



# **Advance Care Planning Resource Guide**

## I. Overview

In 2014, the Oregon Health Leadership Council's Evidence Based Best Practice Committee identified Advance Care Planning (ACP) as an opportunity for improving quality of care and decreasing system costs. An Advance Care Planning Conversation Workgroup was established to develop and implement a payment model for promoting broader adoption of ACP.

In 2015-2016, the workgroup conducted a pilot with a large oncology practice and four health plans. The purpose of the pilot was to demonstrate that trained clinical staff (social workers, nurses, etc.) can conduct ACP conversations concertedly with their providers to deliver satisfactory outcomes under a fee for service reimbursement, and to establish a payment model to support this practice.

### Pilot Outcomes:

- Patient's documented treatment preferences were followed in 97% of patient deaths
- Among those who died, 81% were on hospice and 88% preferred comfort care at the time of death

There have been larger scale national studies showing the efficacy of palliative care interventions (which concentrate on ACP goals of care conversations and focused symptom management) in patients with cancer and other serious illness. These studies demonstrate higher patient/family satisfaction, decreased election of aggressive interventions at the end of life, and in some studies, decreased cost.

The pilot demonstrated that trained nurses and social workers can conduct ACP conversations with patients and continue these discussions throughout the patient's treatment trajectory, in partnership with physicians and other care team members who are open to this collaboration and value the benefit to patients, families and teams. Expanding the cadre of staff who initiate basic ACP discussions serves to further normalize ACP conversations and allow trained staff to focus on more complex ACP discussions.

Following review of the pilot outcomes, the Evidence Based Best Practice Committee endorsed a series of recommendations intended to support the further of adoption of ACP.

### Key Recommendations:

- Adoption of a payment model that promotes the implementation of ACP in oncology and other appropriate specialty practices. This model includes payment for ACP CPT codes (99497 and 99498) by Commercial, Medicaid and Medicare Advantage payers, whether completed by a provider, or an ACP trained/certified nurse, social worker or chaplain utilizing incident to billing. Additional consideration should be given to waiving co-pay requirements to reduce patient barriers.
- Foster/support practices in assessing ACP readiness and adoption of ACP conversations conducted by trained nurses and social workers in oncology other specialty practices
- Development/adoption of nurse, social worker and chaplain ACP Conversation training program (such as Vital Talk) in Oregon with the potential to evolve into a credentialed program as deemed necessary. In addition to RN's and social workers, Advanced Practice Providers and physician champions would benefit greatly from inclusion in training.

## II. Preparing the Practice for System-wide Adoption of ACP

Successful implementation will require nurturing a culture that normalizes ACP as an essential component of high-quality care throughout the practice, across the care continuum. There are several key considerations for practices who are contemplating integrating ACP into their organizations.

1. **Identify** an executive or a senior manager sponsor as well as a physician champion **with genuine interest and passion for ACP. This requires a sustained commitment.**
2. **Engage practice leadership to secure support:**
  - Identify a few key metrics (ACP in problem list, presence of a surrogate, Advance Directives or POLST in chart etc.) and conduct baseline data review.
  - Validate any EMR data pull with random chart audit.
3. **Present data to leadership to confirm interest and bandwidth/resources (protected staff time and relatively small budget commitment) for making ACP a QI priority:**
  - If lack of either revisit in one year.
  - If not selected as a QI focus, there is still an opportunity for ACP culture education, including providing ACP education for staff, creation of visible areas of patient/family aids and ACP documents, and celebration of National Health Decisions Day.
4. **Engage broader physician/RN team once practice leadership commits support:**
  - Announce ACP initiative with an education focused review of practice's ACP baseline deidentified data at provider meeting(s) and then at clinical staff meetings (RN and MA).
  - Follow in-person ACP initiative announcement with the same information via email to MD's with links to specialty-relevant ACP impact literature.
  - Identify clinical champions at each practice site, ideally an RN or MD.
  - Engage in whole staff education including non-clinical staff regarding goals/benefits of ACP. Include opportunities for staff to complete their own Advance Directives.
  - Provide basic QI education to staff teams who will be engaging in workflow/process improvement.
  - Provide ACP/goals of care communication training for the champions and any clinical staff who wish to participate.
  - Begin small tests of change that are relevant to specialty-specific workflows, such as MA inquiry about Advance Directives or surrogate decision maker at initial intake; identification of patients with more urgent need for ACP given recent hospital stay, and referral process to ACP-trained NP or PA for visit).
5. **Create and support the ACP interdisciplinary team**
  - Provide access to articles, videos, continuing education and mentors
  - Conduct regular team meetings to discuss successes and challenges, mentor staff, update on projects, direct to resources and review metrics
6. **Provide training**
  - Nurses and Social workers should complete an ACP conversation training program
  - Educate/train new hires (appropriate to scope of practice) in ACP culture and improvement goals/activities

### III. Clinic Workflows

There are several clinic workflows that need to be developed to effectively implement and sustain ACP. These include, among others, assessments, referrals, scheduling and team communication. As with other QI efforts, workflows need to be evaluated and refined on an ongoing basis to sustain improvements.

