



Advanced Care Planning

This care pathway is intended to provide guidance for Penn State Health and affiliated providers for the evaluation and implementation of Advanced Care Planning (ACP). The guidance provided in this document is driven-by evidence-based standards. This document provides an approach applicable for most patients; however, providers should use clinical judgement and adapt to individual patients and situations.

BACKGROUND

Advance care planning is a process that allows patients and their families to document what they do and do not want when it comes to their health care. ACP increases patient satisfaction, and leads to reduced stress, anxiety, and depression in patients and families.¹ ACP also leads to decreased hospital admissions and in-hospital deaths, and increases the quality of end-of-life care.^{1,2} However, less than 10% and 30% of patients in Penn State Health outpatient and inpatient settings, respectively, have an advance directive on file. Having an advance directive documented in the EMR for a patient is a great step, but that only represents the patient’s feelings at one point in time. Those wishes likely change as people age, in response to illness, and as disease trajectory changes. We can help to align patient care with their wishes by engaging patients in ACP discussions.

WHAT WE WANT TO ACHIEVE

The overall goal is to align patient care with the patient’s goals.

The goals for the Advance Care Planning Pathway are:

1. Improve ACP delivery in the outpatient setting
2. Increase patient education regarding ACP
3. Ensure all members of the care teams are educated on ACP and how it is accomplished
4. Increase provider knowledge and awareness of ACP billing procedures
5. Improve office efficiency in ACP delivery
6. Give all patients an opportunity to discuss ACP

ADVANCED CARE PLANNING DOCUMENTS – ADVANCED DIRECTIVES

- **Health Care (durable) Power of Attorney:** legal document naming a health care agent who can make broad health care decisions, with the same authority as if they were the patient, whenever the patient is unable. Designed to guide *future* health decisions.
- **Living Will:** document that describes the care a patient would desire if they are determined to be in an irreversible medical condition or become permanently unconscious. Designed to guide *future* health decisions.
- **POLST:** a medical order directed by the physician that delineates what specific care should be administered or withheld at the *present time* for a specific patient. It requires the signatures of both a clinician and the patient (or the patient’s authorized surrogate). It is transferable between settings, and is designed to help people with severe life-limiting conditions have their treatment preferences respected for interventions such as CPR, mechanical ventilation, and ICU care. Relates to *current care* of the patient.

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MD NETWORK

1-800-233-4082
Specialty referrals



OUTCOMES MEASUREMENT

In order to reach our goals for Advance Care Planning, Penn State Health will measure:

- ACP documents on file in the EMR
- Use of 99497 and 99498 CPT codes

CARE TEAM OPPORTUNITIES

Care Manager:

- Communicate with patients at the time of transition from a hospital admission and can check the patient's understanding of their illness and introduce the topic of ACP and its importance

Medical Office Assistants:

- First point of contact with patients in the clinic and can initiate pre-visit planning for patients that have an upcoming Annual Wellness Visit

Nursing:

- When rooming patients for the annual wellness visit and transitional care visit, can ask patients if they have an advance directive

Social Work:

- Serve an important role in family meetings regarding ACP to support and advocate for the patient and family
- Assist with education and outreach to community partners to provide ACP information and can offer participation in community educational events
- Can facilitate completion of ACP documents with patients and families

Community Health:

- Community health workers are members of the community who serve as advocates and liaisons between the community and health care and social services
 - Help patients understand health care providers' instructions or conversations
 - Provide community outreach and education regarding ACP

Health Professional Students:

- Students can be engaged in community ACP education events with faith-based groups, senior centers, and community health workers
- Students can facilitate ACP document completion and giving patient educational information via patient navigation

Palliative Care:

- If outpatient palliative care services are offered in the area, these services should be started as early in the disease process as possible by placing a palliative care referral.
- Palliative care can be appropriate at all ages, any stage of serious illness, and even concomitantly with curative treatment. Patients with a heavy symptom burden of chronic disease or a new cancer diagnosis are examples of patients who can benefit from early palliative care.



RECOMMENDATIONS TO CLINICIANS AND OTHER CARE TEAM MEMBERS

The following are based on the goals and measures for this care pathway, as well as general operational practices.

