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Maryland Primary Care Program

Advance Care Planning and COVID-19

Program Management Office

May 21, 2020

Agenda

- Review Care Transformation Requirements for Track 2 related to Beneficiary and Caregiver Experience
- Discuss the importance of Advance Care Planning
- Identify considerations for implementing Advance Care Planning at your practice
- Share an example of a practice workflow
- Learn how to access Advance Directives in CRISP Unified Landing Page (ULP)
- Provide Advance Care Planning resources

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Beneficiary and Caregiver Experience

Track 1

- Convene a Patient-Family Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities

Track 2 (all of the above, plus)

- Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning

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MDPCP Requirements

- Track 2 Practices are required to:
  - Provide advance care planning services to attributed beneficiaries and caregivers
  - Engage patients and their caregivers in this process in a collaborative manner
- Track 1 Practices also encouraged to implement advance care planning into workflows

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Introduction

Advance Care Planning

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Definitions - 1

Advance Directive:

This is a legal document, not a medical order. Because it is not a medical order, it is not used to help doctors, emergency medical technicians, or hospitals treat you in an emergency situation.

- **Living Will:** General guidance about what treatment an individual would or would not want
- **Health Care Agent**: *Sometimes called a "medical (or healthcare) power of attorney" or "medical proxy"*
  - A specific person may be designated to make decisions for you when you are unable to do so
  - Usually part of the Advance Directive, but is sometimes a separate document because it may be broader than just healthcare decisions

Source: Maryland Attorney General

Definitions - 2

Medical Orders for Life-Sustaining Treatment (MOLST): *Also known as DNR (Do Not Resuscitate) Order*

- This document is a medical order signed by a medical professional* and used for treatment.
- It is generally used when the patient is nearing the end of life, such as with a terminal illness or seriously ill.
- This does not name a "health care agent"
- This document would be used together with the Living Will/Advance Directive to guide doctors in the event that the individual is unable to make his/her own decisions.

*includes physicians assistants, interns, and residents

Source: Maryland Attorney General

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Why focus on Advance Care Planning?

- Life-threatening illness is a difficult subject to deal with
- Unexpected end-of-life situations can happen to anyone at any age therefore it is important for everyone to prepare an advance directive
- You can get the medical care you desire while relieving loved ones of making major medical decisions during moments of grief or crisis
- Advance Care Planning help reduce confusion and disagreements about medical care
- Having an Advance Care Plan in place ensures that your wishes regarding your health care are carried out, even when you're unable to make your wishes known
- You may also plan for other arrangements including organ donation after death

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ACP for medical care is key, especially under COVID-19

- Treatments and a vaccine against COVID-19 are only in development
- Early conversations with patients can improve the quality of care
- Advance care planning often happens too late in a disease course
- Primary care teams have longitudinal relationship, ideal to work with patients on their end-of-life preferences
- Advance Directives are advised
- MOLST covers options for cardiopulmonary resuscitation and other life-sustaining treatments and is required for a range of patients (e.g. assisted living, nursing homes, dialysis, hospice, etc.)

Steps to Implement

Advance Care Planning

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Considerations when Implementing - 1

- Advance Care Planning can occur at any time
- Some patients may have existing documents (e.g. Advance Directive, Health Care Agent)
- Over time, as the patient ages and conditions change, these documents may all need to evolve to accommodate these changing circumstances
- When scheduling the appointment, ask patients to bring any of these relevant documents with them to serve as a guide during the ACP discussion with the physician
- Store these documents as part of the medical record

Considerations when Implementing - 2

- Use a standard format to guide the discussion
- Although it is important to document wishes during an initial discussion, it is not intended to be a one-time decision. As a patient moves from hypothetical to actual health status changes, ACP becomes an ongoing process that needs periodic review.
- After the initial planning appointment, an annual review of the ACP can help guide plans as patient conditions and/or attitudes change
- Individuals with residences in multiple states may wish to have advance directives in each state

Workflow Example (PharmD and ACP)

Scheduling & Pre-Visit

- Search for patients that have an upcoming AWV who are at high risk and don't have an ACP in the chart
- Check to see in the chart if there is an existing ACP or if they already have an appointment with the Pharmacist
- Call the patients who need an AWV and discuss the importance of ACP, advise patients to bring any existing ACP documents

Annual Wellness Visit

- Patient receives copy of ACP form at check-in
- Pharmacist reviews medications and has ACP conversation prior to AWV with Provider; advises patient that ACP on same day as AWV will be covered by Medicare
- Order created in encounter
- ACP template in Medical History
- ACP documents given to patient
- Completed documents uploaded and attach to order
- Schedule follow up

Post-Visit & Loop Closure

- Follow up on no-show visits to reschedule
- Update Care Plan with issues/topics discussed at ACP visit
- Upload documents and attach to order and update ACP template in Medical History PRN
- Call patients back to follow up on open ACP orders
- Advise patient that there is always the option to come in to see Pharmacist for ACP assistance

(Courtesy of Centennial Medical Group)

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A Physician's Guide to Talking about End-of-Life Care

Step 1: Initiating discussion

- Establish a support relationship with patient and family
- Appoint a surrogate decision maker
- Elicit general thoughts about end-of-life preferences. Go beyond stock phrases with probing questions.

Step 2: Clarifying prognosis

- Be direct, yet caring
- Be truthful, but sustain spirit
- Use simple everyday language

Step 3: Identifying end-of-life goals

- Facilitate open discussion about desired medical care and remaining life goals
- Recognize that as death nears most patients share similar goals: maximizing time with family and friends, avoiding hospitalization and unnecessary procedures, maintaining functionality, and minimizing pain

Step 4: Identifying end-of-life goals

- Provide guidance in understanding medical options
- Make recommendations regarding appropriate treatment
- Clarify resuscitation orders
- Initiate timely palliative care, when appropriate

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Medicare Billing for Advance Care Planning

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. (List separately in addition to code for primary procedure.)

