Advance Care Planning

TOOLKIT

Overview

- National Quality Forum (NQF 0326)

Advance Care Planning (ACP) is a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Advance care planning is valuable for everyone, regardless of age or current health status. It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity.

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

How to satisfy the measure

The measure is satisfied when the patient's primary care provider discusses advance care plan with the patient and documents it in the patient's medical records.

Services typically provided under CPT codes 99497 and 99498 satisfy the requirement of Advance Care Planning discussed and documented in minutes. If a patient received these types of services, submit CPTII code 1123F or 1124F.

Best practices

- National Hospice and Palliative Care Assoc.

- Discussing type of life-sustaining treatments available
- Deciding what types of treatment a patient would or would not want should they be diagnosed with a life-limiting illness
- Sharing personal values with loved ones
- Determine a healthcare surrogate decision maker (i.e., healthcare representative, power of attorney for healthcare)
- Completing advance directives to put into writing what types of treatment patient would or would not want should they be unable to speak for themselves

Measure Definition

Eligible Population

Denominator

Adults aged 65 years and older who are covered by an LHP product and had a patient visit during the measurement year.

Exclusions

Patients who used hospice services (does not include palliative care) at any time during the measurement year.

Performance Met

Numerator

Advance care planning discussed and documented:

- CPT 99497
- CPT 99498
- CPT II code 1123F

OR

Patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

- CPT II code 1124F

LEGACY HEALTH PARTNERS

Coding

CPT codes 99497, 99498 or CPT II 1123F Patients who have an advance care plan or surrogate decision maker documented in the medical record

–OR–

CPT II code 1124F Documentation in the medical record than an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provider an advance care plan

Workflow considerations

- Document advance care planning/counseling discussion as part of an annual wellness visit note
- Document advance care planning/counseling discussion as part of an inpatient or outpatient note

SUGGESTED NOTE TEMPLATE

Advance care planning

Advance care planning was discussed today and the following is a brief summary of our discussion:

- Advance directive: _____
- POLST: _____
- Other Advance care planning: _____
- Time statement: Not including annual wellness visit (AWV)/Evaluation & Management (E&M) time, total face to face time spent on advance care planning was __ minutes with 100% spent in counseling including the explanation.

Documentation and forms

Key differences between Advance Directives and Physician Orders for Life-Sustaining Treatment (POLST) forms:

	Advance Directive	POLST form
Type of Document	Legal document	Medical order
Clinical recommendation statements	• Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life- sustaining medical treatment. • May be revoked or altered at any time by the patient. • Clinicians who comply with such directives are provided legal immunity for such actions. • Durable power of attorney for health care or health care proxy: A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)	• Used to turn patient's wishes for treatment near the end of life into medical orders • A POLST can never be required by a health care professional, care facility or health system.
Who completes	Individual	Health care professional
Who needs one	All competent adults	Seriously ill or frail (any age) who might not want all available medical treatments for whom health care professional wouldn't be surprised if passed within one year
Appoints a surrogate	Yes	No
What is communicated	General wishes about treatment wishes. May help guide treatment plan after a medical emergency.	Specific medical orders for treatment wishes during a medical emergency.
Emergency Medical Services (EMS) can use?	No	Yes
Ease in locating	Not very easy to find. Depends on where patient keeps it and if they have told someone where it is, given a copy to surrogate or to health care professional to put in his/her/their record.	Very easy to find. Patient has original. Copy is in medical record. Copy may be in a state registry.

The National Hospice and Palliative Care Organization's Caring Connection website provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

Legacy Health Partners
Email: legacyhealthpartners@lhs.org
Team Site: legacyhealth.sharepoint.com/sites/LHP
Website: legacyhealthpartners.org

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