1. Practices, providers, and care teams to identify patients for prioritized ACP discussions
2. Practices to organize their workflow process to schedule ACP discussion visits
3. Practices will facilitate advance directives being uploaded to the EMR
4. Practices to adopt patient education materials regarding ACP
5. Ensure each member of the care team has adequate initial training on ACP
6. Practices to periodically review their ACP workflow to address changing needs in their community

BILLING FOR ADVANCED CARE PLANNING

CPT Codes

- **99497:** Used for Advance Care Planning in the first 30 minutes of face-to-face discussion with the patient, family member(s), and/or surrogate. (Minimum of 16 minutes)
- **99498** (add on): Used for each additional 30 minutes of Advance Care Planning (minimum of 46 minutes or more)
- Only attending face-to-face time with patient counts toward the billable time

Diagnosis Codes (ICD-10)

- Any relevant diagnosis can be used, and there are no specific diagnosis requirements
 - An active condition for which the beneficiary is being counseled (ex. COPD for the patient with whom you are discussing their desire for intubation)
 - A well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit

Copays

- Medicare waives the ACP coinsurance and Part B Deductible when the ACP is:
 - Delivered on the same day as a covered Medicare Wellness Visit (G0438, G0439)
 - Offered by the same provider that covered Medicare Wellness Visit
 - Billed with modifier -33 (preventive services)

ACP Billed with other Evaluation & Management (E/M)

- ACP codes do not need an accompanying E/M code to be billed
- ACP codes *may* be billed on the same day or different day as most other E/M services
 - Add modifier -25 to the visit E/M code
- ACP codes *can* be billed with transitional care management or chronic care management codes
- If providing both E/M and ACP services on the same day, choose E/M code with modifier 25 code based on complexity and ACP code(s) based on face-to-face time
- ACP codes cannot be billed with: Critical care codes, care plan oversight codes, cognitive impairment evaluation codes, initial/continuing neonatal/pediatric intensive care services

Requirements for ACP Discussion Documentation:

- Evidence of face-to-face discussion with the patient
- The encounter was voluntary in nature
- Details of the discussion (e.g., who was present, what was discussed, understanding of illness, spiritual factors, what decisions they are making, what advance directives are completed, if any)
- Statement supporting the total time spent in ACP
 - Start and stop times are required by some insurances
 - At least 16 minutes of time is required to bill



ACP CARE PATHWAY

Prepare the Clinic for Discussion

1. Gather appropriate patient education resources (electronic/hard copies) for your clinic. See appendix A.
2. Gather appropriate ACP documents (electronic/hard copies) for your clinic. Ensure printed copies are in each room for quick workflow. See appendix A.
3. Identify target patients for ACP at your clinic.



Target Populations

- Patients ages ≥55 years scheduled for annual physical
- Patients scheduled for annual wellness visit
- Patients with a serious chronic illness who have recently been hospitalized
- Patients who have expressed interest

Prepare Patients for Discussion

Pre-Visit Planning

- a. Call patients or send letters and patient education materials regarding ACP via the mail or the online portal. This can occur before an upcoming appointment where the agenda is to discuss ACP.

MEDICAL OFFICE ASSISTANTS



Call patients ahead of an annual wellness visit, transitional care visit, or annual physical (>55 years)



Example Script:

“Hello Mr./Ms. __ I am calling regarding your upcoming visit with [insert provider]. There will be an opportunity to discuss Advance Care Planning at your upcoming visit. Advance care planning is a process that allows patients and their families to document what they do and don’t want when it comes to their health care.”



Ask patients to bring in copies of an Advance Directive if they have any



Example Script:

“Do you have any type of Advance Directive including a health care power of attorney form, living will, or POLST form?”

- **If yes:** “Can you bring a copy of it to the upcoming visit so that [insert provider] can review it with you and ensure we have an updated copy? Or you can upload a copy via a portal message and send it to your provider.”
- **If no:** “There is some educational information that I can provide you to begin learning more.”



Provide patient educational materials, a copy of the health care power of attorney form, and a copy of the living will form (see appendix A)



Example Script:

“I can send educational materials via the online portal or by mail, which would be best for you?”



Document discussion and advance directive status in the patient’s chart

- b. Care Managers have the unique opportunity to be the first point of contact following a hospital admission via a transitional care management phone call.



Care Managers



Communicate with patients upon discharge from a hospital admission



- Assess the patient's understanding of their illness
- Discuss the importance of ACP and encourage the patient to discuss this with their provider at the Transitional Care Management (TCM) appointment



If a TCM visit is not scheduled, care managers can also offer an ACP specific appointment with a provider with can be at the office or via telehealth.



Provide ACP educational materials to patients via the portal or mail (see appendix A)

a. Nursing staff can screen patient for completion of ACP documents at the start of a visit.

NURSES



Screen patients that are being roomed for the annual wellness visit, transitional care visit, or annual physical (≥ 55 years) if they have ACP documents:



Check to see if there is a Living Will, Health Care POA form, or POLST form is in the EMR.

