Institute *for* Healthcare Improvement

Community 201 Call

The Conversation Project

July 18, 2018

WebEx Quick Reference

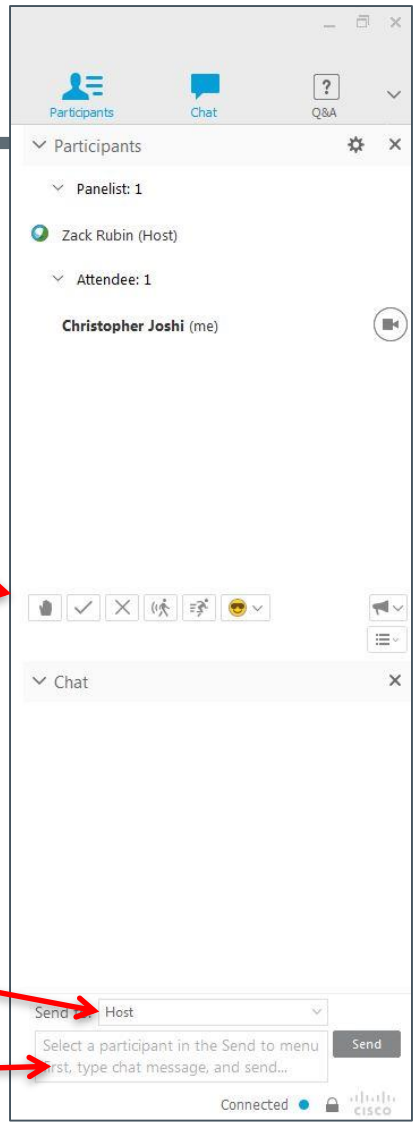
Welcome to today's session!

Please use Chat to "All Participants" for questions

For technology issues only, please Chat to "Host"

WebEx Technical Support: 866-569-3239

Dial-in Info: Audio / Audio Conference (in menu)