When Advance Care Planning services occur at the same time as the Annual Wellness Visit (AWV):	**When Advance Care Planning services occur during another visit (such as E&M, CCM, or TCM):**
• Bill using modifier -33 • No Part B coinsurance or deductible (consistent with the AWV)	• Cost sharing (copay/deductible) applies as for other physicians' services

Source: American College of Physicians

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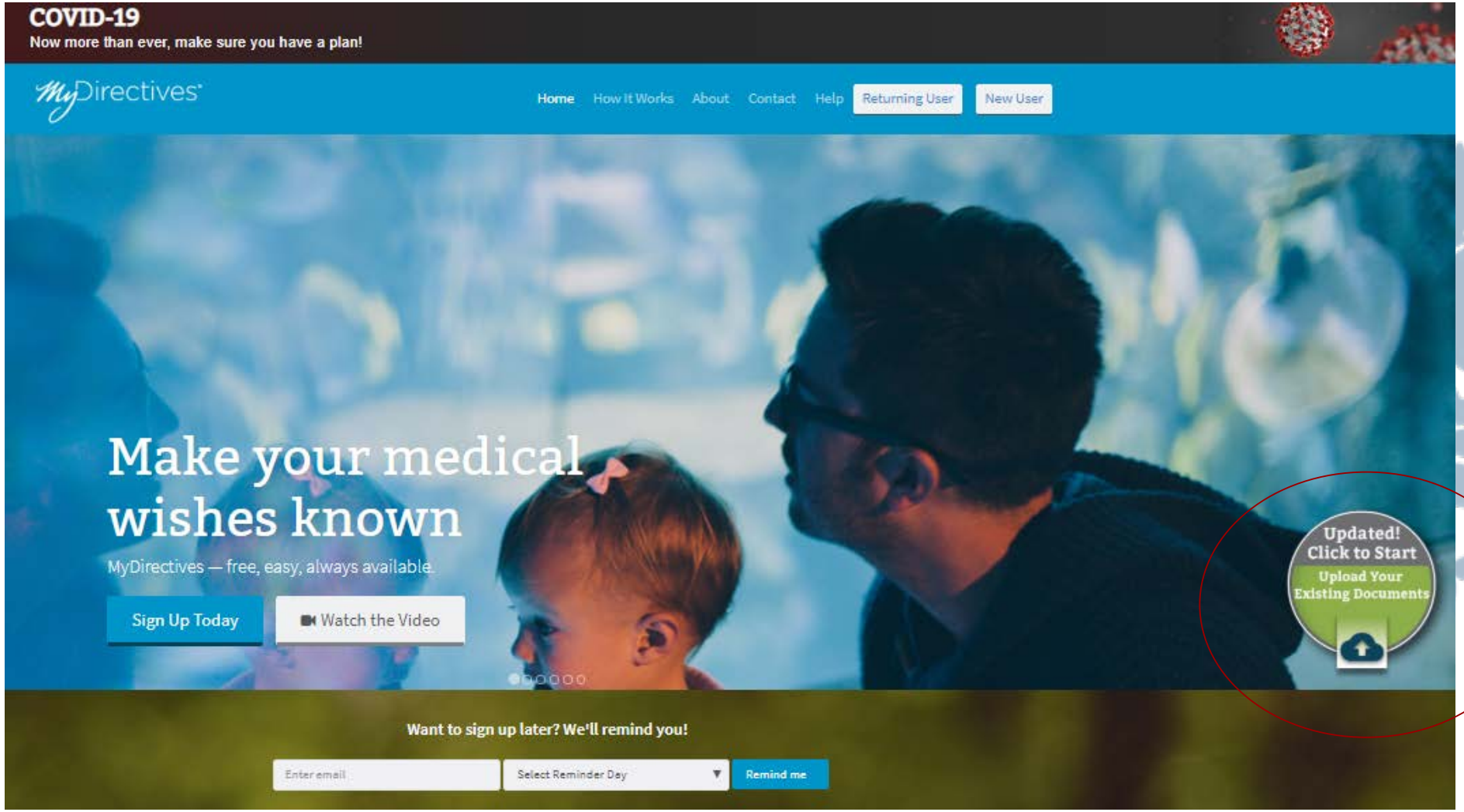
Using CRISP for Advance Care Planning

7160 Columbia Gateway Drive, Suite. 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Agenda

1. Consumer Perspective
2. Provider Perspective: Advance Care Plan Connectivity within CRISP
3. Opportunity: Building ACP into provider's workflow
    1. What the Providers see in CRISP

Consumer Perspective: Creating or Saving an Electronic Advance Directive



www.mydirectives.com

How do Advance Directives Get to CRISP?

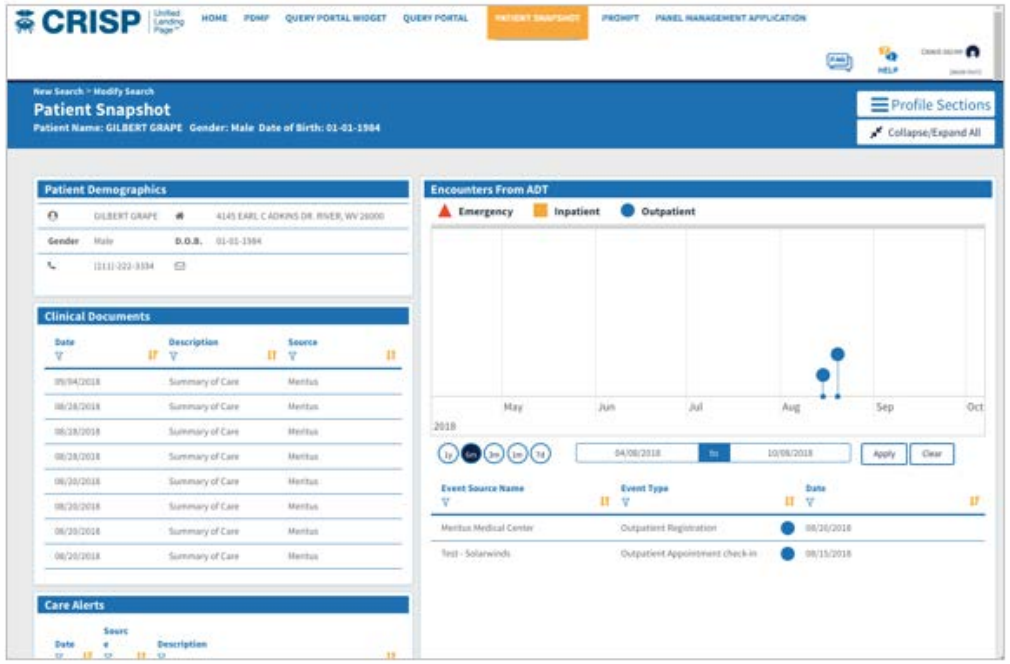
- They never actually get to CRISP
- CRISP is notified by MyDirectives when a Maryland consumer has uploaded (or created) an Advance Directive on MyDirectives.com
- CRISP does not store Advance Directives

How does User Access CRISP at the Point of Care?

