Advance Care Planning

Translating thoughts into good process that work for patients and care teams

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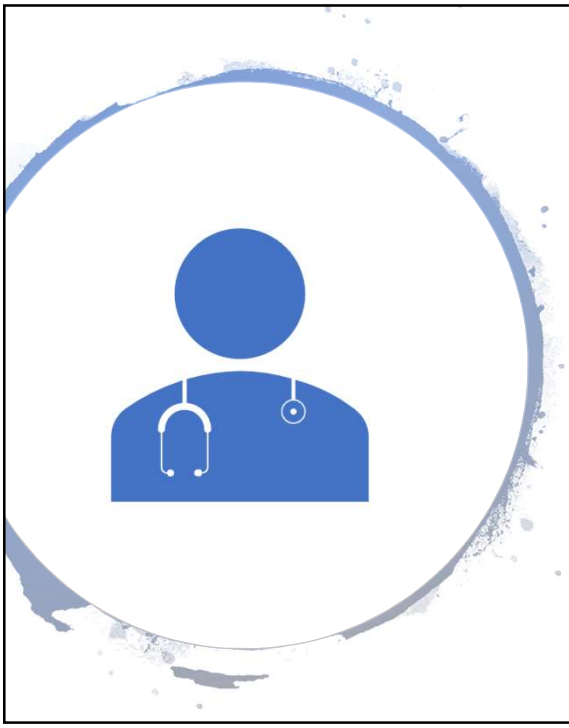

Introductions:

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  - University of Maryland SON
  - ER and CVICU with Johns Hopkins Medical Institutions and The University of Toronto
  - Transitioned to Ambulatory Care with a move to Michigan

What is the hardest part of Advance Care Planning for you or your practice?

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Objectives:

- Review reasons for system dysfunction at the end of life
- Identify how approaches and goals of ACP discussions will vary according to individual health status
- Identify how **My ACP Decision Videos** can encourage discussions on individual values and fears about end of life
- Review how an Effective Practice Approach to ACP:
  - Minimizes the likelihood of over or undertreatment
  - Reduces likelihood of conflicts between family members and health care providers
  - Minimizes the burden of decision making on family members or close friends

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What does Advance Care Planning Mean to You?

'Advance care planning is a process that supports adults at any age or stage of health, in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

International Consensus Definition of Advance Care Planning (Sudore et al 2017)

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Understanding the Evolution:

- 70 years ago dying was a family, spiritual and community event – one which was recognized as natural part of the life continuum
- The rise of technology and institutional healthcare changes this experience – changed our experience with death and dying – removed families and individuals from the experience
- Change in demographics – more people living longer; living with chronic disease which previously would not have happened
- Dying of old age or natural causes is not a listed as a cause on a death certificate
- Mismatch between what over 70% of Americans state they want and what actually happens in the final stages of life
- True in pediatric and young adult populations

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Enter the Healthcare Machine:

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I already talk about Advance Care Plans …..

- Present in the health care transformation discussion for over a decade
- Asking about Advance Care Plans or documents during wellness visits is widely used
- Some utilization of ACP Decision videos – Tools have been available to practice for 2 years

So how are we doing?

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Informed Strategies:

NMHN And Trillium ACO Patients - Days at Home in Last 6 Months of Life

	ALL NMHN And Trillium Patients with Date of Death from 11/1/2018 - 10/31/2019				
	Inpatient Days	SNF Days	Hospice Days	ED Days	Days at Home
Average	9.5	5.7	15.0	1.1	150.7
Maximum	111	129	182	27	182

Primary Practice	Assigned NPI	Last Name	First Name	DOB	Age	Date of Death	Inpatient Days	SNF Days	Hospice Days	ED Days	Days at Home
					79		2	0	0	1	179
					90		2	0	22	4	154
					76		0	0	0	0	182

An example of the reports provided to practices by NPO for the ACO participant; report is limited to ACO (Medicare) patients, Days at home in last 6 months of life.