The Conversation Project Field Team

Patty Webster

Improvement Advisor

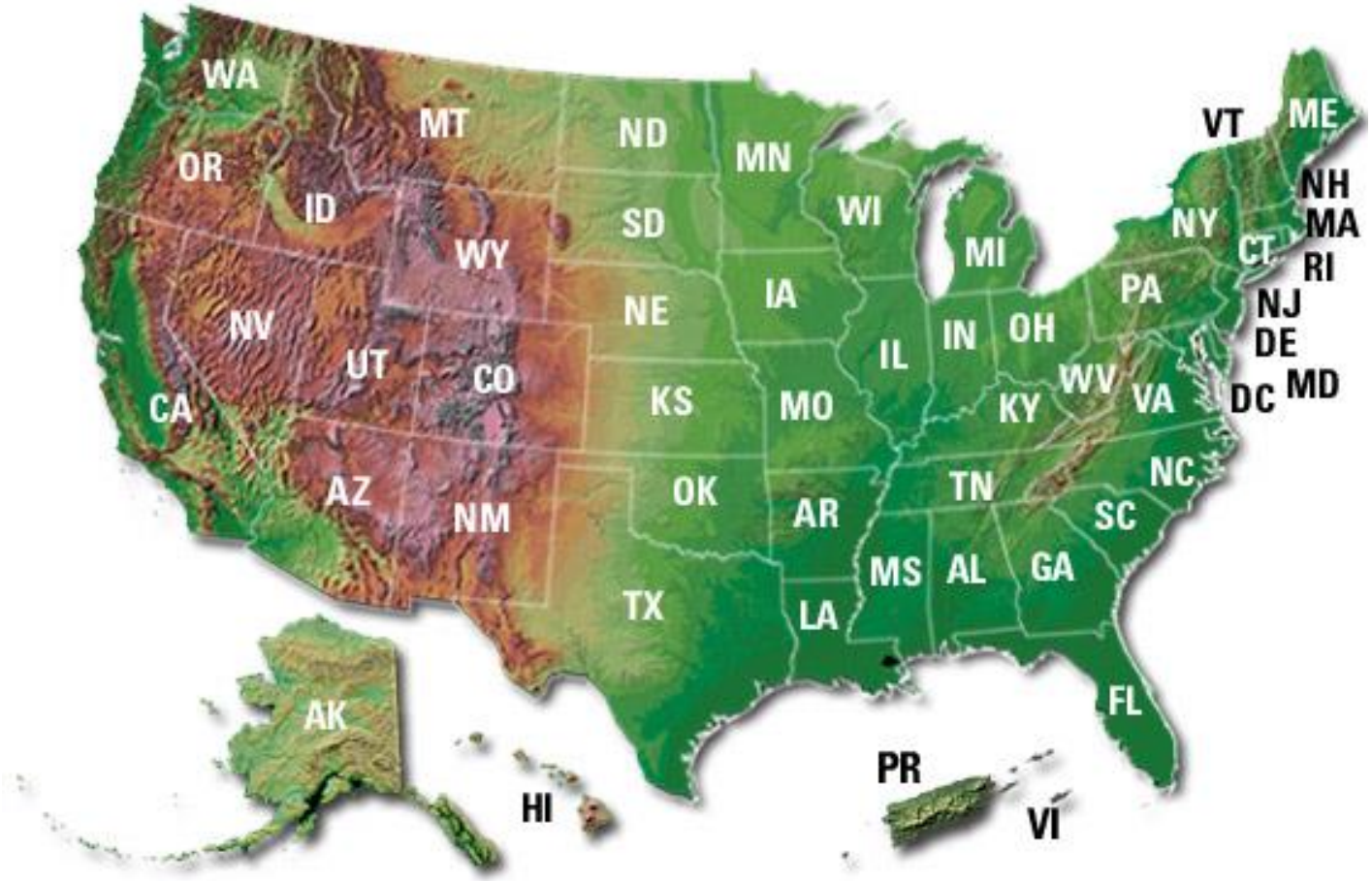
Naomi Fedna

Project Coordinator

Rosemary Lloyd

Advisor to Faith Communities

Where are you located on the map?



Upcoming Community Calls

The next Conversation Project Community Call will take place on:

Wednesday, August 15th, 3:00-4:00 PM ET

Date and Time	Topic
Wednesday, August 15th , 3:00-4:00pm ET	Special interest: Conversation Sabbath
Wednesday, Sept 19th, 3:00 – 4:30 pm ET	Virtual Speaker Training
Wednesday, Oct 17th , 3:00 – 4:00 pm ET	Community Highlights to Prep for Alzheimer's Awareness Month
Wednesday, Nov 21st , 3:00-4:00pm ET	Special interest: Ensuring equity, reaching diverse communities

TCP Community Updates

- New Resources!
  - Revised Resources Page –>Get Involved
  - Conversation Champion Map!
- Quarterly Community Activity Survey is open!

Session agenda and objectives

- Community highlight: Frederick County, MD
- Q&A w/Jackie Dinterman, Manager, Care Management, Frederick Regional Health System, MD
- Group discussion:
  - Keeping this work fresh, sustaining momentum
  - Reaching new or hard-to-reach audiences
- Future calls

Chat: Where you are, what's your focus (e.g. general community, healthcare, faith, other), how long have you been doing this work?

Jackie Dinterman, MA, LBSW

Advance Care Planning: Igniting "The Conversation" in our Hospital and our Community

Jackie Dinterman, MA, LBSW
Manager, Care Management
Frederick Regional Health System

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Need for Change

- FMH approach to Advance Directives had proven ineffective with low prevalence of actual, completed documents – 1%
- Data showed that many of our readmissions were patients with chronic diseases who could benefit from having Advance Directives, palliative care, or end of life discussions
  - Identified need for community education surrounding advance care planning so patients and family members have heard of terms being used in the hospital **prior** to medical crisis or hospitalization occurring
  - Family members are making decisions for loved ones without ever having had an open discussion about end-of-life care or understanding terms
  - Family disagreements, confusion and turmoil placing providers and the healthcare team in the middle of ethical situations when our mission is to provide care

Most importantly, it's the right thing to do to help our patients and our community ….

