to your known wishes
- Does not affect agent’s ability to conduct financial business on your behalf

PART 2: LIVING WILL

This section of the Advance Directive provides instructions for your future medical treatment when you cannot decide for yourself, including inpatient treatment and/or end-of-life care.

- Does not require an attorney or notary in Maryland
- Does not affect your ability to conduct financial business on your behalf

Your Advance Directive must be signed by two witnesses who are both 18 years old. Neither witness can include your Healthcare Agent(s), and neither witness can benefit financially or otherwise from your death.

When should I complete my Advance Directive?

You can complete your Advance Directive once you are 18 years of age. You should do so regardless of your current health conditions or need. Accidents, natural disasters, or health crises can happen at any time. It always seems too early until it’s too late.

Who should get a copy of my Advance Directive?

- Your Healthcare Agent(s)
- Hospital
- Doctors and specialists
- Family and/or loved ones that may be contacted

Where else should I keep a copy of my Advance Directive?

- In your Red Folder (see other side for more information)
- In your vehicle’s glove compartment
- With your current list of medications

What other forms do I need?

**MOLST (MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT)**

This form designates medical orders for current treatment. It is intended to stay with you as you move into and out of various healthcare facilities and settings (e.g., assisted living, home with HHC, nursing home, hospital, hospice). The MOLST Form must be signed by a treating Physician, Nurse Practitioner, or Physician Assistant.

- Does guide EMS personnel
- Replaces old DNR Form
- Does not expire but should be reviewed during transitions of care

**FINANCIAL POWER OF ATTORNEY**

This form designates an agent who will conduct business on your behalf if you should become unable to do so (e.g., pay bills, sell property, etc.). The same person can be your Financial Power of Attorney and your Healthcare Agent. This form must be completed by an individual with capacity to decide for themselves. It is generally recommended that this form be completed with an attorney present.

- Does not automatically apply to making healthcare decisions

What is the Red Folder and how do I use it?

The Red Folder is a place to keep important healthcare paperwork organized and in easy reach. In it we recommend including copies of your Advance Directive, the MOLST form, a current list of your healthcare providers and medications, and a recent photo. The folder is bright red for easy identification and has magnet strips on the back so you can attach it to your refrigerator. Emergency responders (including paramedics, firefighters, and police officers) are trained to look for this folder on refrigerators when responding to a medical crisis.

“An Advance Directive is a gift a person gives to their family and loved ones because it tells them what you want, so they don’t have to struggle with these decisions at a very stressful time for all.”

Rachel Mandel, MD
Vice President of Medical Affairs
Frederick Memorial Hospital

How can I get help with Advance Care Planning?

Appointments with licensed social workers are available free of cost to the community.

For questions, more information, or to set up a personalized appointment or presentation, please contact:

Michelle Ross, LGSW
240-651-4541
mross1@fmh.org
fmh.org/ACP
Advance Care Planning: Igniting “The Conversation” in our Hospital and our Community

Jackie Dinterman, MA, LBSW Manager, Care Management Frederick Regional Health System
It's time to start the conversation

http://www.nhdd.org
What is Advance Care Planning?

Advance care planning (ACP) is an ongoing process in which patients, their families/loved ones, and their healthcare providers:

- Reflect on the patient’s goals, values and beliefs
- Discuss how those goals should direct future medical care
- Create documentation that accurately reflects these choices
- Provide documentation to all parties ahead of a medical emergency
Planning Our Lives

We plan for our weddings, our babies, but we don’t do a very good job of planning for our end of life. It’s the same way that people tell stories about the birth of their children, they also tell stories about the death of a loved one.

– Ellen Goodman, Co-Founder & Director
Conversation Project
• Best time to fill out an Advance Directive.....is when you are healthy. Discussions of goals of care and wishes for treatment are able to be more objective and free from emotional distress.

• It may be helpful to think of an Advance Directive in the same way we view life insurance: have it in case we need it in order to help provide for and comfort our loved ones regarding decisions they have to make regarding our care.

• It can be a gift to your family.....greater peace of mind.
Key Definitions

- **Advance Directive** - a written, verbal or video document of a person's wishes regarding preferences for medical treatment and who is to make medical decisions should the patient be unable to communicate decisions themselves.

- **Health Care Agent (or proxy or Medical Power of Attorney)** - a person chosen by the patient to make medical decisions when they are unable.

- **Living Will** - written expression of medical preferences or instructions.

- **Surrogate** - a person identified, by default, for medical decision making when there is no prior documentation of wishes.
What Is Meant By “End of Life”

• From a medical standpoint, “end of life” is a term frequently used to define a transitional span of time before physiological life ends.
• Ranges from months to moments preceding death
• Be sensitive to the fact that in some cultural and religious groups, there is no “end of life” spiritually
Did you know???

“A new national survey released by The Conversation Project reveals that while more than 9 in 10 Americans think it’s important to talk about their own and their loved ones’ wishes for end-of-life care, less than 3 in 10 have actually held these sorts of discussions.”

September 18, 2013
Where do we die today?

