



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

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

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

Introduction

Advance Care Planning

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

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

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

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

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

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

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):
<ul style="list-style-type: none">• Bill using modifier -33• No Part B coinsurance or deductible (consistent with the AWV)	<ul style="list-style-type: none">• Cost sharing (copay/deductible) applies as for other physicians' services



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

COVID-19
Now more than ever, make sure you have a plan!

MyDirectives
Home How It Works About Contact Help [Returning User](#) [New User](#)

Make your medical wishes known

MyDirectives — free, easy, always available.

[Sign Up Today](#) [Watch the Video](#)

Updated! Click to Start
Upload Your Existing Documents

Want to sign up later? We'll remind you!

Enter email: Select Reminder Day: [Remind me](#)

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)

The screenshot shows the CRISP Unified Landing Page for a patient named GILBERT GRAPE. The page is divided into several sections:

- Header:** CRISP logo, navigation links (HOME, PDMP, QUERY PORTAL WIDGET, QUERY PORTAL, MEDICAL TRANSCRIPTION, PROWPT, PANEL MANAGEMENT APPLICATION), and user profile (DANIEL BROWN).
- Patient Snapshot:** Patient Name: GILBERT GRAPE, Gender: Male, Date of Birth: 01-01-1964.
- Patient Demographics:** GILBERT GRAPE, 4145 EARL C ADKINS DR. RIVER, WV 26000, Gender: Male, D.O.B.: 01-01-1964, Phone: (301) 322-3334.
- Clinical Documents:** Table with columns: Date, Description, Source. Rows show Summary of Care documents from Meritus dated 08/04/2018 to 08/20/2018.
- Care Alerts:** Table with columns: Date, Source, Description. Rows show alerts from 07/17 to 07/22.
- Encounters From ADT:** Filtered by Outpatient. Shows a timeline from May to October 2018. A table below lists events: Meritus Medical Center (Outpatient Registration on 08/20/2018) and Test - Solarwinds (Outpatient Appointment check-in on 08/15/2018).

OR

In-Context

(Single Sign-On Directly from EMR)

The screenshot shows the CRISP InContext interface overlaid on an EMR screen. The interface includes:

- Header:** CRISP InContext logo and CRISP Portal link.
- Navigation:** Links for PDMP, News, Care Alert, Overdose Notification, and Prior Visits.
- Medication:** ACETAMINOPHEN-COD #3 TABLET, Pharmacy: CVS Pharmacy, Prescriber: Smith, Jane, Payment: Commercial Insurance.
- Table:** Columns: State, Written, Filed, Days Supply, QTY. Row: MD, 2017-11-16, 2017-11-17, 20, 33.
- Medication:** PROMETHAZINE VC-CODEINE SR/LP, Pharmacy: Walmart Pharmacy, Prescriber: Jones, Larry, Payment: Medicare.
- Table:** Columns: State, Written, Filed, Days Supply, QTY. Row: MD, 2017-11-16, 2017-11-17, 30, 25.
- Footer:** Feedback and Alerts & Notifications (Biossary).



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)

The screenshot displays the CRISP Patient Snapshot interface. The top navigation bar includes links for HOME, PDMP, QUERY PORTAL WIDGET, QUERY PORTAL, PATIENT SNAPSHOT (highlighted), PROMPT, and PANEL MANAGEMENT APPLICATION. The patient's name, GILBERT GRAPE, and demographic information (Male, DOB: 01-01-1984) are shown at the top. The main content area is divided into three sections: Patient Demographics, Clinical Documents, and Encounters From ADT.

Patient Demographics

NAME	GILBERT GRAPE	ADDRESS	4145 EARL C ADKINS DR. RIVER, WV 26000
GENDER	Male	D.O.B.	01-01-1984
PHONE	(311)-222-8334		

Clinical Documents

Date	Description	Source
08/04/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus
08/28/2018	Summary of Care	Meritus

Encounters From ADT

Emergency Inpatient Outpatient

May Jun Jul Aug Sep Oct 2018

04/08/2018 to 10/08/2018 Apply Clear

Event Source Name	Event Type	Date
Meritus Medical Center	Outpatient Registration	08/28/2018
Test - Solarwinds	Outpatient Appointment check in	08/15/2018



Unified Landing Page Access to Advance Directives (2)

4. Search for Advance Directive

New Search > Modify Search

Patient Snapshot

Patient Name: Gilbert Grape Gender: Male Date of Birth: 01-01-1984

Advanced Directives and Medical Orders

Type	Source
Advance directive form	ADVAULT
Combined Medical Power of Attorney and Living Will form	OHQA
Do Not Resuscitate (DNR) card	OHQA
E-Directive Registry Sign-Up form	OHQA
uADD	ADVAULT



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.