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Igniting the Conversation in Frederick

- Created the Advance Care Planning Committee:
  - Helping to keep people healthy, not just treat them when they are sick
  - Multidisciplinary
  - Full continuum of partners
  - Significant emphasis on community
- Goal of the Committee:
  - To provide education and awareness to Frederick County residents re. the importance of communicating personal wishes/preferences for end of life care
    - What is important to an individual; what defines quality and gives meaning
  - To provide tools and resources to individuals, caregivers, and healthcare providers to help encourage conversations
  - Improve the understanding of Palliative versus hospice care
  - 10 events per year
- Community Education and Outreach
  - Nursing homes/Assisted Livings/Independent Livings
  - Community Events
  - Civic Organizations
  - Media

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AD Initiative Working Group

- Jackie Dinterman, Chair
- Sharon Smith, Hood College
- Kathy Troupe, NP, Heart Failure
- Carol Grissom, Glade Valley Nursing & Rehab
- Patricia Ortiz-Sanmiguel, Hospice of Frederick Co.
- Elisabeth McCall-Martin, Pain/Supportive Care
- Janet Harding, Cultural Awareness/Bridges
- Peter Brehm, The Frederick Center
- Rosario Campos, Asian American Center/Bridges
- Nikki Moberly, Community, PFAC member
- Kay Myers, Pastoral Care
- Sue Eyler, Bridges (Faith-Based Lay Health Educators)
- Rachel Mandel MD, VPMA and James Grissom, MD
- Melissa Lambdin, Marketing and Communications
- Judy Williams, Interpreting Services
- Katie Rhinehart, Heartfields Assisted Living
- Michelle Ross, Advance Care Planning Social Worker
- Dolly Sullivan, Professional and Clinical Development
- Melanie Bryan, Dept of Aging
- Jodie Pritt, FMH/James Stockman Cancer Institute
- Kathy Tyeryar, Goals of Care Navigator
- Cookie Verdi, FMH Select!
- Chris Lovetro, Community Attorney

Mission:

1. Educate the community about the importance of Advance Directives
2. To provide tools and resources to individuals, caregivers, and healthcare providers to help encourage conversations
3. Increase the number of Advance Directives executed in the community and hospital
4. Raise awareness among providers about Advance Directives
5. Support the concept of the “Conversation Project”

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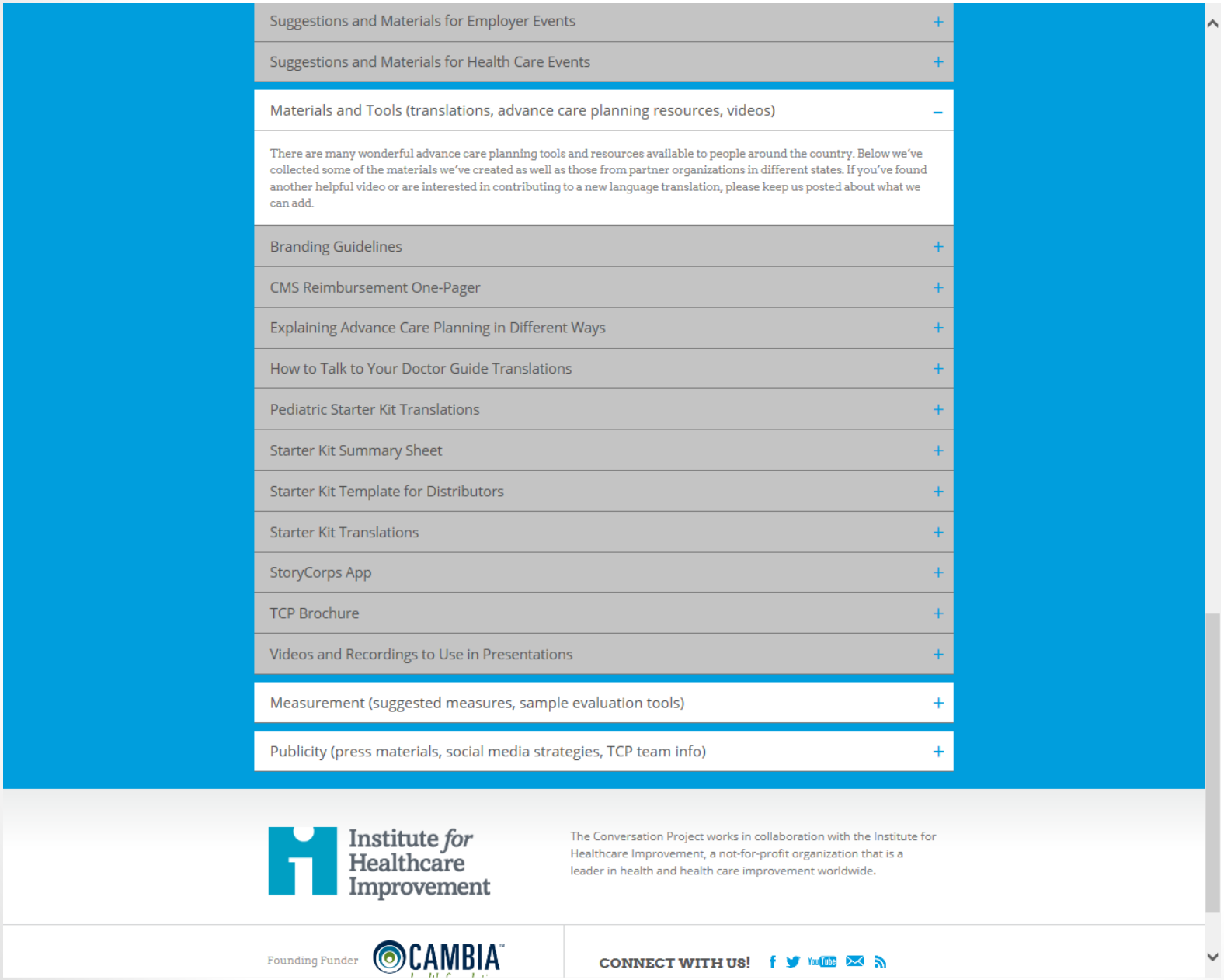
http://theconversationproject.org/