88% of people say they want to die at home

20% of people actually die at home
It’s about conversations....
The Conversation Project

Goal:

• To hold “kitchen table” style discussions with family and loved ones before a medical crisis occurs, so that what matters to you, when it comes to end-of-life care, is known.
• Avoid or decrease family disagreements, confusion and turmoil that can last long after the loved one has left the hospital
• Encourages decision-making while stress is low and options can be considered
Great Tools Are Just One Click Away

- Conversation Starter Kit
- How to Talk to Your Doctor Starter Kit
- Translations/Different languages
- Pediatric Starter Kit
- Starter Kit for Families and Loved Ones of People with Alzheimer’s Disease or Other Forms of Dementia
Now that we’ve had The Conversation...

......what documents will I need to complete?
Advance Directives

Living Will
- Provides instructions for future treatment at end of life.
- Directs that life-sustaining treatment be withdrawn or withheld when person (a) is in a terminal condition, or (b) in persistent vegetative state, or (c) end stage condition.
- Does not guide EMS personnel
- Guides Inpatient treatment
- Does not need to be notarized in Maryland
- Generally is portable from state to state.

Healthcare Agent
- A person(s)(Agent) to make health care decisions for you when you are unable to make decisions for yourself.
- Able to consult with doctor, view medical records, make all decisions related to health care of patient.
- Is bound to make decisions according to wishes of the patient.

MOLST – Medical Orders For Life-Sustaining Treatment
- Medical orders for current treatment. It is intended to stay with patient as he/she moves into/out of various health care facilities and settings (e.g., assisted living, home with HHC, nursing home, hospital, hospice).
- Needs to be signed by a Physician, PA or NP.
- Does guide EMS personnel.

Financial POA
- A person who will conduct business on your behalf if you should become unable to do so (e.g., pay bills, sell property, etc.)
- Does NOT apply to making healthcare decisions - the Durable Medical Power of Attorney is required for that
- The same person can be your Financial POA and your Medical POA or they can be two separate individuals.
How do I choose a Health Care Agent?

This can be anyone over the age of 18 and they do not have to be related.

When deciding, one might consider someone:

- Who knows me well?
- Understands what is important to me
- Is agreeable to having these difficult conversations with me
- Will listen to and be able to honor my wishes
- Willing to speak up and be my advocate
- Can separate their personal feelings while representing mine
- Is available. Will being my HCA be very disruptive to their current lifestyle?
- Is reachable. Will they answer the phone?
- Who is able to manage conflict?
Advance Care Planning Checklist

- Use the Conversation Project Toolkit (theconversationproject.org)
  - Think about what you want and how you want to live
  - Plan when and how to talk to your loved ones
  - Decide who you want as a healthcare agent

- Talk to your healthcare agent
  - Tell them about your wishes and the responsibility of a healthcare agent
  - Obtain their agreement, and discuss any concerns or questions they have about supporting your wishes
  - Fill out the form “Appointment of Healthcare Agent” (FMH Advance Directive – Part A)

  - Two people need to witness your signature and sign the document. Your Healthcare Agent cannot be a witness.
  - The document does not need to be notarized and you do not need an attorney.

- Store the original signed and witnessed documents in a safe place with other important documents, such as your birth documents and your will, and tell someone where you keep them.

- Keep a signed and witnessed copy of your Advanced Directive, Part A and Part B:
  - In a place where Emergency Medical Staff or friend could find it (on the side of the fridge, for example)
  - In the glove compartment of your vehicle
  - In your red folder on the side of your refrigerator

- Deliver a signed and witnessed copy of your Advanced Directive to:
  - Family members and friends who would be contacted or involved with your care
  - Your Healthcare Agent
  - Your Doctor(s), to keep with your records.
  - Any hospital where you receive care, for storage with your records.
  - Your clergy if you wish

- Put a card in your wallet that says you have an Advanced Directive, along with a person to contact in the event of an emergency and their phone number.
What do I need for it to be legal?

In Maryland, Advance Directives require two (2) witnesses that must:

- Be over the age of 18
- Not be your health care agent(s)
- Not benefit from your passing

A Notary and/or attorney is NOT required

Maryland will accept all Advance Directives completed from other states.

State specific information can be found at www.caringinfo.org
A community Social Worker at Frederick Memorial Hospital, Nicole Wetzel, created the Red Folder in 2015 when she realized that once a patient had created important documentation, there was no one standard place for it to be stored.

All Frederick County Ambulance Companies now look for the Red Folder on patient’s refrigerators when they respond to 9-1-1 calls. If they don’t have one, EMS will provide one!

Things to Include in the Red Folder:

- Advance Directive
- MOLST Form (Medical Order for Life Sustaining Treatment)
- Updated Medication list
- List of Doctors
- A recent photo

If you have a patient who is discharging to home with a code status of anything other than Full Code, please provide them a copy of their MOLST & a Red Folder!
What should I do with my completed documents?

- Give the original signed and witnessed copy to your Primary Health Care Agent

- Keep a signed and witnessed copy of your Advanced Directive:
  - In your Red Folder on your refrigerator
  - In the Glove Compartment of your vehicle
  - In your suitcase when you travel
  - In a fire-safe box at home

- Deliver copy to:
  - Family members and friends who might be contacted about your care
  - Any Alternate or secondary health care agents
  - All of your Doctors (Family, specialists, Dialysis center)
  - Any hospital where you might receive care ahead of any unexpected admission

- Put a card in your wallet that says you have an Advanced Directive, along with a person to contact in the event of an emergency and their phone number.

- Review these documents every few years to ensure they still accurately reflect your wishes. Advance Directives do not expire and a new one can be completed at any time.

