MDPCP
MARYLAND PRIMARY CARE PROGRAM

Practice Resource

Advance Care Planning

BACKGROUND AND IMPORTANCE

Advance Care Planning (ACP) is the process of making decisions regarding the type and level of care that a patient would like if they are ever in a situation where they cannot make decisions for themselves. Advance care planning can be done with all patients, not just with those who are severely ill.

Advance Care Planning allows your practice to engage patients in structured and documented conversations to:

- Reduce confusion and disagreements about medical care
- Improve quality of care
- Manage the difficult subject of life-threatening illness slowly and with care
- Identify end-of-life goals
- Define a treatment plan

MDPCP REQUIREMENTS

Track 1

Track 1 practices are *strongly encouraged but not required* to implement advance care planning into workflows

Track 2

Track 2 practices are *required* to provide advance care planning services to attributed beneficiaries and caregivers

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Practice Resource

Advance Care Planning

DOCUMENTATION OF END-OF-LIFE WISHES

There are several ways to document a patient's end-of-life wishes, including in an Advance Directive and MOLST

Advance Directive

(there can be two components)

1. ***A living will*** is general guidance about what treatment a patient does or does not desire if they become unable to make or communicate decisions about care AND/OR
2. ***A health care agen***t, also known as a "medical power of attorney" or "medical proxy", is a specific individual who is designated to make decisions for the patient when they are unable to do so. One part of the advance directive includes naming a health care agent, but sometimes this can be a separate document.

MOLST

The MOLST is a medical order signed by a medical professional and used for end-of-life treatment decisions. For example, the MOLST form may contain a DNR (Do Not Resuscitate) Order. An advance directive does not necessarily mean DNR; rather, it expresses what someone does and does not want.

	Advance Directive	MOLST
Names a health care agent	YES	NO
Is a medical order	NO	YES
Is a legal document	YES	NO
Used to help treat in an emergency situation	NO	YES
Signed by a healthcare provider (PA, NP, resident, intern, physician)	NO	YES
Needs an attorney	NO	NO

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MARYLAND PRIMARY CARE PROGRAM

Practice Resource

Advance Care Planning

WORKFLOW EXAMPLE

This is an advance care planning workflow integrated into an Annual Wellness Visit (AWV) that was developed by an MDPCP Practice in Track 2. The checklist below can be utilized to guide the Advance Care Planning (ACP) workflow.

Action Item	Recommended Responsible Staff	Done?
SCHEDULING AND PRE-VISIT		
Search for patients that have an upcoming AWV who don't have an ACP in chart	Staff	☐
Check to see in chart if there is an existing ACP or if they have appointment with healthcare staff	Staff	☐
Call patients who need an AWV and discuss importance of ACP, and advise them to bring any existing ACP documents	Staff	☐
ANNUAL WELLNESS VISIT (AWV)		
Review copy of ACP form at check-in	Patient	☐
Review medications and have ACP conversations prior to AWV with provider	Staff	☐
Create order in encounter using ACP template in Medical History and ACP documents given to patient	Provider	☐
Completed documents uploaded, documents attached to order, and schedule follow-up visit	Staff	☐
POST-VISIT AND LOOP CLOSURE		
Update Care Plan with issues topics discussed at ACP visit. Upload documents and attach to order and update ACP template in Medical History PRN	Provider	☐
Call patients to follow up on open ACP orders	Staff	☐
Follow up with healthcare staff for ACP assistance	Patient	☐
Upload advance directive to myDirectives	Patient	☐