AD Initiative Outreach

- Initiative began February 2015
- National Healthcare Decision Day events
- “Bridges” program for LHE x 7 cohorts
- Nursing Homes, Assisted Livings, IL’s
- Colleges and Universities
- FMH Staff Lunch and Learns
- Friday Physician CME’s
- FMH 55+ Select
- Multiple Rotary Presentations
- Well Aware Magazine
- Women’s Giving Circle
- Frederick Community Health Fair, Elder Expo, Great Frederick Fair Senior Table
- Chaplain Intern Sessions
- Asbury United Methodist Church Community Block Party
- Frederick County PRIDE celebration
- Healthcare Symposium at Ceresville Mansion

ADVANCE CARE PLANNING

THE TIME IS NOW

Jackie Dinterman was a social worker on the FMH Intensive Care Unit for more than 10 years. During that time, she watched many families grapple with heart-wrenching decisions regarding the care and treatment of loved ones who could no longer speak for themselves. Faced with their loved one's progression of a chronic illness, complications resulting from surgery, or an acute event such as a stroke, families were exhausted, stressed, and confused. They often disagreed with one another about "what mom would want," sometimes doing what Dinterman could only assume was irreparable damage to their relationships with one another.

Helping families avoid this stressful situation is one of the reasons that Dinterman is passionate about Frederick Memorial Hospital's Advance Care Planning initiative.

"Advance Care Planning (ACP) is the process of reflecting on, discussing, and planning for a time when a person can no longer make his or her own medical decisions," she explains. "The ACP initiative is based on partnerships both inside and outside the hospital designed to raise awareness, provide education and inspire people of all ages and stages of wellness to plan for these types of issues before there's a crisis, when they can think and express themselves more clearly."

One of the key components of the Advance Care Planning initiative is The Conversation Project, a national campaign designed to encourage people to talk with one another about how they want to live during the last phase of their lives. To support and encourage as many people as possible to have "the conversation," FMH is working closely with a wide variety of community-based organizations to spread the word, including primary care practices, assisted living facilities and nursing homes. Lay health educators affiliated with the FMH Bridges program are working within Frederick's faith-based communities, and members of the Advance Care Planning committee are holding workshops and discussions for the community at large to stress the importance of the topic. In addition, the hospital has created a Patient and Family Advisory Council (PFAC) to keep the patients and their families at the center of this initiative.