- Continue to have ‘the Conversation’ with loved ones

Anyone can provide us a copy of their Advance Directive, even if they’ve never been a patient at FMH!
The Advance Directive Document

• Maryland does not specify the use of any specific document or form
  May attach additional pieces of paper
• This is a voluntary document
  No one part must be completed
  Write as little or as much as you wish
• Does not expire but can be updated at any time
• FMH DOES allow employees to witness Advance Directives as long as other witnessing criteria is met
Common responses/questions:

“I am healthy/young, I don’t need to think about this yet”

• Every person over the age of 18 is encouraged to complete a directive
• “It always seems too early, until it is too late”
• Accidents happen every day that may leave us unable to speak for ourselves either temporarily or permanently

“We’ve talked, why should I write this down?”

If your loved ones can’t be reached or are unavailable, your written directive is still to be followed by your medical team
“I’ll just leave it to my family to decide...”

Law sets priority among “surrogates”

1. Guardian of the person (by court)
2. Spouse or Domestic Partner
3. Adult child(ren)
4. Parent(s)
5. Adult sibling(s)
6. Other relatives or friends

Law gives EQUAL decision-making power to ALL members of the same group — AND — Medical Care cannot be withheld or withdrawn unless 100% of members agree or go to court
“They’ll know what to do…”

• Will they?

• Deciding ‘in the dark’ is hard

• We are not reliable decision-makers under stress
  - ”I remember talking about this, but I cannot remember what Mom said she wanted”

• High risk of disagreement can leave lasting bitterness among family members/loved ones

• Lasting burden
  - ”Did we make the right decision?”
  - ”Should we have done something different?”

FREDERICK MEMORIAL HOSPITAL
A Personal Story
Ways to “Break the Ice”

• “I was thinking about what happened to (Uncle Joe), and it made me realize that we’ve never talked...”

• “Even though I’m okay right now, I’m worried that (I’ll get sick), and I want to be prepared.”

• “I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I’m wondering what your answers would be.”
The Starter Kit: Get Ready

Now, think about what you want for end-of-life care.

**What matters to me is _____.**
Start by thinking about what’s most important to you. What do you value most?
What can you not imagine living without?

Now finish this sentence:
What matters to me at the end of life is________________________________________.

Sharing your “What matters to me” statement with your loved ones could be a big help down the road. It could help them communicate to your doctor what abilities are most important to you—what’s worth pursuing treatment for, and what isn’t.
What Matters to Me…

• “I want to say goodbye to everyone I love, have one last look at the ocean, listen to some 50’s music, and go.”
• “Peaceful, pain-free, with nothing left unsaid.”
• “I want to be surrounded by my family, music playing, in my home if possible.”
• “I want to be able to eat chocolate!”
• “I want my dog lying next to me.”
• “In the hospital, with excellent nursing care.”
The Starter Kit: Get Set....

Where I Stand Scales
Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

<table>
<thead>
<tr>
<th>As a patient, I’d like to know...</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the basics about my condition and my treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>As doctors treat me, I would like...</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctors to do what they think is best</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To have a say in every decision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If I had a terminal illness, I would prefer to...</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not know how quickly it is progressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Know my doctor's best estimation for how long I have to live</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Starter Kit: Go

Mark all that apply:

Who do you want to talk to? Who do you trust to speak for you?

- Mom
- Dad
- Child/Children
- Partner/Spouse
- Minister/Priest/Rabbi
- Friend
- Doctor
- Caregiver
- Other: ________________

When would be a good time to talk?

- The next big holiday
- At Sunday dinner
- Before my next big trip
- Before I get sick again
- Before my kid goes to college
- Before the baby arrives
- Other: ________________

Where would you feel comfortable talking?

- At the kitchen table
- At a cozy café or restaurant
- On a walk or hike
- Sitting in a garden or park
- On a long drive
- At my place of worship
- Other: ________________
Clarifying Supportive/Palliative Care and Hospice Care

Kathy Troupe, Nurse Practitioner
Heart Failure Program
Frederick Regional Health Systems
# Hospice vs. Palliative Care

All Hospice Care is Palliative, but not all Palliative Care is Hospice.

## Palliative (Supportive) Care
- Care focused on improving the quality of life of patients with serious, chronic or life-threatening disease
- Provided across the continuum of the disease, not just at end-of-life
- Focus is on symptom management and overall wellness
- Can include treatment for side effects, psychological, social and spiritual needs
- Often used interchangeably (incorrectly) with hospice care

## Hospice
- Care focused on quality of life but for patients with a prognosis of six months or less
- Provides comfort-oriented care that neither hastens death nor prolongs life
- Manages symptoms, eases physical, emotional and spiritual pain
- Embraces the patient and family
- Volunteers provide patient support and caregiver respite
- Provides grief support and counseling for bereaved
# HOME HEALTH CARE, SUPPORTIVE CARE, & HOSPICE CARE