Advance Care Planning

MYDIRECTIVES

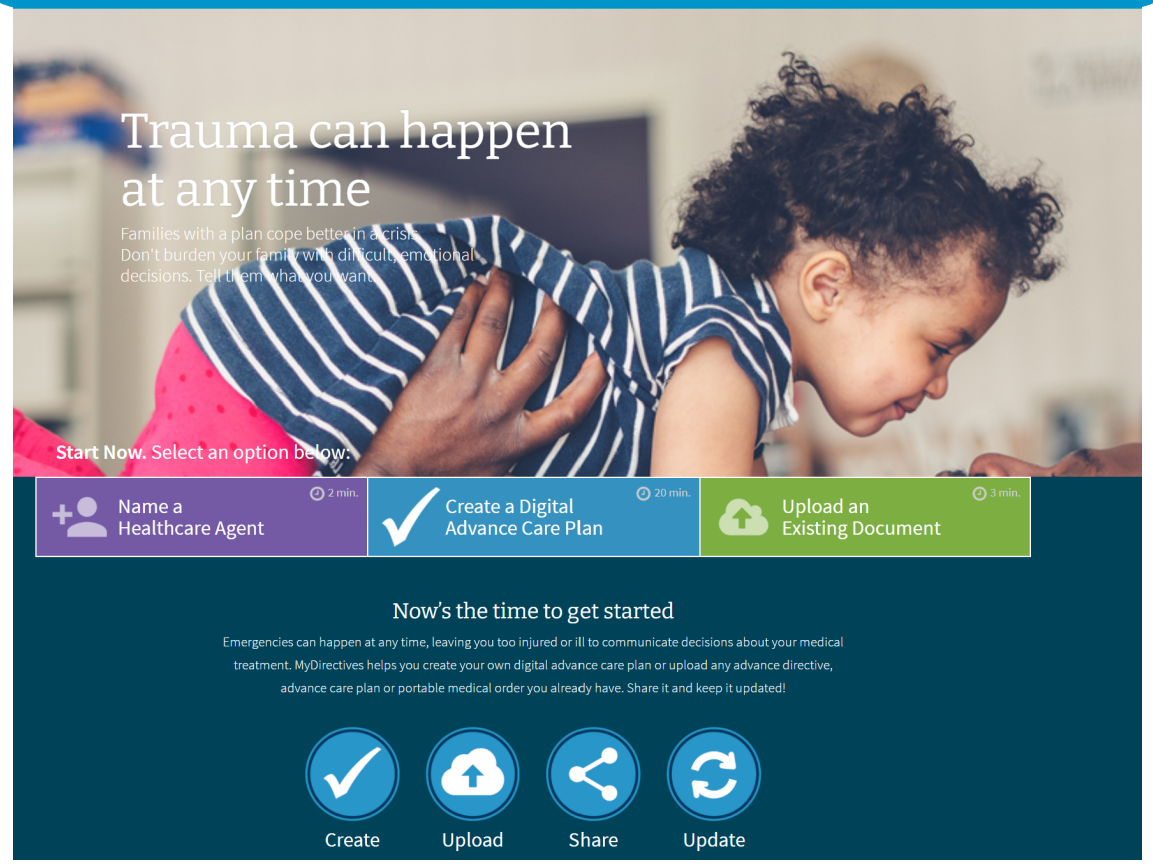
A patient's advance care plan can be stored securely online in MyDirectives and accessed from CRISP. Please note that CRISP does not store Advance Care Plans. Rather, CRISP is notified by MyDirectives when a Maryland patient has uploaded or created an Advance Directive on MyDirectives.com.

Through MyDirectives.com, a patient can:

- Upload an existing advance care planning document
- Update the advance directive at any time
- Upload additional documents like a MOLST
- Name a healthcare agent
- Create an electronic advance care plan