- Of the ACO participants who died during the specified time frame how was their life spent
- # of days that an individual spends at home vs. as an inpatient
- # of days spent in hospice is ~2 weeks
- On average almost a month spent elsewhere than at home

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Informed Strategies:

- Trending data far more valuable than individual level data
- Data is available at a practice level; helps to clarify opportunities
- Using this data to stimulate small changes far better than sweeping process overhauls
- Time saving tools to overcome barriers and limitations may increase effectiveness

> "Almost all quality improvement comes via simplification of design, manufacturing, layout, processes, and procedures."
> ~Tom Peters

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Wanted Care vs. Care Provided

There are various reasons why this happens.

- Limited Time
- No Routine ACP Process
- Communication Problems
- Cannot Start The Conversation

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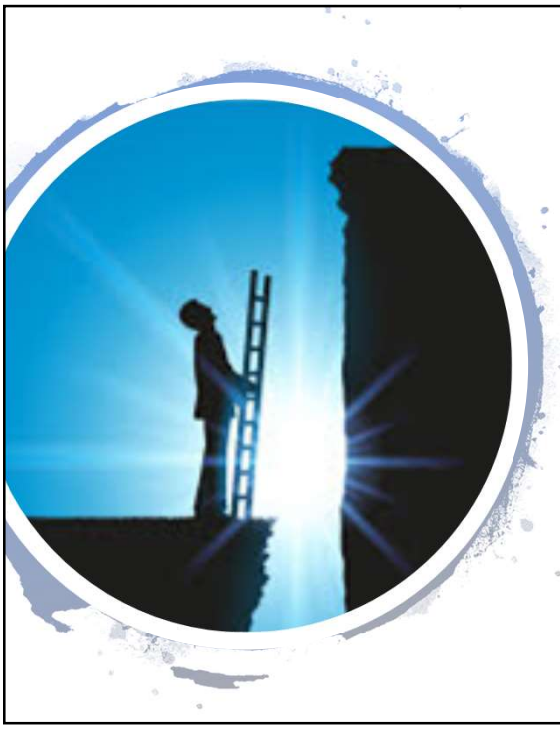

Common Barriers to ACP Processes:

- Emphasis on paperwork completion
- Lack of information portability
- Historical/ Perception of lack of reimbursement
- Historical/ Perception of time investment
- Complex system, complex language
- Clinician and individual comfort with discussion
- Medical Model of care focus on diagnose and treat
- Options and Coordination for Hospice and Palliative Care

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Biggest Barrier to Effective Discussions:

- Clinicians are an end result-oriented group of people
- If the end result is perceived as a specific item / document, then we tend to race to get that checked off
- This is a process and evolving conversation
- Check boxes don't work and will not improve outcomes

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What is Most Important:

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ACP Decisions:

- NPO Purchased access to videos to help eliminate barriers
- Initially a pilot to develop best practices
- Currently 8 practices with access; 6 practices have shown 1 or more video in the past 6 months

ACP DECISIONS

We are a non-profit foundation comprised of a group of clinicians dedicated to empowering patients, families and healthcare providers in advance care planning.

Our video decision support tools are carefully crafted after rigorous review by leading experts in medicine, geriatrics, oncology, cardiology, ethics, and decision-making.

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Videos as a part of your ACP Strategy:

- Detailed understanding of complex issues
- Brings patient and providers to the same starting point to begin personalized conversations
- Evidence based tool
- Crosses language barrier
- Addresses many of the common barriers

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Conversations at Different Stages of Life