EITHER

Unified Landing Page

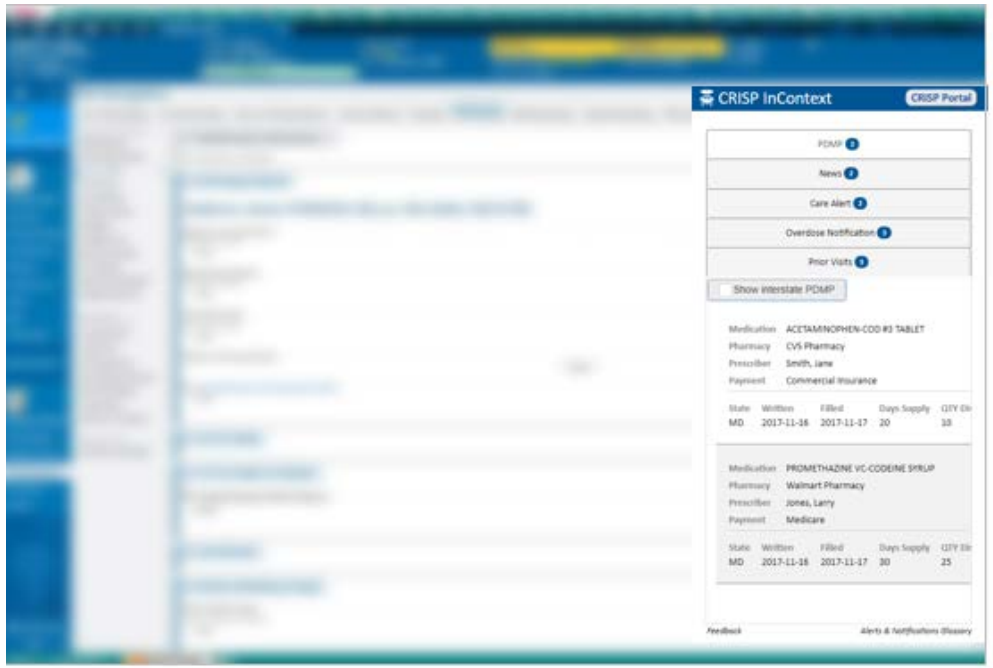
(CRISP Portal via new browser window)



OR

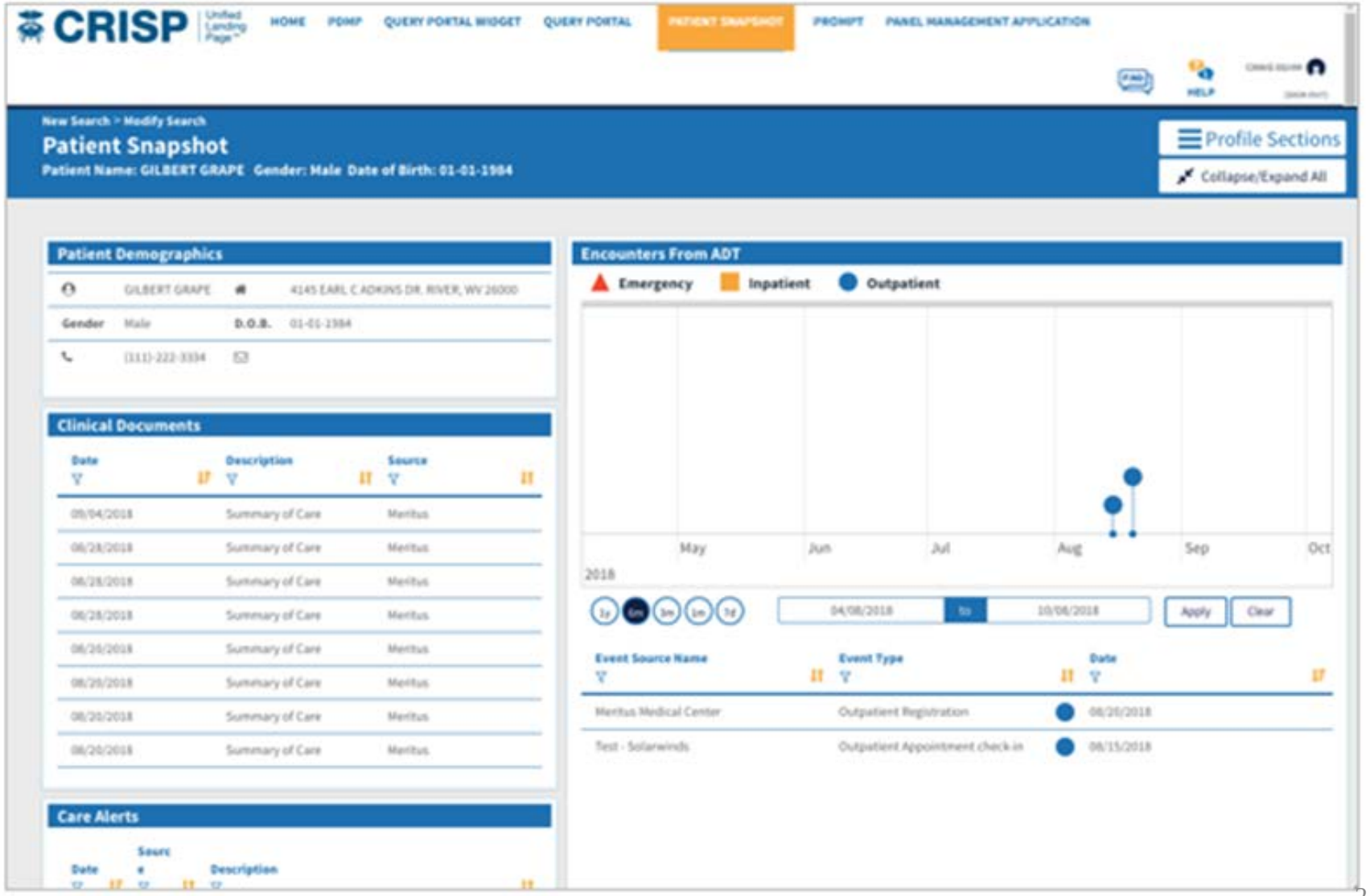
In-Context

(Single Sign-On Directly from EMR)