**Comparison Chart**

<table>
<thead>
<tr>
<th></th>
<th>HOME HEALTH CARE</th>
<th>SUPPORTIVE CARE (PALLIATIVE CARE)</th>
<th>HOSPICE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission Criteria</strong></td>
<td>Patient must be homebound with skilled nursing or therapy needs</td>
<td>Patient at any stage of advanced illness who desires symptom support whether social, physical, emotional, or spiritual. Is not required to be homebound. May be seeking curative therapies.</td>
<td>Terminally ill (prognosis 6 months or less) and desiring symptom relief whether social, physical, emotional, or spiritual. Is not required to be homebound. Focus is on Quality of Life.</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Diagnosis included in Plan of Care as ordered by Physician.</td>
<td>All diagnoses and symptoms</td>
<td>One diagnosis is selected to be the terminal diagnosis and is the Hospice Program financial responsibility; Other diagnoses included in plan of care and treated but continue to be covered by traditional Medicare/MA/private insurance coverage</td>
</tr>
<tr>
<td><strong>Physician Responsibility</strong></td>
<td>Services ordered by Physician with Face-to-Face completed. Services must be medically necessary. Services renewed every 60 days. Primary Physician must be available for needed orders.</td>
<td>Palliative consult must be ordered by physician; Plan of care reviewed by Palliative Team; PCP continues care as well</td>
<td>Plan of care reviewed by Hospice Team at weekly IDT team meetings; Certification for subsequent benefit periods are made by the Hospice physician; PCP continues care as well</td>
</tr>
<tr>
<td><strong>Caregiver</strong></td>
<td>Patient is focus of care.</td>
<td>Patient and caregivers are the focus of care</td>
<td>Plan established for caregiver as well; Focus of care is on patient/family/caregiver</td>
</tr>
<tr>
<td><strong>Visit Frequency</strong></td>
<td>Physician and Home Health determined.</td>
<td>Determined by Palliative Team; Physician and Nurse Practitioner will see patient in sub-acute rehabilitation facility or long term care facility, in home, in hospital and in the Palliative Care office</td>
<td>Determined by patient and Hospice Team</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>No restrictions.</td>
<td>No restrictions</td>
<td>Must be coordinated by Hospice Team; Admission to Acute inpatient Hospice in FMH or Residential Hospice in Kline House or patient/ family home</td>
</tr>
<tr>
<td><strong>Service Covered</strong></td>
<td>Skilled Nursing; Home Health Aide; Social Worker; Physical Therapy; Occupational Therapy; Speech Therapy; Medical Supplies; Ordered by Physician.</td>
<td>Initial consult by Physician; Physician, Nurse Practitioner, Social Worker, Chaplain visits and frequency as determined in plan of care; Bereavement Services are offered through the community services of Hospice of Frederick County</td>
<td>Physician/Nurse Practitioner; Skilled nursing RN; Home aide; social worker; spiritual counselor; volunteer; PT/OT/ST/Dietary consults as needed; Medical equipment; medical supplies; medications/biologicals related to terminal illness; Bereavement Services</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>Medicare pays 100%; Medical Assistance pays 100%; Private Insurance subject to deductibles and co-pays.</td>
<td>Medicare, Medical assistance, private insurance; deductibles and co-pays apply; no charge for chaplain, volunteers, social work or bereavement services;</td>
<td>Covered 100% for Medicare and MA; Private Ins per contract and subject to deductible/co-pays; Patient/family choose services</td>
</tr>
<tr>
<td><strong>Staff (after hours)</strong></td>
<td>Nursing on-call 24 hours a day/ 7 days a week</td>
<td>Staff on call as needed</td>
<td>Nursing, Physician, NP on call</td>
</tr>
</tbody>
</table>
Personal Story:

The Impact Advance Care Planning Can Have on Your Family

Kathy Troupe, Family Member
The Hello Game
The Proxy Quiz for Family or Physician

How well does your family, proxy, or doctor know your health care wishes? This short test can give you some sense of how well you have communicated your wishes to them. Consider this a tool to promote better conversation and understanding.

**INSTRUCTIONS:**

**Step 1:**
Answer the 10 questions using the **Personal Medical Preferences** test which follows.

**Step 2:**
Then, ask your health care proxy, family member, or close friend to complete the **Proxy Understanding of Your Personal Medical Preferences** test. The questions are the same. Don't reveal your answers until after they take the test. They should answer the questions in the way they think you would answer. (Try the same test with your doctor, too.)

**Step 3:**
**Grading** — Count one point for each question on which you and your proxy (or you and your doctor) gave the same answer. Their proxy score is rated as follows:

<table>
<thead>
<tr>
<th>Points</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Superior</td>
</tr>
<tr>
<td>8 – 9</td>
<td>Good</td>
</tr>
<tr>
<td>6 – 7</td>
<td>Fair</td>
</tr>
<tr>
<td>5 or below</td>
<td>Poor</td>
</tr>
</tbody>
</table>

... You are doing a great job communicating!
... Need some fine tuning!
... More discussion needed.
... You have a lot of talking to do!
The Proxy Quiz

Step 1: Personal Medical Preferences

Complete this questionnaire by yourself.

1. Imagine that you had Alzheimer’s disease and it had progressed to the point where you could not recognize or converse with your loved ones. When spoon-feeding was no longer possible, would you want to be fed by a tube into your stomach?
   a. Yes
   b. No
   c. I am uncertain

2. Which of the following do you fear most near the end of life?
   a. Being in pain
   b. Losing the ability to think
   c. Being a financial burden on loved ones

3. Imagine that...
   • You are now seriously ill, and doctors are recommending chemotherapy, and
   • This chemotherapy usually has very severe side effects, such as pain, nausea, vomiting, and weakness that could last for 2-3 months.