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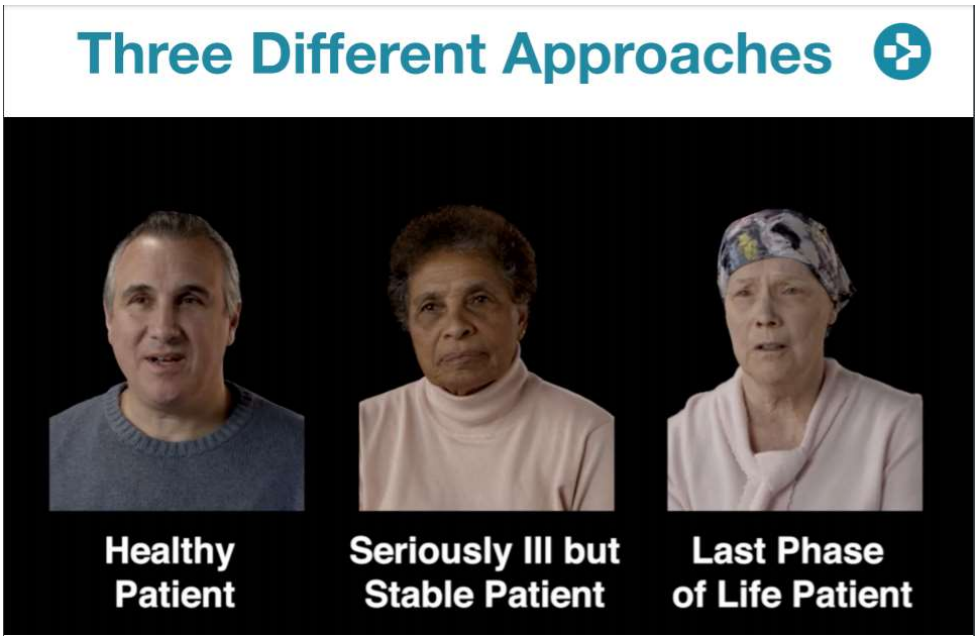

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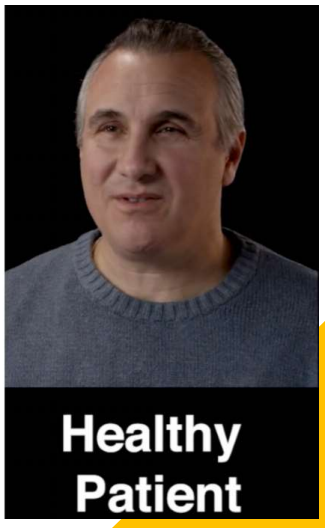
- Focus on establishing ACP conversations as a normal part of preventive care in the practice
- Asking about full ACP decisions is too abstract at this stage and likely to change
- Focus on obtaining a health care proxy
- Starting point for discussions; setting the foundation



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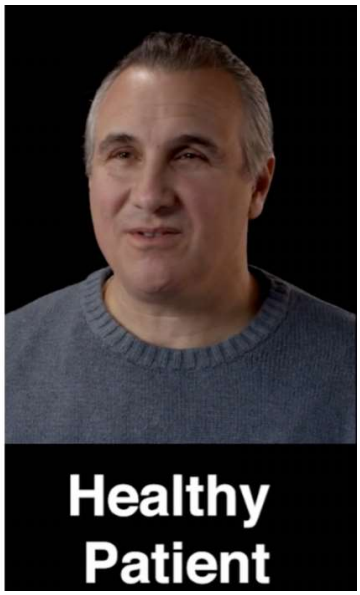

- Standardizing the approach at a time when the individual is healthy
- Engage the patient with Motivational Interviewing Techniques

Can you tell me what you know about a health care proxy or substitute decision maker for healthcare?

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Tools to Consider:

- What is a health care proxy? – Healthy Adult Video - ~6 min
- Choosing a health care agent. – Healthy Adult video ~7 min
- Guide to Choosing a Health Care Agent - PDF handout

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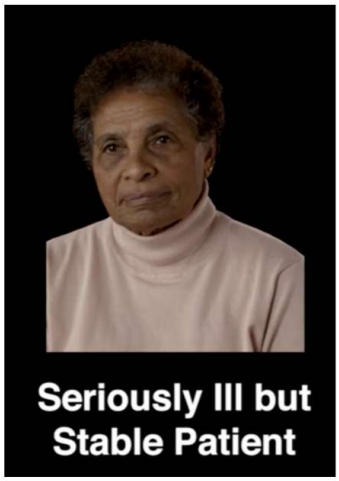
- Emphasis that although there is serious conditions present, right now there is the ability to keep the condition controlled.