MyDirectives

CRISP Unified Landing Page



Advance Care Planning

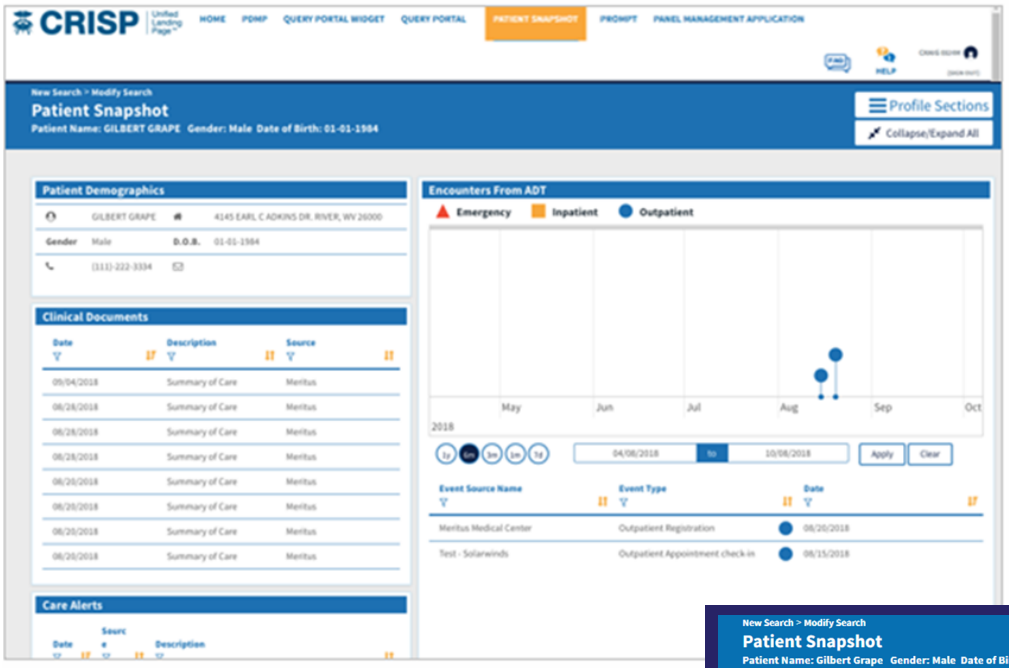
MYDIRECTIVES

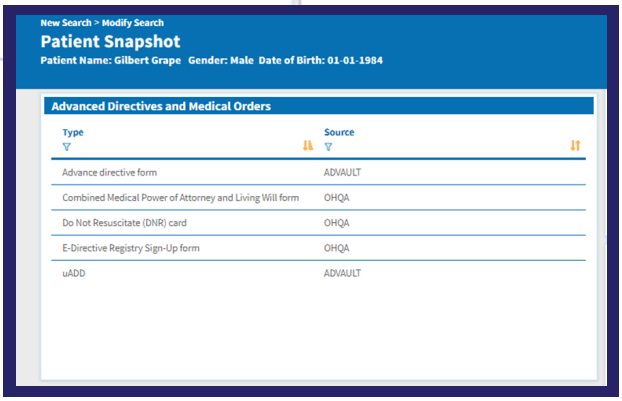
SEARCHING FOR A PATIENT'S ADVANCE DIRECTIVE ON CRISP

Any advance directive in the MyDirectives system can be found in a patient's record in CRISP