Advance Directives Vault

Advance Directives available through CRISP are provided by mydirectives.com, a third-party website (separate from CRISP) that partners with patients to store their directives electronically. CRISP Portal users are only able to view completed Advance Directives in mydirectives.com. Click the get Directives button below to check for a directive for this patient.

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

0a9867dc-6cc1-4d49-80c6-39ce4597262b - Google Chrome

api.crisphealth.org/Directive/view/0a9867dc-6cc1-4d49-80c6-39ce4597262b

0a9867dc-6cc1-4d49-80c6-39ce4597262b 1 / 11

MyDirectives®

Summary for Physicians

Printed October 22, 2019 5:14 AM CST

Important note to readers of this document:
To verify that this document is the most current version available for Gilbert Grape, please click here, or go to <https://mydirectives.com/verify> and enter this ID: **a25e810** and this check sum: **MwNDakxxAY**, or scan the QR code on the left.

GILBERT GRAPE

Version 1 signed on 8/27/2019 3:26 PM CST.
See uADD™ and Signing Certificate for details.

For more information, see MyDirectives.com.

Patient Information

Grape, Gilbert Gender: Male
4145 Earl C Adkins Dr DOB: 1/1/1984
Baltimore, MD 26000
(443) 991-3081
ggrape4145@maillinator.com

Preferences

If I'm Terminally Ill:
• I would like them to keep trying life-sustaining treatments until my healthcare agent decides it is time to stop life-sustaining treatments and let me die gently.

If I Have a Severe, Irreversible Brain Injury or Illness and Cannot Communicate or Perform Basic Self-Help:
• I would like them to keep trying life-sustaining treatments until my healthcare agent decides it is time to stop life-sustaining treatments and let me die gently.

Cardiopulmonary Resuscitation (CPR)
I understand that this is not a physician order, so medical personnel may not be able to honor my wishes, but here are my thoughts on CPR:
• I want CPR attempted unless my doctor says I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.

