Breaking News in Advance Care Planning: Vital Tools for Transitions

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Objectives

- Implement new billing options for ACP counseling
- Plan for changes in the Proxy Decision Maker statute
- Implement a best-practice protocol for MOST discussions

Options for Billing for ACP

CPT Codes for Advance Care Planning!

- CMS Final rule for physician payment
- Two CPT codes for ACP:
  - 99497: 1st 30 min, F2F explanation & discussion of ACP
    - With patient and/or surrogate
    - By physician or "other qualified health professional"
    - May or may not include completion of advance directives
  - 99497: Ea. add'l 30 min.
- Biller must be "managing physician" (inc. "NPPs")
- "Other qualified health professional" must be under direct supervision of physician
- Patient may be any Medicare beneficiary

Reminder: CO Medicaid billing for MOST

- Since 2013, Medicaid billing for MOST counseling
  - S0257: 30 min. session, in addition to the appropriate Evaluation & Management service. 1x/yr only
- Biller must be physician, NP, PA, or licensed mental health provider
- Patient must have serious, chronic, or terminal illness
- Must be able to produce evidence of training in MOST process & form if audited.

Proxy Decision Maker Updates

Changes to Proxy Decision Maker

- Proxy Decision Maker v. Healthcare Agent
- Problem of “unrepresented” patient
- HB 16-1101:
  - If patient lacks any “interested persons”:
    - Attending may designate, along with Health Care Ethics Committee consensus, another “willing physician” as proxy
    - Routine medical decisions made by attending
    - Any decisions requiring informed consent or EOL, proxy physician makes decisions
    - Designation ends at discharge

MOST Conversation Best Practice

How POLST/MOST Works

- For seriously ill
- Guides, requires conversation
- Addresses current condition, wishes
- Clear choices; allows annotation
- Belongs to, stays with patient
- Portable across settings
- Regularly updated
- Copies, faxes, scans valid
- Use cannot be required; honoring choices is required

Where Does MOST Fit in?

Age 18

Complete an advance directive (MDPOA, living will)

Update periodically as life circumstances, health change

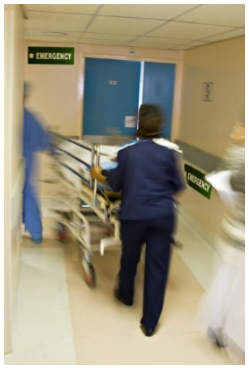
CONVERSATION

Diagnosed with serious or chronic, progressive illness (at any age)

COMPLETE A MOST FORM

Treatment wishes honored

MOST in Action



Advance Care Planning Is a Process of

- Discerning goals – medical and nonmedical
- Planning care to meet goals
- Following specific instructions (documents)
- Steering all parties in same direction

➔ *Documents only one part of the process!*

➔ *Documents are the OUTCOME of the CONVERSATION*

Timing of MOST Completion

- In hospital:
  - At discharge, prior to transfer
- In nursing facility admission:
  - Within 48 hours of admission
- In palliative care:
  - At conclusion of consult
- In home health care:
  - At first or second home visit
- In hospice admission:
  - Within 48 hours of admission (sooner if pt acute)

MOST Conversation

1. Determine capacity of person to participate
2. Describe purpose of ACP/normalize
3. Ask about any previously completed documents – esp. MDPOA
   - If none – appoint or initiate Proxy process
4. If MDPOA agent present, confirm understanding of role
   - Clarify, correct as needed

MOST Conversation (cont'd)

5. Explore understanding of medical condition, prognosis, likely course
   - Clarify/correct as needed
   - Note questions for physician
6. Explore understanding of potential complications
   - Clarify/correct as needed
   - Note questions for physician

→ *Remember to use simple, easy to understand language, without technical/medical jargon!*

MOST Conversation (cont'd)

7. Explore/refer back to experiences of
   - Person, family
   - Recent experiences coping with illness
8. Explore "quality of life"
   - Activities
   - Purpose and meaning
   - Fears
   - Worries about illness or care
   - Needs
   - Support
9. Introduce MOST form

MOST Conversation (cont'd)