"Remember, Advance Care Planning is not an end-of-life plan," says PFAC member Nikki Moberly. "We call it "a plan for living," because it's about making sure that people live out their last days according to their wishes. And one conversation can make all the difference."

Gene Burger was a generous man. He loved working in his garden, and thoroughly enjoyed giving away its bounty. When he lapsed into a coma following a stroke earlier this year, his family was greatly comforted because he had thought to give them one last gift—peace of mind. Years ago, Gene and his wife had taken the time to do some advance care planning. Because he had written down what was important to him, Gene's family was able to direct his care according to his wishes, in the manner he clearly wanted.

For ideas and tips about how to get a conversation like this started in your own family, or to download a starter kit on this topic for your personal use, visit theconversationproject.org.

10 | SUMMER 2015 | WELL AWARE

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AD Initiative Movement

- **31** events **first** year; Past 3 years to date: 164 events/education
- Approximately 13,450 people touched by outreach/events
- 100,000 households received Well Aware Magazine (6 articles in three years)
- Grant received for purchase of Red Magnetic Folder for storage of important papers as a giveaway
- Advance Directives in 10 different languages
- Developed Your Life, Your Plan logo and materials
- Education from our Interpreters and Diversity department to learn about approaching diverse populations – 2nd and 3rd year focused on reaching out to more diverse populations
- Developed Ambassador and Facilitator programs to help with education
- Department of Aging every 3 months – education and completing AD's
- In 2017 hired a full time advance care planning Social Worker to coordinate events and assist patients and community members with understanding and completing Advance Directives and MOLST forms
- 1st Frederick County NHDD Proclamation in April 2018
- Partnership with Asian American Center and Hospice of Frederick County to provide more education and opportunities for completing Advance Directives through grants they have received.
- Getting Started Guide for Congregations – adding to our Bridges Lay Health Educators program

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10TH ANNUAL
Frederick Community Health Fair 2017
Asian American Center of Frederi
Enhance. Empower. Enric
FREDERICK MEMORIAL HOSPITAL
SATURDAY OCTOBER 28
8 A.M.-3 P.M.
Great Frederick Fairgrounds • 797 East Patrick Street, Frederick
FREE!
VOLUNTEER. SPONSOR. EXHIBIT. GET INVOLVED!

HEALTH AND WELLNESS SERVICES AND ACTIVITIES: FREE!

- Advance Directives
- Bridges Lay Health Education Program
- CARE Clinic/Social Workers/Community Health Workers
- DEXA (Bone density scanning)
- Flu Vaccines (all ages)
- HERT (Hospital Emergency Response Team)
- Medical Doctor Exam
- Medicare Advantage Insurance Program
- Mental Health Referral
- Medical Screenings for: *Blood Pressure, Cholesterol/Diabetes, Hearing, Heart Disease, Hepatitis B, Hepatitis C, HIV/AIDS, Lung Disease, and Vision*
- Oral Health Screening and Referral
- Registered Dietician Counseling
- Women's Health/SAFE Program
- **INVITED MEDICAL SPECIALISTS:**

Allergy/Immunology, Audiology, Cardiology, Dermatology, Ear, Nose, Throat (Otolaryngology), Endocrinology, Gastroenterology, Hematology/Oncology, Neurology, OB/GYN, Orthopedics, Pulmonary Medicine, Urology

Community Health. It Takes a Village.
Asian American Center of Frederick
Enhance. Empower. Enrich.
FREDERICK MEMORIAL HOSPITAL
aacfmd.org • healthfair@aacfmd.org • 301-694-3355 • #AACF2017CHF

FMH Employees... Did You Know?

For My Health

You and your spouse can each **earn up to 10 wellness points per calendar year** by engaging in Advance Care Planning and completing your Advance Directive.

To get started, fill out and submit the required points request form on the back of this flyer. **Have you already completed your Advance Directive** and/or placed it in your medical record at FMH? You can still earn points by completir and having your Advance Care Planning information verified.

Additional information, including a copy of the FMH Advance **fmh.org/ACP.** Call Michelle Ross, LCSW, FMH Advance Car 240-651-4541 to schedule your appointment.