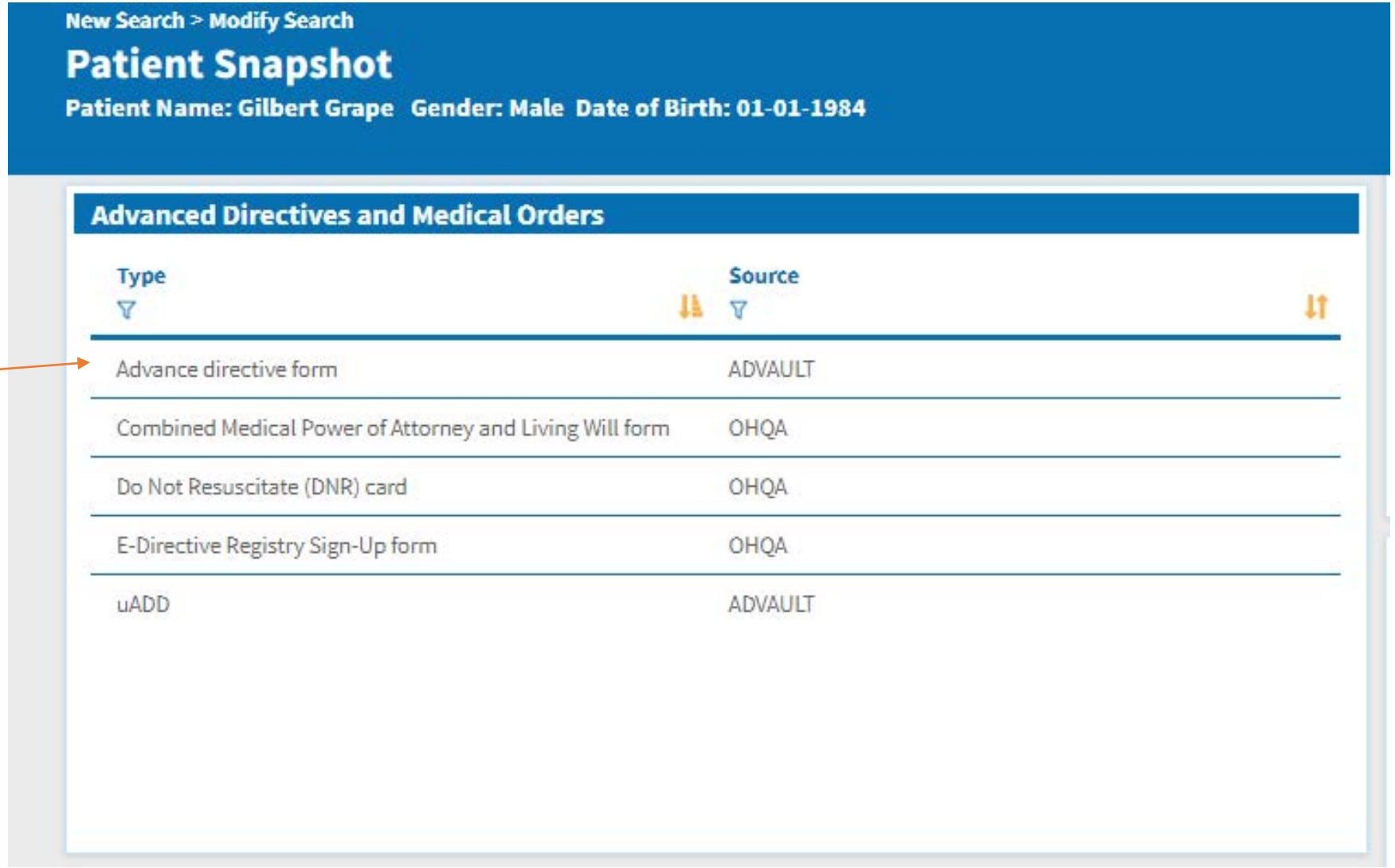
Unified Landing Page Access to Advance Directives (1)

1. Logon to ULP (https://ulp.crisphealth.org/)
2. Search for Patient
3. Patient Snapshot (shown here)



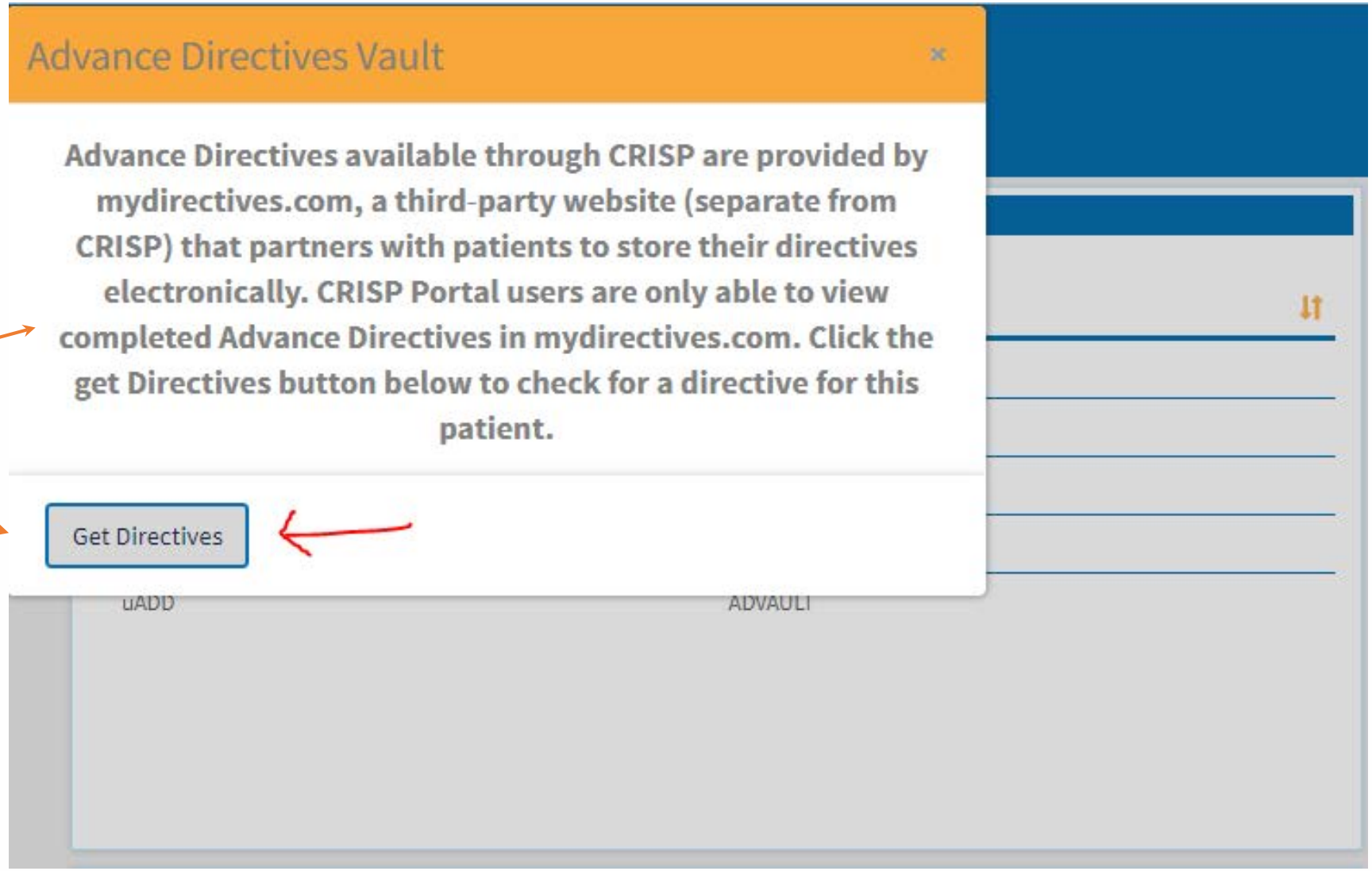
Unified Landing Page Access to Advance Directives (2)