   Would you be willing to endure the side effects if the chance of regaining your current health was less than 1 percent?
   a. Yes
   b. No
   c. I am uncertain

4. In the same scenario, suppose that your condition is clearly terminal, but the chemotherapy might give you 6 additional months of life. Would you want the chemotherapy even though it has severe side effects (frequent pain, nausea, vomiting, and weakness)?
   a. Yes
   b. No
   c. I am uncertain

5. If you were terminally ill with a condition that caused much pain, would you want to be sedated, even to the point of unconsciousness, if it were necessary to control your pain?
   a. Yes
   b. No
   c. I am uncertain

The Proxy Quiz

Step 2: Proxy Understanding of Your Personal Medical Preferences

To be completed by your named health care proxy, family member, close friend, or physician.

Instructions: Answer the following questions in the way you think “N” (Name: ________________) would answer.

1. Imagine that N had Alzheimer’s disease and had progressed to the point where he/she could not recognize or converse with loved ones. When spoon feeding was no longer possible, would he/she want to be fed by the insertion of a tube into the stomach?
   a. Yes
   b. No
   c. N would be uncertain

2. Which of the following do you think N fears most near the end of life?
   a. Being in pain
   b. Losing the ability to think
   c. Being a financial burden on loved ones

3. Imagine that N...
   • Is now seriously ill, and doctors are recommending chemotherapy, and
   • This chemotherapy usually has very severe side effects, such as pain, nausea, vomiting, and weakness that could last for 2-3 months.

   Would N be willing to endure the side effects if the chance of regaining his/her current health was less than 1 percent?
   a. Yes
   b. No
   c. N would be uncertain

4. In the same scenario, suppose that his/her condition is clearly terminal, but the chemotherapy might give 6 additional months of life. Would N want the chemotherapy even though it has severe side effects (frequent pain, nausea, vomiting, and weakness)?
   a. Yes
   b. No
   c. N would be uncertain

5. If N were terminally ill with a condition that caused much pain, would N want to be sedated, even to the point of unconsciousness, if it were necessary to control the pain?
   a. Yes
   b. No
   c. N would be uncertain
During advanced illness, employees and employee caregivers have significant needs, including planning for a health crisis, caregiving, and support for grief and bereavement. Each year, millions of employees must navigate between caring for their ill loved ones, their household duties and workplace responsibilities, leading to emotional distress and billions in lost productivity to employers.

The mission of the Employer Committee of the Coalition to Transform Advanced Care (C-TAC) is to empower employers to take positive steps toward supporting employees on all levels, including caregiving responsibilities, advanced illness planning and individual care planning, advanced illness issues and grief and bereavement.

The single most powerful intervention for employers is training for supervisors to help employed caregivers to balance work and caregiving. There are many individuals and organizations already tackling this issue in unique and innovative ways. However, it is clear that more must be done to meet the needs of working caregivers.

To that end, the C-TAC Checklist for Employers puts forward four categories of action items your organization can use to assist employee caregivers. C-TAC recognizes that organizational capacity to accomplish these goals varies greatly and has built flexibility into the checklist. Even small steps can make a large difference to those dealing with advanced illness and caring for loved ones.

The four categories of caregiving support listed below are merely guidelines, presented in the order intended to best break down barriers and yield results. Still, even accomplishing a few of the many suggestions listed here will be invaluable to organizations and employees. The four categories are:

- Informal Resources
- Individual Care Planning
- Administrative Support
- Evaluation and Metrics

“The efforts of C-TAC promote the best-practice delivery of health care, while empowering individuals to make informed choices for themselves and their family members, thus limiting the distractions that interfere with their overall well-being and the productivity in their work.”

- J. Brent Pawlecki, MD
  Chief Health Officer,
  The Goodyear Tire & Rubber Company
ACP Initiatives

External

• Collaboration with community partners
• Developing program
• Developing educational materials
• Marketing events
• Myths
  • You need an attorney
  • Only old people need one
  • The doctor will be more likely to “pull the plug” if I have one
• Religious or cultural barriers

Internal Challenges

• Meditech 6.1 does not have a separate AD button
• Providers have to click through “Legal Indicators” to see if there is an Advance Directive (wasted time)
• No process in place to scan an AD into the record for someone in the community and never a patient
• No standard process for Home Health, Hospice, practitioner offices to file an AD
• Time involved with advance care planning conversations
**Special Indicator**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Last Edited By</th>
<th>Last Edit Dt/Tm</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>Script, User</td>
<td>04/04/2016 15:53</td>
</tr>
<tr>
<td>ACO</td>
<td>Script, User</td>
<td>10/04/2016 18:02</td>
</tr>
<tr>
<td>MOLST</td>
<td>Edgar, Teresa L</td>
<td>03/10/2018 17:10</td>
</tr>
</tbody>
</table>

**Active Problem**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Category</th>
<th>Status</th>
<th>Curr Visit</th>
<th>Onset</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza A</td>
<td>Medical</td>
<td>Acute</td>
<td></td>
<td></td>
<td>J10.1</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Medical</td>
<td>Acute</td>
<td></td>
<td></td>
<td>I95.9</td>
</tr>
<tr>
<td>UTI (lower urinary tract infection)</td>
<td>Medical</td>
<td>Acute</td>
<td></td>
<td></td>
<td>N39.0</td>
</tr>
<tr>
<td>Vomiting and diarrhea</td>
<td>Medical</td>
<td>Acute</td>
<td></td>
<td></td>
<td>R11.10</td>
</tr>
<tr>
<td>Dementia without behavioral disturbance</td>
<td>Medical</td>
<td>Chronic</td>
<td></td>
<td></td>
<td>F03.90</td>
</tr>
<tr>
<td>Rectal ulcer</td>
<td>Medical</td>
<td>Acute</td>
<td></td>
<td></td>
<td>K62.6</td>
</tr>
<tr>
<td>Constipation</td>
<td>Medical</td>
<td>Resolved</td>
<td></td>
<td></td>
<td>K59.00</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Medical</td>
<td>Resolved</td>
<td></td>
<td></td>
<td>E86.0</td>
</tr>
</tbody>
</table>
Flags in the EMR