<u>Accessing CRISP at the Point of Care</u>

1. To access CRISP at the Point of Care, navigate to the Unified Landing Page *(screenshot below)*





2. Go to Patient Snapshot and search for the Advance Directive

Advance Care Planning

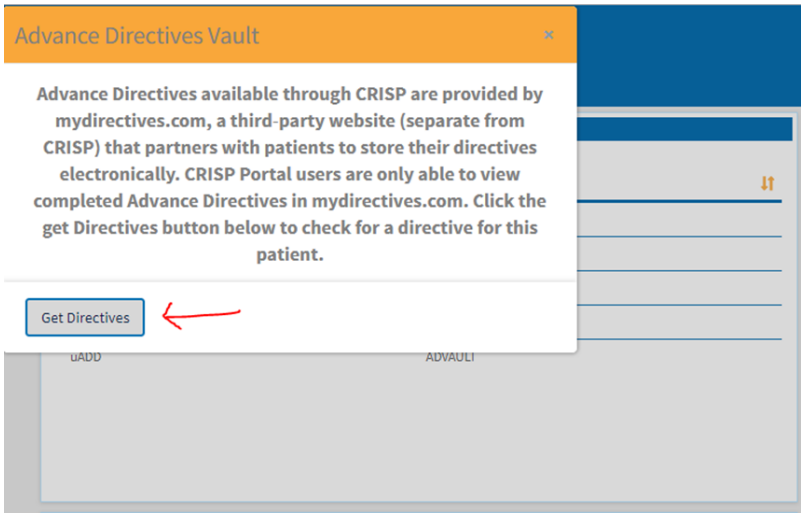
MYDIRECTIVES

SEARCHING FOR A PATIENT'S ADVANCE DIRECTIVE ON CRISP

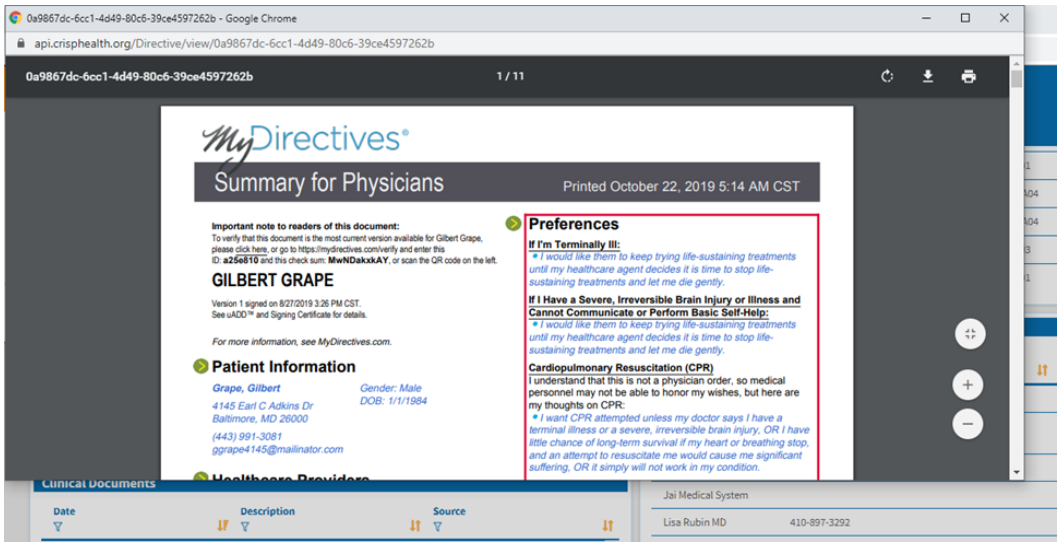
Any advance directive in the MyDirectives system can be found in a patient's record in CRISP

<u>Accessing CRISP at the Point of Care</u>

3 Click on the Directive you wish to view. A pop-up will appear— select "Get Directives"



4 A new window will appear with the Advance Directive



Advance Care Planning

RESOURCES

Below are general, statewide, and county-specific (where available) resources regarding advance care planning, including templates, fact sheets, videos, conversation starter kits, and points of contact. Health care providers can connect patients to these resources.

RESOURCE	DESCRIPTION	WHEN/HOW TO USE
general		
Common Practice's Hello Game	Hello is a conversation game about living, dying, and what matters most. Free download available online to play over video chat	Recommend this conversation game as a safe, easy, and fun way to talk about living, dying, and next steps
Five Wishes	Five Wishes changes the conversation around advance care planning by ensuring it is not just an end-of-life planning tool, but also the beginning of an important family conversation	Recommend this tool to allow the patient's family or caregiver to know exactly what you want, with respect to spiritual, legal, and medical wishes (all in one document)
The Conversation Project's Starter Kit	The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care	Use this starter kit to get thoughts together to have a conversation with loved ones
Medicare Learning Network Advance Care Planning (ACP) Fact Sheet	This resource includes information about provider and patient eligibility information, how to code ACP services, how to bill ACP services, and an example of ACP in practice	Utilize this resource for additional information regarding ACP services during Medicare Annual Wellness Visits (AWVs)
CDC Advance Care Planning: Ensuring Your Wishes Are Heard	This guide details end-of-life care planning, including advance directives, associated barriers, and the "hows" and "whys" of communicating these wishes	Use this guide to better understand advance care planning
statewide templates		
Maryland Office of the Attorney General Advance Directive Form	Download the advance directive from this website (in PDF and Word document form) to fill out and be printed. The form can be used to make healthcare choices	Patients can email to request for a printed copy to adforms@oag.state.md.us, call (410) 576-7000, or write to the Office of the Attorney General, Health Decisions Policy Division, 300 W. Preston Street, 3rd floor, Baltimore, MD 21201
Maryland Medical Orders for Life-Sustaining Treatment (MOLST) Form	The website has the Maryland MOLST order form and instructions, a healthcare decision making worksheet, and the law and regulations	Direct staff to this website to obtain the Maryland MOLST form