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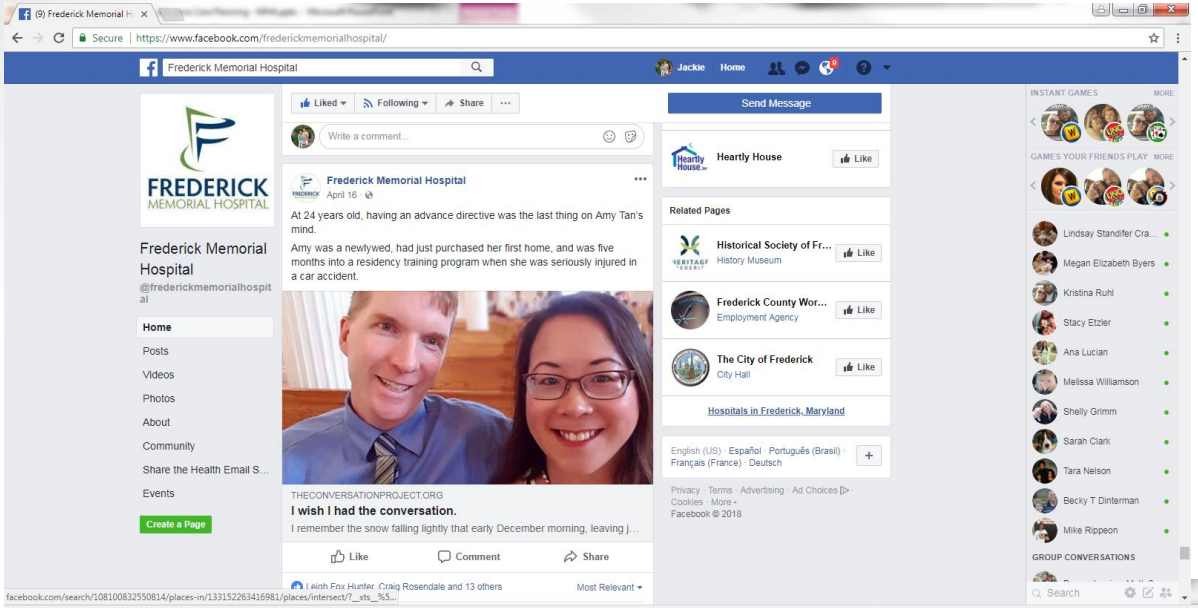
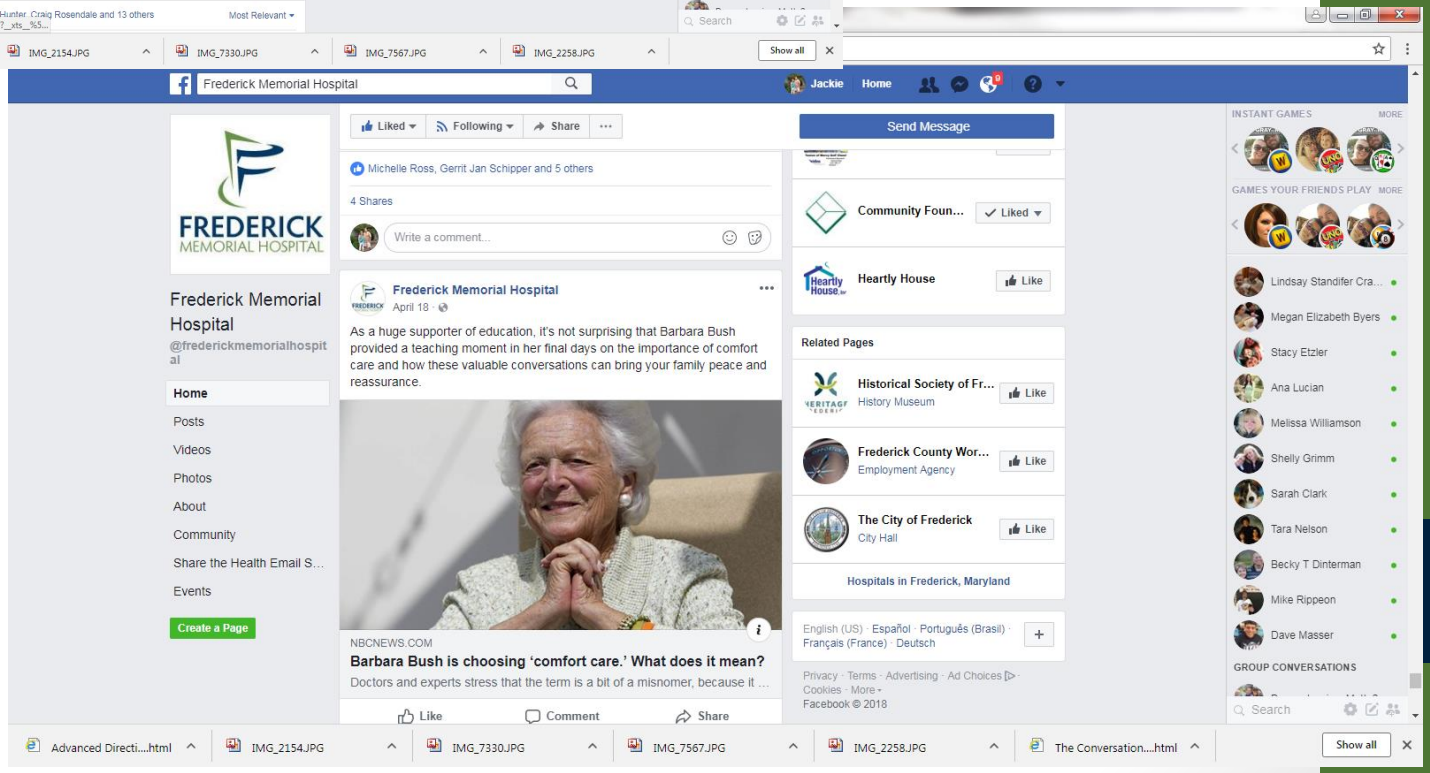