#### 1. Identifying and Tracking ACP Conversations

- Create mechanisms to prioritize ACP for patients with cancer recurrence, advanced disease, poor prognosis diagnosis (e.g. pancreas), serious co-morbid conditions, treatment for palliative intent.
- Utilize existing interdisciplinary care conferences to inform the treatment team of patient's prognosis, goals of care and any psychosocial/cultural considerations.
- Develop and implement method to identify high priority ACP patients (e.g., use EHR information on the disease type, line of therapy, and/or treatment intent to generate patient lists.
- Track ACP activity via EHR documentation.
- Offer ACP counselors personalized searchable patient lists or calendars to prompt follow-up with patients to continue ACP.

#### 2. Timing of ACP Conversations

- For patients initiating first chemotherapy, defer initial ACP to cycle 2 or later (unless clinical needs or patient requests earlier ACP visit) to **avoid early information overload**.
- Plan at least 30 minutes for the initial ACP visit. If visit is occurring in the treatment room, scheduled treatment time should be at least 60 minutes.
- Be flexible regarding time for follow-up of ACP visits; some patients still need time to think about Advance Directives development, or designating health care surrogate, while others may be ready to explore more detail regarding personal values and end-of-life considerations.
- Initial and follow-up ACP conversations with oral chemotherapy patients can be challenging due to brief office visits and long intervals between visits for some patients. Consider scheduling an ACP visit to coincide with an office visit.

#### 3. ACP Conversation Considerations

- Clinical staff (Medical Assistants, LPN's, RN's) can be trained to ask basic ACP questions, such as inquiring if the patient has identified a health care surrogate or completed AD with another provider, attorney, etc.
- The ACP counselor normalizes ACP and completion of an Advance Directive:
  - Establish rapport with the patient and family using effective communication skills such as active listening, reflection and empathy.
  - Remain available to the patient and family along disease trajectory to assist with completion of Advance Directive.
  - Recognize and honor cultural beliefs regarding end-of-life discussions
- Anticipate the potentially sensitive nature of ACP, particularly for younger patients/parents of young children.
- For patients with completed Advance Directive, explain rationale for providing a copy to the oncology clinic.
- Be prepared to discuss POLST for patients who express strong wishes that they do not want resuscitation or aggressive life support.
- Always communicate POLST discussion and ACP challenges to treating provider to allow warm **handovers** for continuing ACP conversation
- Review ACP documents periodically with patient to ensure documents continue to reflect their wishes

## IV. Billing and Reimbursement

The payment model described below uses ACP CPT codes 99497 and 99498. This standardized payment model is recommended for commercial, Medicaid, and Medicare Advantage insurance benefits.

Advanced Care Planning can occur at any time. It can be done at the same time as the Annual Wellness Visit (AWV) or as part of an E&M, Transition Care Management (TCM), or Chronic Care Management (CCM) visit.

### CPT Codes 99497 and 99498

**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 professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.

**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 professional; each additional 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.

#### “Advance Care Planning” may include:

- Discussion of goals and preference for care
- Complex decision-making regarding life threatening or life-limiting illness
- Explanation of relevant advance directives, including (but NOT requiring) completion of advance directives
- Engaging patients, family members and/or surrogate decision makers, as clinical situation requires

#### Who can report ACP Codes?

- “Qualified” providers (Physicians, Nurse Practitioners, Physician Assistants) under Medicare Part B can report ACP codes for payment
- RN’s and Social workers utilize ‘incident to’ billing

#### ACP Codes and “Incident to” billing

- Requires that general ‘incident to’ provisions are met:
  - Patient must be an established patient under the ongoing care of the billing provider
  - The physical location of the conversation must take place in an office, billed with Place of Service (POS) 11
  - The service (ACP) is one that the provider could provide, but has delegated to a capable employee
  - The delegated employee must be an employee of the physician group/practice
  - A supervising physician must be available in-person to participate in the service as needed and address questions. The supervising physician must be the billing physician, but does not need to be the ordering physician

#### ACP can be billed on the same day as:

- New or Established outpatient visits (99201-99215)
- Annual Wellness Visits (AWV)-once yearly—use modifier 33 to waive patient deductible or coinsurance
- Consults (99241-99255)
- Transitional Care Management (TCM) (99495-99496)

### **ACP Codes cannot be billed with:**

- Most Critical Care Codes
- Care Plan oversight codes
- New Cognitive Impairment Evaluation Codes

### **Frequency and Copays:**

- No limit to frequency, guided by medical necessity
  - AWV (no copay) is limited to once per year for straight Medicare
  - We recommend waiving copay where feasible for all other ACP visits using incident to billing with nurses and social workers
- Documentation should support all services, especially high frequency or prolonged time
- It is anticipated that when ACP is billed multiple times for the same patient, Medicare indicates they would expect to see a change in the health status and/or wishes for end of life care

### **Documentation Best Practices:**

- Document a brief summary of the voluntary conversation
  - Detail should reflect and justify length/complexity of the conversation
  - Document who was present, including the patient
  - Document either start/stop time, or total time in minutes
- Form completion may or may not occur
  - If forms are completed, document which forms were completed and maintain a copy in the record
- No diagnosis requirements, but if a serious illness is featured in the documentation, it should be reported on the claim