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Condition</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test, Della No name</td>
<td>38</td>
<td>F</td>
<td>Headache</td>
<td>Unass...</td>
</tr>
<tr>
<td>Underwood, Sam</td>
<td>24</td>
<td>M</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>Test, Brittney Print</td>
<td>28</td>
<td>F</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>Test, kid</td>
<td>6</td>
<td>M</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>Test, Acctprov8</td>
<td>27</td>
<td>F</td>
<td>Chemical Exposure</td>
<td>Unass...</td>
</tr>
<tr>
<td>TEST, PALLIATIVE</td>
<td>45</td>
<td>M</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>Test, EMSRecall02</td>
<td>40</td>
<td>F</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>Test, EMSRecall</td>
<td>40</td>
<td>F</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>ED, Two</td>
<td>38</td>
<td>F</td>
<td>Chest Pain</td>
<td>Unass...</td>
</tr>
<tr>
<td>ED, Six</td>
<td>76</td>
<td>F</td>
<td>Fall Injury</td>
<td>Unass...</td>
</tr>
<tr>
<td>ED, Three</td>
<td>40</td>
<td>F</td>
<td>Abdominal Pain</td>
<td>Unass...</td>
</tr>
</tbody>
</table>
Leading the nation with its innovative program – Respecting Choices
96% of People who die in La Crosse have an advance directive.
National average is 30%
La Crosse spends less on health care for patients at end of life than any other place in the country according to the Dartmouth Health Atlas.
Moved to “What assistance does the individual need to plan ahead for future healthcare decisions?”
Goals are to assist patients in understanding the progression of their illness and specific life sustaining treatments and alternatives if required.
Provided by trained professional facilitators – Social Workers, Nurses, Parish Nurses, physicians and clergy
informed healthcare decisions. This model has been replicated in many different healthcare settings demonstrating the strongest research evidence and the widest generalizability toward ACP in improving outcomes of patient care than any other research. Return on investment using the RC ACP model of care is multifaceted and assists organizations to achieve their mission and vision along with organizational, system and community goals.

Evidence-based outcomes
Respecting Choices improves patient care
- Creates sustained person-centered outcomes through a well-designed system
- Assists in providing care and treatment that is consistent with patient goals and values
- Ensures ACP plans are clear and available to healthcare providers
- Integrates specific and easy-to-understand plans into medical decision making
- Facilitates individualized, person-centered planning discussions in a consistent and standardized manner across all care settings
- Results in high patient and family satisfaction with ACP conversations
- Results in high satisfaction with hospital care in general
- Creates positive impact on family members by reducing stress, anxiety and depression in surviving relatives
- Increases prevalence of planning in racially, ethnically and culturally diverse communities
- Improves satisfaction with planning for adolescents with medically stable but serious illness
- Increases parent/guardian understanding of their adolescent loved one’s preferences
- Increases surrogate’s understanding of patient’s goals of care
- Decreases decisional conflict

Respecting Choices improves population health
- Improves prevalence of written advance directives
- Integrates ACP throughout the community
- Increases hospice use at end of life
- Creates consistent ACP planning materials used for patient education and community engagement
- Increases hospital CPR success (alive at discharge) while decreasing CPR prevalence with associated poor outcomes
- Increases number of ADs naming an appointed surrogate decision maker
- Increases congruence in patient and surrogate decisions

Respecting Choices controls the per capita cost of care

<table>
<thead>
<tr>
<th>Per capita cost of care</th>
<th>La Crosse Wisconsin</th>
<th>Statewide Wisconsin</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduces unwanted hospitalizations—percent hospitalized at least once during last six months of life</td>
<td>59.5% (below 10th percentile)</td>
<td>67.5%</td>
<td>71.5%</td>
</tr>
<tr>
<td>Reduces costs of care in last two years of life due to elimination of unwanted treatment</td>
<td>$48,771</td>
<td>$67,443</td>
<td>$79,337</td>
</tr>
<tr>
<td>Decreases hospital care intensity in last two years of life</td>
<td>0.49 (half the national average)</td>
<td>0.72</td>
<td>1.00</td>
</tr>
<tr>
<td>Reduces inpatient days in last two years of life</td>
<td>10.0 days (below 10th percentile)</td>
<td>13.2 days</td>
<td>16.7 days</td>
</tr>
<tr>
<td>Reduces hospital deaths</td>
<td>20.4%</td>
<td>20.9%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Reduces percent of decedents seeing 10 or more different physicians during last six months of life</td>
<td>22.7% (well below 10th percentile)</td>
<td>31.0%</td>
<td>42.0%</td>
</tr>
<tr>
<td>Reduces percent of decedents spending seven or more days in ICU/CCU during last six months of life</td>
<td>3.8% (well below 10th percentile)</td>
<td>6.8%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Reduces percent of decedents admitted to ICU/CCU in which death occurred</td>
<td>9.5% (well below 10th percentile)</td>
<td>13.1%</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