Your recent visit to the hospital indicates that your heart failure is worsening but with the new medication changes, I'm hopeful that we should be able to keep you out of the hospital



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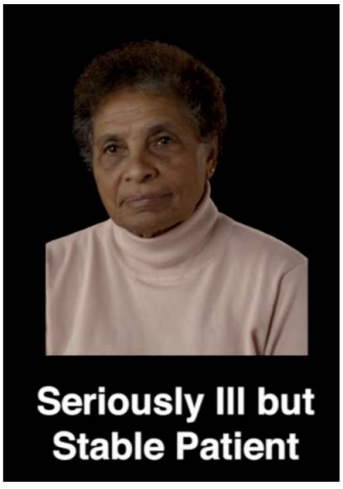

- Transition to ACP discussion by asking if your conditions worsen or you get very sick it is important to know how you would want to be treated?
- Use Motivational Interviewing techniques to ask if they have every thought about what is important to them?

If your condition worsens or you get very sick, it is important for me to know how you would want to be treated. Have you ever needed to make medical decisions like this for someone else?

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Tools to Consider:

- What's Important to You- Advance Care Planning for Healthy Adults Video ~5 ½ min
- What is a health care proxy – Advance Care Planning for Healthy Adults Video ~6 min
- Choosing a Health Care Agent – Healthy Adult Video ~7 min
- Guide to Choosing a Health Care Agent – PDF Handout
- What's Important to You - Advance Care Planning for a General Audience Video – 6 min
- What's Important to You: Advance Care Planning for a General Audience - PDF Handout
- Goals of Care – General Audience Video – ~ 5 ½ min

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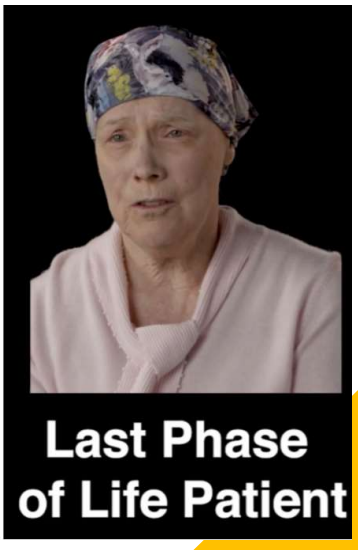
- 2-part conversation
- requires a physician discussion of prognosis before any additional discussion can take place
- without a discussion of prognosis discussions of values and believes or decision making about goals of care remain abstract
- PCP longitudinal relationship

Just to be sure we are on the same page; can you tell me your understanding of your condition at this point?



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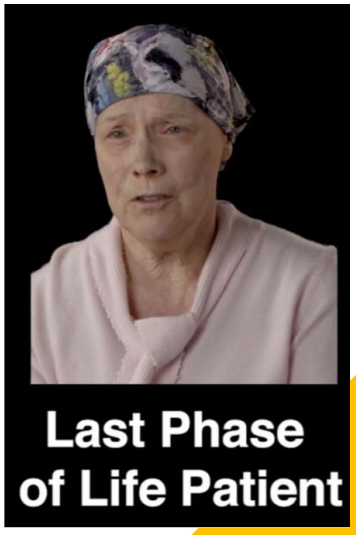
- Talking about the provision of care and not the absence of care
- Review what the individual identified as meaningful and valuable

Are you ready to talk about what the future looks like? I understand that this is very difficult for you. I do think it is important that we talk about the future so I can be sure, that whatever happens, I will be providing the kind of care you want.



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Never too early

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Examining Personal Values and Beliefs:

- What kind of things are important to you in order to make life worth living?
- What fears do you have about getting sick or needing medical care?
- If you were very sick, are there any treatments that might be too much for you?
- Do you have any beliefs that might influence your medical decisions?

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Exploring: Values and Fears

- What is most important to you?
  - What makes you happy?
  - Are there certain activities or abilities that are necessary for you to feel like your life is valuable?
  - How important is it to be physically independent?
- If you were very sick are there treatments that might be too much for you?
- Would any symptoms make life not worth living to you?

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Who has had this type of conversation with a patient in the past?

How comfortable are you?

How effective are you?