4. Search for Advance Directive



Unified Landing Page Access to Advance Directives (3)

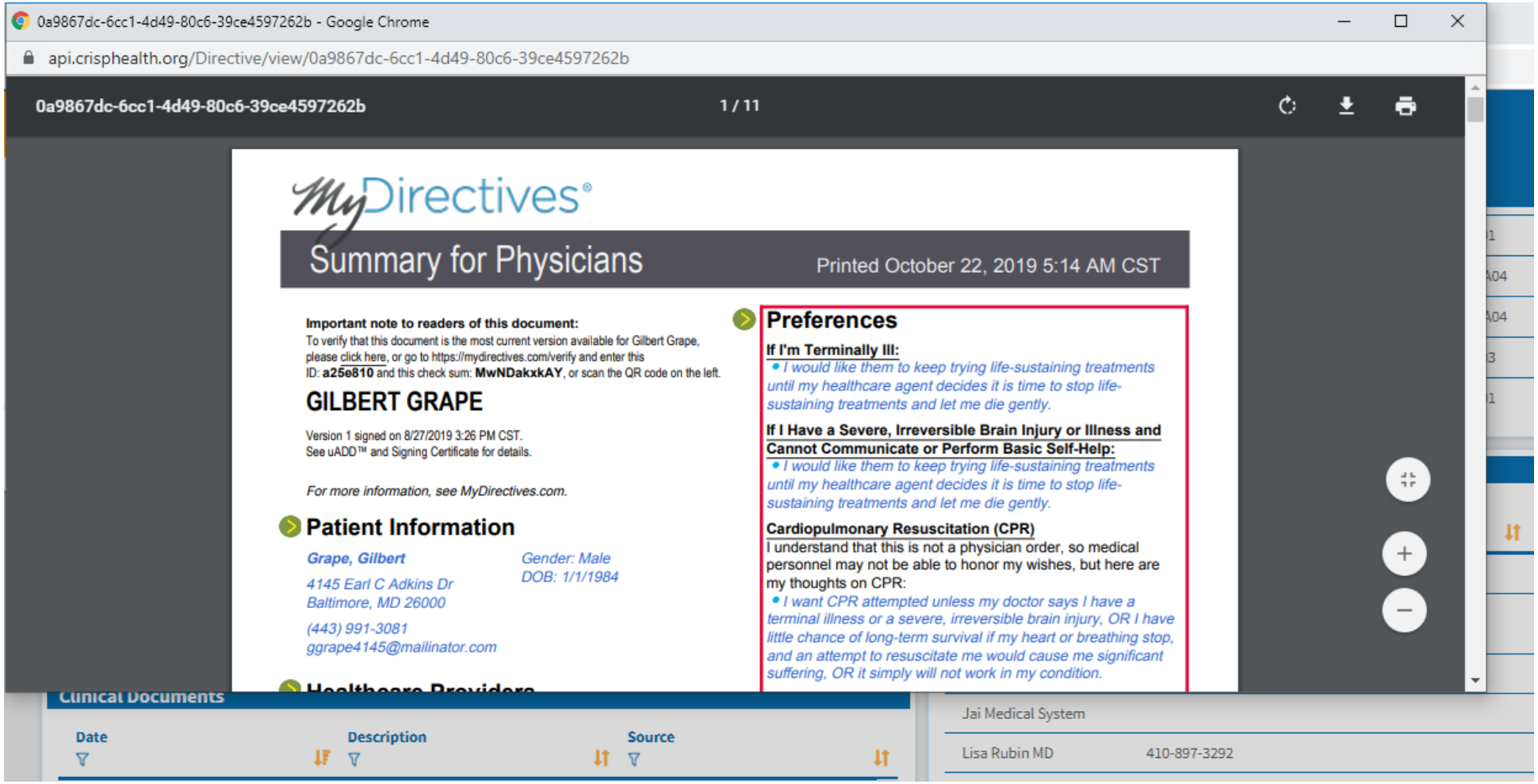
5. Click on the Directive you want to see.
6. A pop up appears.
7. Click on Get Directives.