Reduces healthcare costs: for each dollar spent on ACP the cost of healthcare is reduced by $2. The ROI is $1 for every dollar spent.
ACP SW Pilot Results

• Pilot: April 2015 – October 2015 – had CT Social Worker focused (part time) on patients transferring to SNF’s – high readmission rates
• At start of pilot, only 1% of inpatients without ADs were counseled about or executed an AD. This increased to 70% during pilot.
• Patients admitted with AD already completed went from 20% to 25% by October.
• The data from two SNF patient groups was analyzed; one with new Advance Directives (Case) and one group without (Control)
• The two groups were inpatients at the same time
• We evaluated the following metrics for the two groups:
  • Encounters for the six months before and after the index hospitalization
  • Utilization and charge per case for each group for six months before and after the index admission date
  • Readmission rate for each group
  • Hospice Referral rate for each group
# Utilization Rates

<table>
<thead>
<tr>
<th>Case (108)</th>
<th>Encounters</th>
<th>Avg LOS IP</th>
<th>Avg total costs</th>
<th>Avg Total Charges</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mos Pre</td>
<td>220</td>
<td>166</td>
<td>$9,016</td>
<td>$11,290</td>
<td>$2,483,890</td>
</tr>
<tr>
<td>6 mos Post</td>
<td>97</td>
<td>135</td>
<td>$6,722</td>
<td>$8,321</td>
<td>$807,130</td>
</tr>
<tr>
<td>% Change</td>
<td>-56%</td>
<td>-19%</td>
<td>-25%</td>
<td>-26%</td>
<td>-66%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Control (100)</th>
<th>Encounters</th>
<th>Avg LOS IP</th>
<th>Avg Total Costs</th>
<th>Avg Total Charges</th>
<th>Total Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mos Pre</td>
<td>146</td>
<td>159</td>
<td>$5,966</td>
<td>$7,843</td>
<td>$1,145,040</td>
</tr>
<tr>
<td>6 mos Post</td>
<td>94</td>
<td>124</td>
<td>$5,454</td>
<td>$7,403</td>
<td>$695,888</td>
</tr>
<tr>
<td>% Change</td>
<td>-36%</td>
<td>-22%</td>
<td>-9%</td>
<td>-6%</td>
<td>-39%</td>
</tr>
</tbody>
</table>
# Readmission Rates: 30 d

<table>
<thead>
<tr>
<th></th>
<th>IP/OBS Admits</th>
<th>No. of Readmissions</th>
<th>Readmission Rate</th>
<th>Cost per readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case</td>
<td>56</td>
<td>7</td>
<td>12.5%</td>
<td>$5,600</td>
</tr>
<tr>
<td>Control</td>
<td>47</td>
<td>10</td>
<td>21%</td>
<td>$7,651</td>
</tr>
</tbody>
</table>

These are encounters, not unique patients
The hospice patients were excluded
Total cost for Case group: $39,200
Total cost for Control group: $76,510

**The Case group had fewer readmissions with less expense per admission**
Impact of AD on Hospice Use

- Overall Hospice Use %: 23% for AD, 14% for No AD
- FMH IP %: 43d for AD, 14d for No AD

Graph shows a comparison of hospice use between AD and No AD patients, indicating a significant difference in hospice utilization and length of stay.
Frederick SNFs Readmission % Compared to Statewide Rates

Frederick Regional Health SNFs Readmission Rate After Discharge from FMH Compared to Maryland Statewide SNFs Readmission Rate

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland Statewide SNFs Readmission Rate</td>
<td>20.68%</td>
<td>20.61%</td>
<td>19.61%</td>
<td>20.91%</td>
<td>20.71%</td>
<td>19.94%</td>
<td>19.07%</td>
<td>18.70%</td>
</tr>
<tr>
<td>Frederick Regional Health SNFs Readmission Rate</td>
<td>22.03%</td>
<td>15.52%</td>
<td>21.21%</td>
<td>18.34%</td>
<td>20.90%</td>
<td>17.78%</td>
<td>16.73%</td>
<td>10.20%</td>
</tr>
</tbody>
</table>

VHQC Office: 804-289-5320
It All Comes Together Where It Counts...At the Bedside

- Senior Leadership supported a full time ACP Social Worker
- Respecting Choices Facilitator training
- The Advance Directive IT Multidisciplinary Group made it possible to reliably file this paperwork in the EHR so that the clinicians had access
- IT collaborated with the Social Worker to set up an EHR based assessment, tracking and documentation tools
- The **ACP Social Worker** has a 45% Advance Directive completion rate
- The ACP Social Worker has an ACP conversation/completes AD with 91% of patients that she is referred *9% are patients with dementia or inability to understand/complete.
- 41% of patients who die at FMH has an Advance Directive (17% in 2015)

<table>
<thead>
<tr>
<th>Task</th>
<th>2017</th>
<th>CYTD 2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP Conversation</td>
<td>718</td>
<td>248</td>
<td>966</td>
</tr>
<tr>
<td>AD Completed</td>
<td>306</td>
<td>125</td>
<td>431</td>
</tr>
<tr>
<td>Referrals</td>
<td>854</td>
<td>198</td>
<td>1052</td>
</tr>
</tbody>
</table>
Physicians Role in Advance Care Planning

End-of-Life Care Conversations: Medicare Reimbursement FAQs

The changes in Medicare reimbursement policy that went into effect January 2016 provide an opportunity for more clinicians and patients to engage in conversations about preferences for care at the end of life. However, many people are confused about where to start. Whether you are uncertain about the new rules for CMS reimbursements or about starting those conversations with patients, this document will help you understand this new landscape for end-of-life care discussions.