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Tools to Consider:

- What's Important To You - Things To Think About When You Are Seriously Ill ~6 ½ min
- Goals of Care: Advanced Disease~ 5 ½ min
- Goals of Care: Advanced Disease – PDF Handout

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Pediatric ACP

- Target Population is different:
  - Life limiting disease
  - Children with Medical Complexity
- Legal and ethical issues specific to pediatric population:
  - Ability to consent age 18
  - Strong cultural norms to protect
  - Parental differences
  - Medical Establishment/ Parental differences
  - Draw the child into the conversation
- Dying children protecting their parents/ Parents trying to shield their child
  - Parental and child regret/ anxiety
- Cultural influences

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Tools to Consider:

- Guide to CPR for Parents of Children with a Serious Illness Video - ~4 ½ min
- Exploring Advance Care Planning in Young Adults: Serious Illness - ~15 min
  - Specific similar videos for lung disease, heart disease and advanced cancer
- Exploring Advance Care Planning in Young Adults: Serious Illness
- Goals of Care: Advanced Disease~ 5 ½ min (adult)
- Goals of Care: Advanced Disease – PDF Handout (adult)

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Sustainability:

- Reimbursement for work completed
- Fee for Service Billing and Value Based Reimbursement
- Medicare:
  - 99497 (~$84)
  - 99498 (~$78)
    - Modifier 33 added to code shows that service was furnished as a preventative service (because AWV limited to 1/ year then so to is ACP codes without any copays applied) ; Modifier 25 if added to an EM code
  - If ACP discussion takes place with Medicare Wellness Visit (MWV) then no copays apply; if furnished outside of the MWV then copays or coinsurance would apply
- Care Management Codes:
  - S0257 (BCBS/ PH) ~$30

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Preparing for Late Stage Conversations:

- Physician Champion
  - Coordination with Specialty practices
  - Roles within visit
- Identify Patients:
  - Huddles
  - Transition of Care Calls
  - ADT Reports
- Ensure Sufficient Time:
  - Proactive approach to managing schedule

Prepare and be OK with not being perfect

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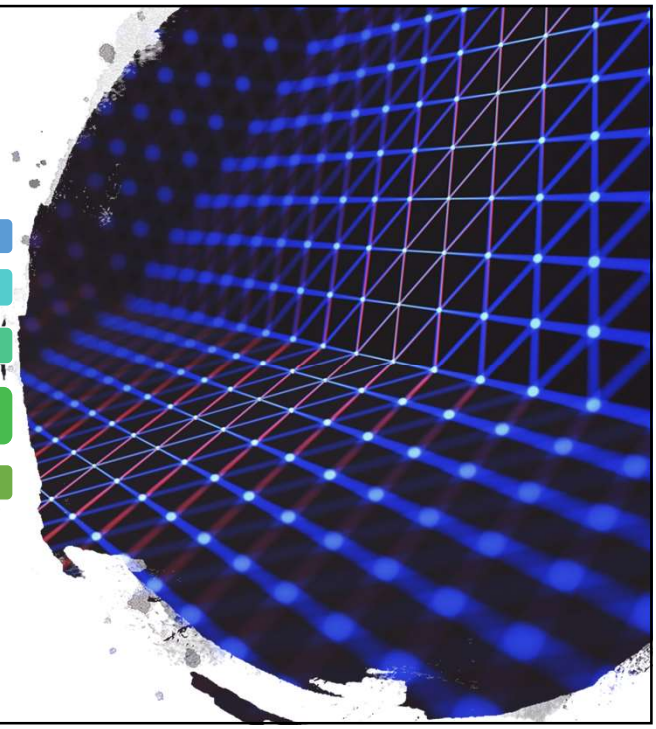
Developing Process



- Target Population
- Establish the team
- Identify clear roles for the team
- Identify / document the process that you want to start with
- NPO Tools:
  - Practice Checklist
  - Provider Checklist
  - Suggested Workflows
  - ACP Decision Video Tools/ metrics

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Documentation Best Practices: Templates can be a life saver

- Document a brief summary of the voluntary conversation:
  - Detail should vary based on length/complexity of the conversation, which would also justify time duration.
  - If a video or hand out is provided/ which ones
  - Remember that values and beliefs are key to continuing the conversation
  - Individuals reactions and situational conversations can also provide keys to continuation of the conversation
- Document the time and who was present: – Either by start/stop time or total # 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: – If a serious illness is a driver to the conversation, it is expected that such diagnosis will be reflected on the claim.

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What is your plan?

Questions

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