Unified Landing Page Access to Advance Directives (4)

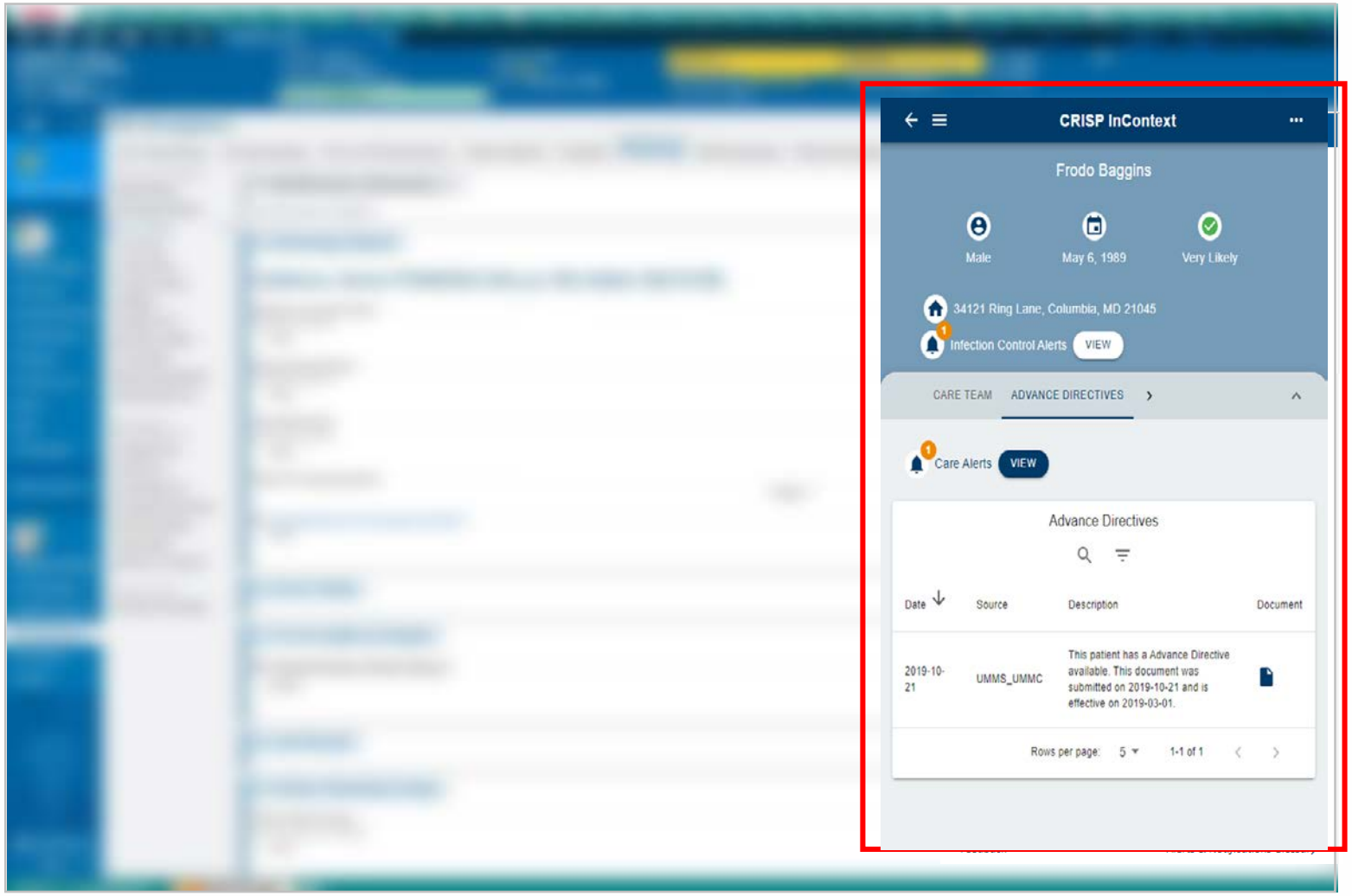
8. A new window will open with the directive

- NOTE: viewing of AD is done on the MyDirectives website



In-Context (SSO) Access to Advance Directives (1)

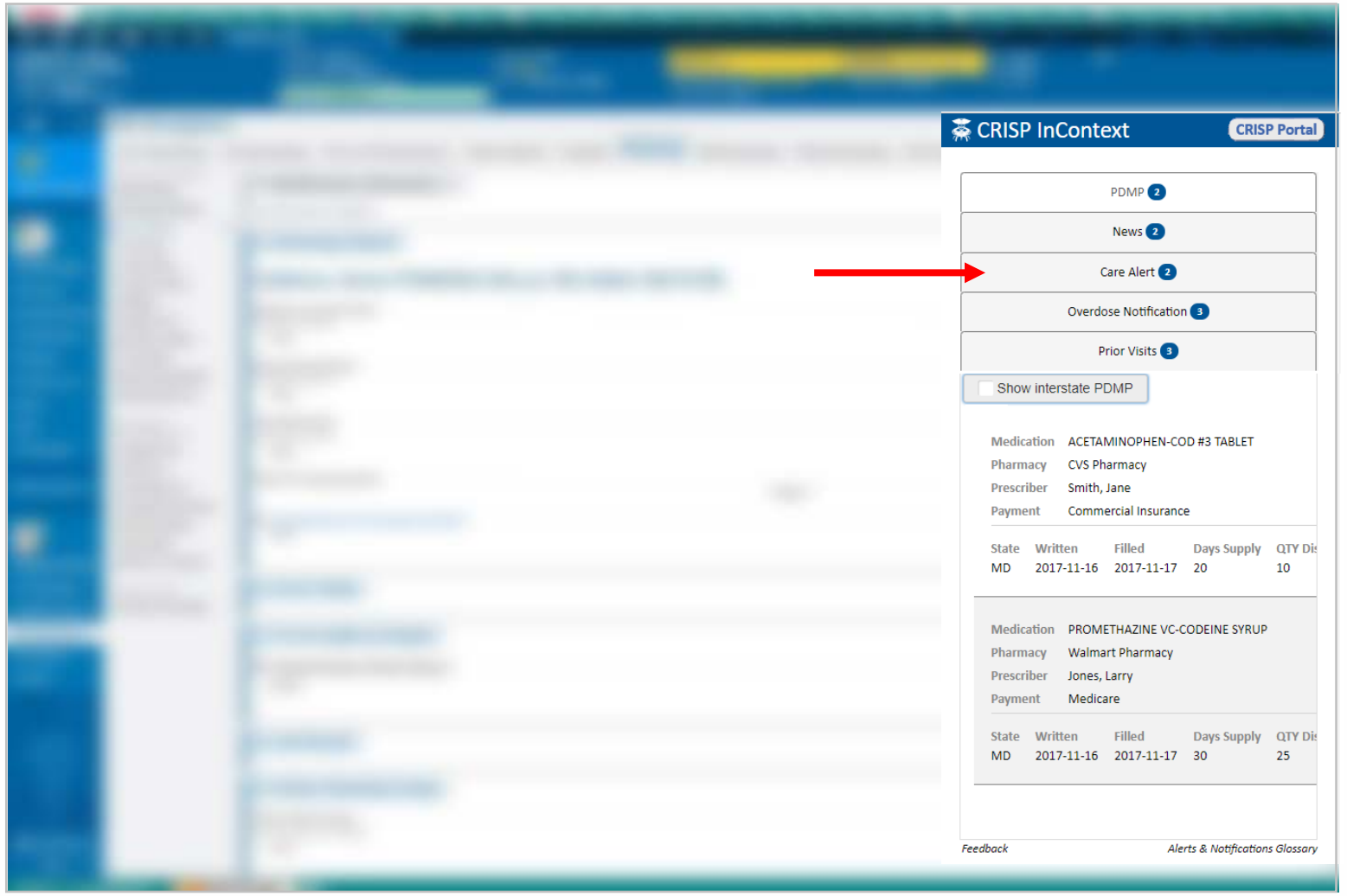
1. Provider opens EHR to patient chart
- App can be configured to be always available (shown on right side of screen)
- App can launch on the click of a button