Before getting started, check to see if a local coverage determination has been made, and check with your local billing expert to ensure your practice is compliant with their recommendations. Make sure that the new reimbursement codes have been added to your system’s billing apparatus. These codes may not be available until your facility approves them for use.

1. Do these new codes need to be used in the context of an illness?
   No. In fact, any medical management must be billed separately.

2. What are the new advance care planning (ACP) codes from CMS that became active in 2016?
   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 professional
   99498 – Each additional 30 minutes (listed separately in addition to code for primary procedure)

3. How much time must be spent to use the new codes?
   More than half of each interval must be used. For example:
   • Use 99497 if you meet or exceed 16 minutes.
   • Use 99497 + 99498 if you meet or exceed 46 minutes.

4. Does the conversation have to be in person to use the new codes? Does it have to be with the patient?
   The conversation has to be in person (you cannot use the code for telehealth), but it doesn’t have to be with the patient. It can be with a surrogate or family members.

5. What are the documentation requirements?
   • Total time in minutes
   • Patient/surrogate/family “given opportunity to decline”
   • Details of content (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Has any advance directive offered/filled out? Follow-up)

6. What costs might patients incur from these codes?
   When a provider discusses advance care planning with a patient at his/her Annual Wellness Visit, there is no cost to the patient. However, if the provider has an ACP conversation at other times, Part B cost sharing applies and the patient may be responsible for copay/coinsurance.

7. How much do payers reimburse for these codes?
   99497 = 1.5 RVUs
   99498 = 1.4 RVUs

8. Are there limits to the number of times that the new codes can be used?
   There are no limits to the number of times the codes can be used. ACP can be addressed as needed with a change in condition. Each time they are used, 99497 should be used for the first 30 minutes and 99498 should be used for each additional 30 minutes.

9. Which health care providers can be reimbursed for having ACP discussions with patients under the new rule? Can physicians charge for the codes if another staff member engages the patient in the ACP discussion?
   Physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAAs) (i.e. those who are authorized to independently bill Medicare for Current Procedural Terminology (CPT) services) are the only providers who can use these codes. “Incident to” rules apply in the outpatient setting. This means that a provider can use these codes if they perform an initial service and a non-billing team member (e.g., registered nurse, social worker) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider. Example: The physician starts an ACP conversation, then says, “I’d like to introduce you to our nurse who will talk with you about choosing a surrogate medical decision maker and discuss with you how you might have a conversation with that person,” then deets them afterwards with the patient. Work with your local billing expert regarding “incident to” rules.

10. How can physicians bill for these conversations for non-Medicare patients?
    If the patient has private insurance, find out if ACP conversations are covered. Otherwise, you can use "counseling and coordination of care" codes, but only in the context of a serious illness.

How do your colleagues have the conversation?

A multispecialty panel discussion around the challenges of talking to your patients about advanced care planning and Advance Directives

Friday April 15, 12:30-1:30 PM
Classrooms 1 & 2, Frederick Memorial Hospital Main Campus · 400 W. 7th Street, Frederick, MD 21701

FEATURED SPEAKERS
Richard Geaugh, M.D., Primary Care Physician
Amir Hegazi, M.D., Otolaryngologist
Aruna Jain, M.D., Hospitalist
David Klein, M.D., Emergency Department Physician
Ed Riedel, M.D., Cardiologist
Kelly Shire, M.D., Surgeon

Come hear your colleagues discuss how they manage the complexities of advanced care planning, including the coordination and communication with patients that is critical to the delivery of patient-centered healthcare. Each panelist will present the unique aspects of their specialty highlighting the challenges as well as the ways in which they break down these barriers. The goal of this program is to facilitate an open discussion around important and difficult topics. Your participation in the discussion is encouraged and welcome.

Learning objectives:
• Identify the ethical principles and issues associated with Advanced Care Planning (ACP)
• Discuss the importance of ACP
• Inform about opportunities to counsel patients about ACP
• Discuss how to educate patients and families about resources available
• Explain how to change practice patterns to reach to broader patient base

ACREDITATION STATEMENT
Frederick Memorial Hospital is accredited by Accreditation Council for Continuing Medical Education, Inc as an accredited provider for continuing medical education for physicians.

CREDENTIAL STATEMENT
Frederick Memorial Hospital designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

DISCLOSURE STATEMENT
Speakers have declared no financial relationship and they will not be discussing the off-label or investigational use of products.

Planners for this activity have disclosed no relevant financial relationships.
NHDD Proclamation
Additional Resources

• Respecting Choices
  http://www.gundersenhealth.org/respecting-choices

• The Conversation Project
  http://theconversationproject.org

• National Health Care Decisions Day
  http://www.nhdd.org
“One day, it should become universally true that when we lose a loved one, no matter how sad we are, we can nonetheless look back and say "at least s/he was cared for exactly the way she would have wanted."

Lachlan Forrow M.D.
Advisor to The Conversation Project

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