10. Complete the form

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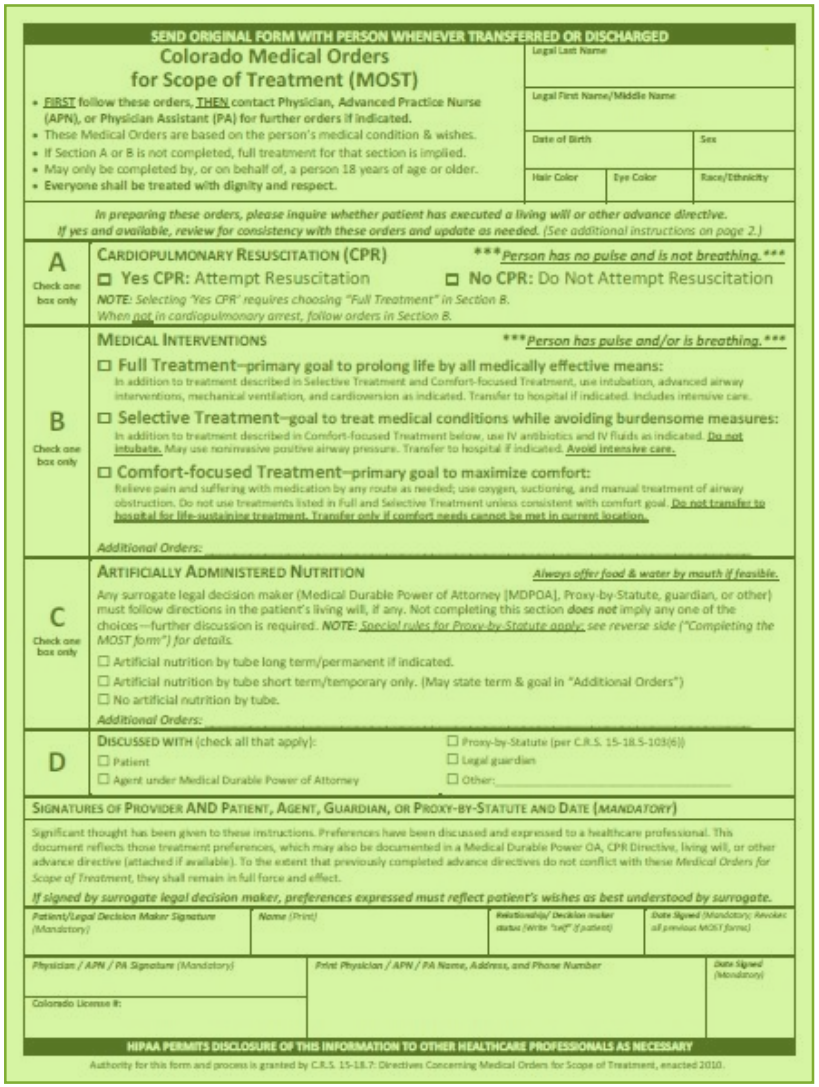

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- Everyone shall be treated with dignity and respect.

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. (See additional instructions on page 2.)

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) ***Person has no pulse and is not breathing.***

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: Selecting "Yes CPR" requires choosing "Full Treatment" in Section B. When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS ***Person has pulse and/or is breathing.***

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION *Always offer food & water by mouth if feasible.*

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section *does not* imply any one of the choices—further discussion is required. *NOTE: Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):
☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other: _____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (MANDATORY)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature (Mandatory) | *Name (Print)* | *Relationship/ Decision maker status (Write "Self" if patient)* | *Date Signed (Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature (Mandatory) | *Print Physician / APN / PA Name, Address, and Phone Number* | *Date Signed (Mandatory)*

Colorado License #:

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

MOST Conversation (cont'd)

10. Complete the form

General pattern for each section:

- Explore understanding
- Explore understanding of risks, burdens, benefits
- Explore goals, expectations
- Explore fears or concerns
- Align choices with patient goals

MOST Conversation

12. Review/update as needed:
    - At any change in condition, new dx
    - Primary care: at wellness visit
    - Nursing facility: at quarterly care conference
    - Hospital: at discharge, admission/readmission
13. Send ORIGINAL with patient
    - Faxes, copies, scans just as valid

- Note: Medicaid AND Medicare billing available!

MOST Conversation – Some Tips & Tricks

- If “Yes CPR”; Full Treatment only option
- Consider starting with Section B
- Explore patient goals THEN align choices on form
- Section C: Double-check any wording regarding AN in the person’s living will
- Proxies cannot refuse AN independently
- Signatures:
  - Obtain signatures: person/agent; physician/ APN/PA → ENSURE SIGNER REVIEWS
  - T.O.s OK; fax OK
  - File/follow-up per facility policy

Important!

- Revised form available from CADC website
  - www.coloradoadvancedirectives.com
- Old forms continue to be valid; update when appropriate
- Intensive trainings for MOST conversation:
  - June 22, Grand Junction – register on our website
  - August 23, Colorado Springs
  - TBA, Denver area

Resources

- *Colorado Advance Directives Consortium: www.ColoradoAdvanceDirectives.com*
  - *Form master, Instruction booklet, FAQs, link for ordering paper*
- *CIVHC: Palliative Care Best Practice: A Guide for Long Term Care and Hospice: http://civhc.org/PCBPGuide.aspx/*
- *Primary Palliative Care Guideline (HealthTeamWorks)* http://www.healthteamworks.org/guidelines/palliative-care.html
- *POLST National Organization: www.polst.org*
- *Caring Connections: www.caringinfo.org*
- ***Your Right to Make Healthcare Decisions –** available on the CADC website*

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