In-Context (SSO) Access to Advance Directives (2)

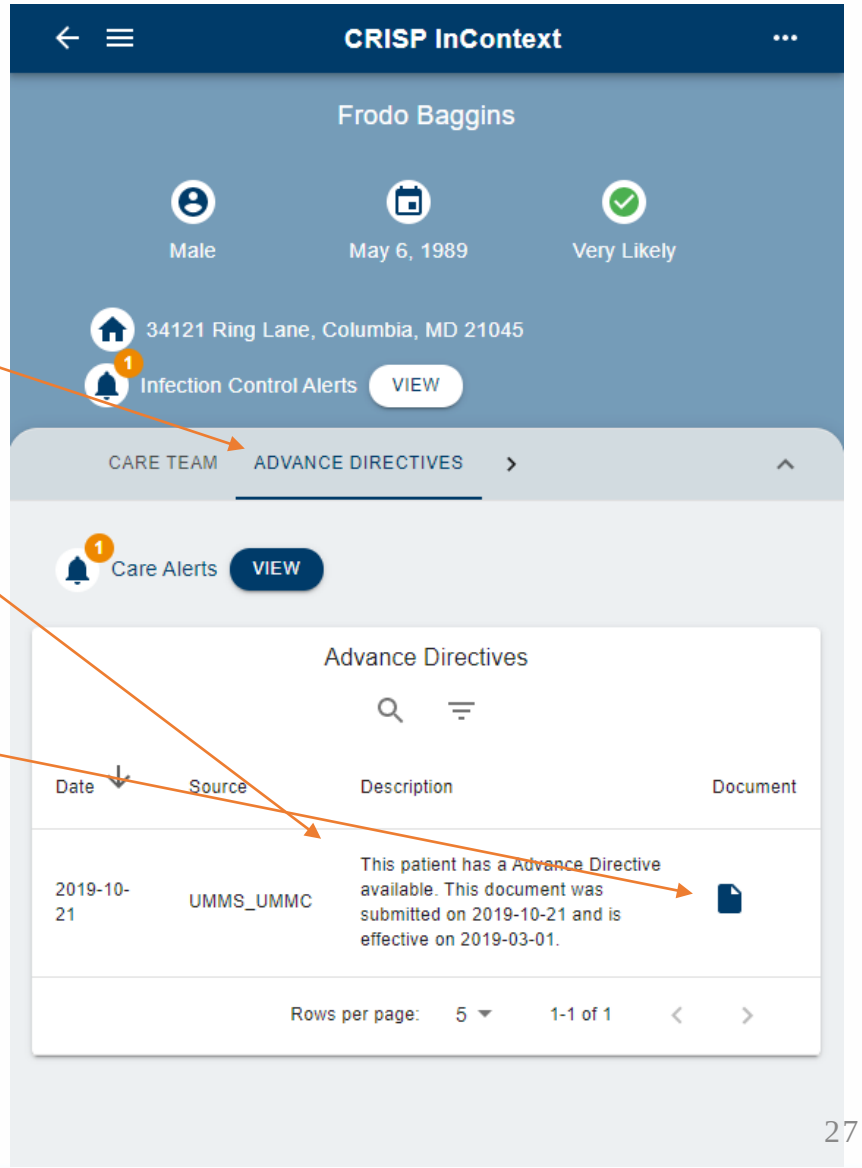
2. Different tabs can be selected in the app to view:

- PDMP for eligible users
- Overdose Events
- Care Alerts
- Prior Visits
- Care Teams and Programs
- Advance Directives



In-Context (SSO) Access to Advance Directives (3)