Clinical Documents

Date	Description	Source

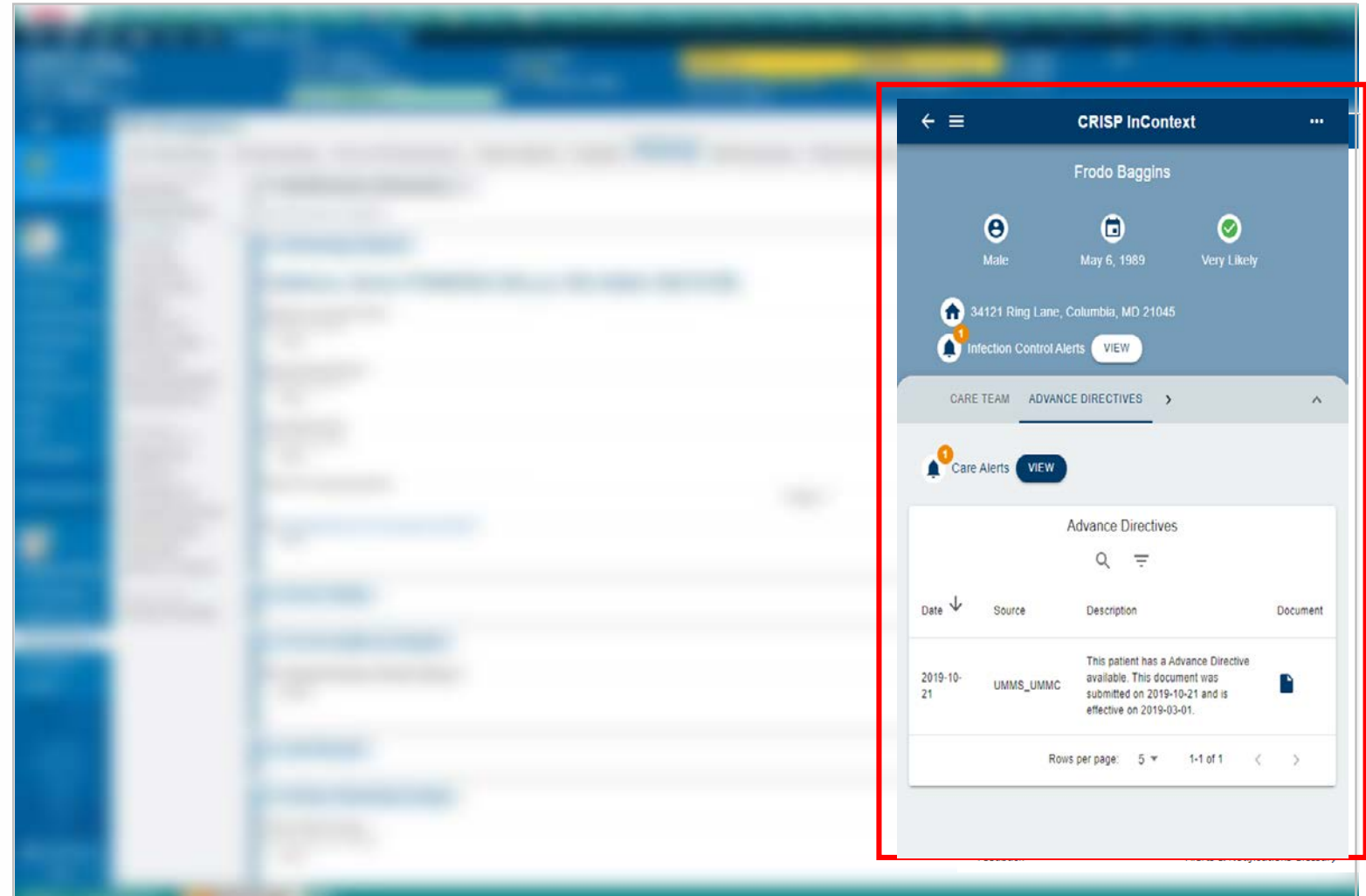
Jai Medical System

Lisa Rubin MD 410-897-3292



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**

The screenshot shows the CRISP InContext app interface. On the right side, there is a vertical list of tabs: PDMP (2), News (2), Care Alert (2), Overdose Notification (3), and Prior Visits (3). A red arrow points to the 'Care Alert' tab. Below the tabs is a toggle switch labeled 'Show interstate PDMP'. Below that, there are two medication records. The first record is for ACETAMINOPHEN-COD #3 TABLET, prescribed by Smith, Jane at CVS Pharmacy. The second record is for PROMETHAZINE VC-CODEINE SYRUP, prescribed by Jones, Larry at Walmart Pharmacy. At the bottom of the screen, there are links for 'Feedback' and 'Alerts & Notifications Glossary'.

Medication	Pharmacy	Prescriber	Payment
ACETAMINOPHEN-COD #3 TABLET	CVS Pharmacy	Smith, Jane	Commercial Insurance
PROMETHAZINE VC-CODEINE SYRUP	Walmart Pharmacy	Jones, Larry	Medicare

State	Written	Filled	Days Supply	QTY Dispensed
MD	2017-11-16	2017-11-17	20	10
MD	2017-11-16	2017-11-17	30	25



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”

The screenshot displays the CRISP InContext mobile application interface. At the top, the patient's name "Frodo Baggins" is shown. Below this, there are three icons: a person icon labeled "Male", a calendar icon labeled "May 6, 1989", and a checkmark icon labeled "Very Likely". Further down, the address "34121 Ring Lane, Columbia, MD 21045" is listed. A notification for "Infection Control Alerts" with a "VIEW" button is present. The "ADVANCE DIRECTIVES" tab is selected and expanded, showing a "CARE ALERTS" section with a "VIEW" button. Below this, a table titled "Advance Directives" is displayed. The table has columns for "Date", "Source", "Description", and "Document". A single row is visible, showing a date of "2019-10-21", a source of "UMMS_UMMC", and a description stating: "This patient has a Advance Directive available. This document was submitted on 2019-10-21 and is effective on 2019-03-01." A document icon is shown in the "Document" column. At the bottom of the table, there is a pagination bar indicating "Rows per page: 5" and "1-1 of 1".

Date	Source	Description	Document
2019-10-21	UMMS_UMMC	This patient has a Advance Directive available. This document was submitted on 2019-10-21 and is effective on 2019-03-01.	



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

0a9867dc-6cc1-4d49-80c6-39ce4597262b - Google Chrome

api.crisphealth.org/Directive/view/0a9867dc-6cc1-4d49-80c6-39ce4597262b

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Clinical Documents

Date	Description	Source

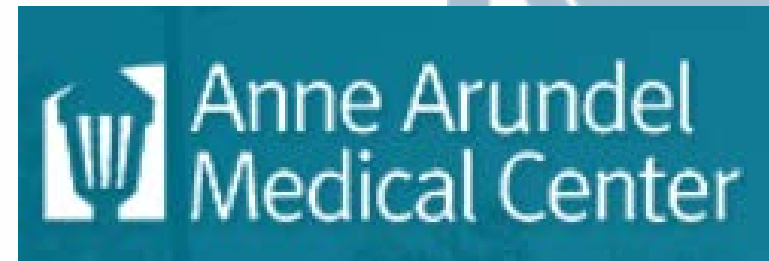
Jai Medical System

Lisa Rubin MD 410-897-3292



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

Advance Care Planning

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](#)

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

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)

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

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

Thank you!



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