- If the patient says they have one, but it is not on file, the nurse can encourage the patient to bring it to the next appointment



If the patient does not have an Advance Directive:

- **Provide the patient with appropriate forms***
 - Health Care Power of Attorney Form
 - Living Will
- **Provide ACP patient education materials**

*POLST forms are appropriate for patients that have a severe life-limiting illness and want limits placed on medical interventions at the present time



- a. Providers can begin to introduce the topic of ACP and its importance with patients and the families over the course of a few appointments in anticipation of a more in-depth discussion at a future time.

PROVIDERS



Begin to convey the importance of ACP to patients at prior visits, when there is a change in a patient’s health management, or a change in a patient’s disease trajectory:

“It’s important for us to know what is important to you. Have you ever completed advance directives or medical power of attorney papers to help us understand your wishes?”

- o *If yes*, “I’d like you to bring them in so we can talk about how they apply to your current condition and what may happen in the future”
- o *If no*, “I would encourage you to talk with those important to you about what you want. Then we can talk about it at the next appointment and put your wishes down on paper.”

“Have you ever thought about how you would want us to care for you if you get really sick or close to death? Can we dedicate some time toward that at your next appointment?”

“It is important we know who you would want to speak for you if you are unable to make decisions about your care. At your next appointment, can we talk more about that?”

“You may want to have _____ with you at your next appointment because we will be discussing changes in your care”

Have the Discussion

WHO should be included in the discussion:

- The patient
- The surrogate decision maker if applicable
- Family or other loved ones that the patient would like included



Elicit Patient Input:

- o First assess understanding
- o Ask what is important to the patient
- o Ask how medical conditions and symptoms affect their function and priorities

There are many tools to help guide providers through conducting ACP discussions (see appendix). The **VALUES** tool below may be helpful for determining what is important to the patient.

V	Values that are important to the patient	What is important to you at this time?
A	Activities that are significant for patients	-When you think about the future, what are the things you want to do? -What are the activities you like to do now?
L	Living well/tradeoffs	-What would be an unacceptable way of living for you? -If you get sicker, how much are you willing to go through for the possibility of gaining more time?
U	Uncertainties/fears/worries	-What fears or worries do you have regarding your health? -What concerns you about your future?
E	Experiences with serious illness	-What experiences have you had in dealing with family/friends who have died or been seriously ill? -What was the last hospitalization related to your illness like for you? -What did you learn from those experiences?
S	Sources of strength/spirituality	-What gives you strength to cope in difficult times? -Do you have religious or spiritual beliefs that are important to you?

*From Berns et. al 2017 (adapted from Respecting Choices, the Serious Illness Conversation checklists, and Prepareforyourcare.org)



Explain medical interventions that are being considered for the patient or that you believe may be in their future such as hospitalizations, surgeries, or emergency resuscitation effects



Make recommendations about what is medically appropriate



Advance Directive documents should be discussed during the ACP conversation, but documents do not have to be completed at this time if the patient is not ready. For most patients a Health Care POA form and/or a living will are appropriate. For patients that have a severe life-limiting illness and want limits placed on medical interventions like CPR or mechanical ventilation, a POLST form may be appropriate.

After the Discussion

1. Any completed ACP documents should be scanned into the EMR
2. ACP discussions should be continued as patients' life circumstances or health changes
3. A follow up appointment to discuss ACP can be scheduled as needed. There is no limit on the number of times the ACP billing codes can be used for a single patient.



ACP should be re-visited at least annually and Advance Directive forms should be updated if necessary. All care team roles should continue as described above.



Appendix A: Resources and Documents

Provider Resources

- [ACP Overview Video](#) (13 min) and [ACP Billing Video](#) (9 min) located on Penn State Health Compass
- ACP Conversation Guides
 - [Transitions/Goals of Care | VitalTalk](#)
 - [PAUSE Talking Map | VitalTalk](#)

Patient Resources

- [ACP Patient Brochure Penn State](#)
- [Patient education: Advance directives \(The Basics\) - UpToDate \(psu.edu\)](#)
- <https://order.nia.nih.gov/sites/default/files/2018-03/advance-planning-tip-sheet.pdf>
- Online Resources for Patients to Complete Advance Directives
 1. [Prepare for Your Care](#)
 2. [My Living Voice](#)

Appropriate Forms for ACP process

HMC forms:

- Penn State [Health Care Power of Attorney Form](#)
- Penn State [Health Care Power of Attorney Form in Spanish](#)
- If a patient is interested in filling out both a health care power of attorney form and a living will, we recommend providing a combined document: [Living Will & Power of Attorney Form](#)

State forms

- PA POLST Form [file \(papolst.org\)](http://file.papolst.org)

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