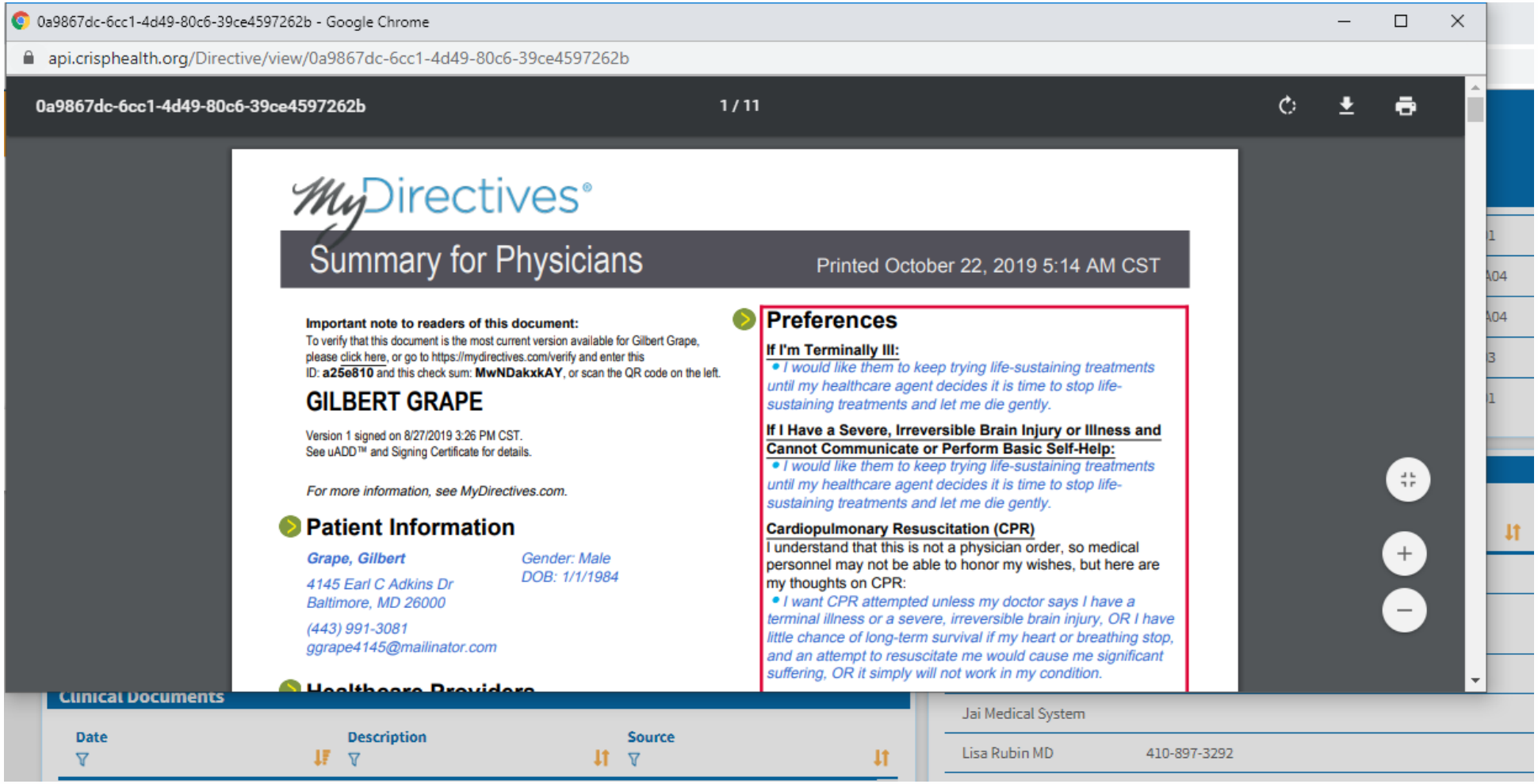
3. User clicks “Advance Directives” tab
4. Tab expands to notify user if patient has electronic AD on file with ADVault
5. Click on “Document”



In-Context (SSO) Access to Advance Directives (4)

6. A new window will open with the directive

- NOTE: viewing of AD is done on the MyDirectives website



Who's Doing it Now?

- **Howard County General Hospital**
  - Advance Care Planning Coordinator funded by Horizon Foundation grant, part of Speak(easy) Howard
- **Anne Arundel Medical Center**
  - Advance Care Planning Coordinator
- **Nexus Montgomery Regional Transformation Partnership**
  - 6 hospitals in Montgomery County have contracted with JSSA to create Voice Your Choice
  - Voice Your Choice website

Resources

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Resources - Conversation Starters

- The Conversation Project by Institute for Healthcare Improvement (IHI)
  - Conversation guide during COVID-19
  - COVID-19 resources
- How to Talk to Your Patients about End of Life Care (IHI)
- Courageous Conversations by Jennifer Collins Taylor
- *Hello* Conversation Starters Game
  - JAMA article 5/8/20 - study with African American participants (less than 25% have completed an advance directive)
    - After the intervention, 91 of 220 attendees (41%) completed a new advance directive
    - 176 of 220 attendees (80%) discussed end-of-life wishes with loved ones
    - 214 of 219 attendees (98%) completed at least 1 ACP behavior
- What are the Components of Optimal End of Life Care? Video by IHI (2 minutes)
- A Physician's Guide to Talking about End-of-Life Care

Resources - Advance Care Planning

FREE Intro to Advance Care Planning Course (CDC)

Advance Care Planning (ACP) Fact Sheet by Medicare Learning Network

- Provider and patient eligibility information
- How to code ACP services
- How to bill ACP services
- An example of ACP in practice
- Resources

Medicare Billing FAQs

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Resources - Advance Directives

Maryland Office of Attorney General: A Guide to Maryland Law and Health Care Decisions

- Free forms included
- Guide includes FAQs

Aging with Dignity: Five Wishes Conversation Guide for Clinicians (12 Pages)

- When to have Five Wishes conversations
- How to start the conversation
- Tips and recommendations for discussions on each of the five areas covered
- Suggested language for Five Wishes conversations
- Advance Care Planning checklist
- Guide for selecting the most appropriate advance care planning document
- Available for $2-$5 each in 28 languages either in paper form or an online version

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Resources - MOLST

Maryland's Medical Order for Life Sustaining Treatment (MOLST) Training Task Force:
Made up of more than 70 organizations, associations, facilities, providers, professionals, and consumers. The members shared their knowledge, skills, experience, and time to develop and review the Maryland MOLST form and instructions, training tools, and Train the Trainer program.

- MOLST Forms and Regulations including Health Care Decision Making Worksheet
- Tools for Health Care Professionals
- Guide for Health Care Professionals (Detailed guide, 45 pages)
- FAQs (Frequently asked questions about the Maryland MOLST order form and related processes including issues related to Maryland's EMS System, 15 Pages)
- Resources (links to other organizations)
- Training to health care professionals and the public: Request a presentation from Certified Maryland MOLST Trainers (CMMT)

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Resources - Mental Health

MDH Behavioral Health Administration

Advance Directive for Mental Health Treatment **Form**

- Provides the chance to take part in a major way in your own mental health care decisions when not able to and allows you to express your consent or refusal to medications for your mental illness and other health care decisions, including use of seclusion and restraints
- Please know that Maryland law allows a healthcare provider to override your refusal for medication for a mental disorder in limited situations if you are involuntarily committed to a psychiatric hospital

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Key Points

- Advance Care Planning (ACP) is a requirement for Track 2 in MDPCP
- ACP can occur at any time and conversations will be tailored to each patient (e.g. average healthy person versus person advanced illness)
- Having this discussion early with your patients can help with ensuring that your patients' wishes are heard
- If patients have any legal questions about their own personal situation, please advise to consult with their own attorney
- Advance Directives and MOLSTs are different and they serve as important tools in ACP
- There are several free resources online and in the community to assist you
- Providing ACP services to your patients is reimbursed by Medicare
- CRISP and MyDirectives technology allow you to access patient Advance Directives 24/7 and securely online

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Thank you!

Contact your Practice Coach if you have any additional questions or would like more information

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