Advance Care Planning

RESOURCES

RESOURCE	DESCRIPTION	WHEN/HOW TO USE
other templates		
MyDirectives	MyDirectives makes it easy to create a state-of-the-art advance care plan for free	Provide patients this resource to help them create a digital advance care plan, name a healthcare agent and/or upload an existing document
county-level resources		
Alleghany County		
Adult Evaluation and Review Services (AERS)	AERS is the lead agency for the Senior Care Program and the National Family Caregiver Support program, and the AERS programs collaborate with various local and state agencies	Referrals are accepted from other agencies, clients, family, or other concerned individuals. For more information or to make a referral, call 301-759-5210
Anne Arundel County		
Anne Arundel Medical Center Resources	This website outlines details regarding advance medical directives	Direct patients to this resource to help them exercise their right to put their healthcare decisions in writing
Baltimore County		
GBMC Healthcare Advance Care Planning Video	This GBMC website outlines information on advance care planning	Send patients to this website for information on advance care planning and additional external resources
Calvert County		
Calvert Health Guide	This guide includes resources for planning ahead for major healthcare decisions	Use this guide for more information regarding oral directives, MOLSTs, and living wills
Carroll County		
Carroll & Frederick Counties Advance Care Planning Guide	Find out more about planning for health care in several topics	Use this resource when you would like more information regarding choosing a health care agent, writing an advance directive, and talking about advance care planning
Cecil County		
Center to Advance Palliative Care (CAPC) at Union Hospital, ChristianaCare	CAPC is participating in a state-wide palliative care collaborative and supporting the hospital with advance care planning assistance	Refer patients to CAPC for a palliative care social worker to perform advance care planning

MDPCP
MARYLAND PRIMARY CARE PROGRAM

Practice Resource

Advance Care Planning

RESOURCES

RESOURCE	DESCRIPTION	WHEN/HOW TO USE
Charles County		
Capital Caring Health	Capital Caring Health has teamed up with The Conversation Project to educate people on the value of making decisions about their own wishes for end-of-life care	Send Charles County patients the information for Capital Caring Health to assist with advance care planning efforts
Frederick County		
Carroll & Frederick Counties Advance Care Planning Guide	Find out more about planning for health care in several topics	Use this resource when you would like more information regarding choosing a health care agent, writing an advance directive, and talking about advance care planning
Frederick Health	Michelle Ross, LGSW, an Advance Care Planning Social Worker is available full-time to assist patients, families, staff, and community members with the advance care planning process	Call Michelle Ross, LFSW, at (240) 651-4541 or email mross@frederick.health
Garrett County		
Garrett County Community Action Committee	GCCAC offers information and assistance for seniors, including regarding long-term care services, health insurance, and more	Refer Garrett County patients to this resource for information and assistance
Harford County		
Healthy Harford	This website is a rich resource for information regarding advance care planning	Direct your Harford County patients to this resource for assistance with advance care planning
Howard County		
Speak(easy) Howard	Speak(easy) Howard is helping every adult in Howard County to name their health care agent and talk about their medical care preferences	Send Howard County patients here for tips on how to prepare in Howard County and for advice from local leaders
Montgomery County *(continued on next page)*		
Montgomery Hospice & Prince George's Hospice Advance Care Planning Resources	This website includes webinars, forms, and external resources regarding advance care planning	Refer your Montgomery County patients to this resource for assistance with advance care planning

Maryland
DEPARTMENT OF HEALTH

Advance Care Planning

RESOURCES

RESOURCE	DESCRIPTION	WHEN/HOW TO USE
Montgomery County *(continued)*		
Voice Your Choice	A community-based program of Nexus Montgomery that promotes advance care planning through training, education, and public awareness	Provide this resource patients to empower them to have a say in their care if they are unable to speak for themselves
Montgomery County Palliative Care & End of Life Coalition	This website includes local resources for organizations that offer workshops, online resources and tools, and ACP storage options	Provide this resource to Montgomery County patients for assistance regarding end-of-life resources
Prince George's County		
Montgomery Hospice & Prince George's Hospice Advance Care Planning Resources	This website includes webinars, forms, and external resources regarding advance care planning	Refer your Prince George's County patients to this resource for assistance with advance care planning
St. Mary's County		
St. Mary's County Health Dept. Resources	The St. Mary's County Health Dept. offers a variety of community and clinical services that supports the health of aging adults and seniors	Utilize this resource for aging adults and seniors who would like more information, like: adult evaluation and review services, personal care programs, and active living
Talbot County		
Talbot Conversations: Make Your End-of-Life Wishes Known	A pledge form, a Conversation Starter Kit, and Advance Directive paperwork are included to help patients participate in Talbot Conversations	Send patients over to this Talbot Hospice resource for assistance with advance care planning. Contact (410) 822-6681 for questions or concerns
Washington County		
Hospice of Washington County: Making Healthcare Decisions	Hospice of Washington County wants to ensure that the community is knowledgeable and able to make good, informed decisions about end-of-life care	Refer Washington County patients to this resource for assistance, professional support, and expertise