Frederick Memorial Hospital
Frederick Memorial Hospital
@frederickmemorialhospital
Home
Posts
Videos
Photos
About
Community
Share the Health Email S...
Events
Create a Page
Frederick Memorial Hospital
April 16
At 24 years old, having an advance directive was the last thing on Amy Tan's mind.
Amy was a newlywed, had just purchased her first home, and was five months into a residency training program when she was seriously injured in a car accident.
THECONVERSATIONPROJECT.ORG
I wish I had the conversation.
I remember the snow falling lightly that early December morning, leaving j...
Like
Comment
Share
Send Message
Hearty House
Like
Related Pages
Historical Society of Fr...
History Museum
Frederick County Wor...
Employment Agency
The City of Frederick
City Hall
Hospitals in Frederick, Maryland
Lindsay Standifer Cra...
Megan Elizabeth Byers
Kristina Ruhl
Stacy Etzler
Ana Lucian
Melissa Williamson
Shelly Grimm
Sarah Clark
Tara Nelson
Becky T Dinterman
Mike Rippeon
GROUP CONVERSATIONS


Frederick Memorial Hospital
Frederick Memorial Hospital
@frederickmemorialhospital
Home
Posts
Videos
Photos
About
Community
Share the Health Email S...
Events
Create a Page
Michelle Ross, Gerrit Jan Schipper and 5 others
4 Shares
Frederick Memorial Hospital
April 18
As a huge supporter of education, it's not surprising that Barbara Bush provided a teaching moment in her final days on the importance of comfort care and how these valuable conversations can bring your family peace and reassurance.
NBCNEWS.COM
Barbara Bush is choosing 'comfort care.' What does it mean?
Doctors and experts stress that the term is a bit of a misnomer, because it ...
Like
Comment
Share
Send Message
Community Foun...
Liked
Hearty House
Like
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Historical Society of Fr...
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Frederick County Wor...
Employment Agency
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Melissa Williamson
Shelly Grimm
Sarah Clark
Tara Nelson
Becky T Dinterman
Mike Rippeon
Dave Masser
GROUP CONVERSATIONS

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Presentations

- Start with Imagine video
- What is advance care planning and importance – a gift; like an insurance plan
- Key definitions
- Stats of how many people feel it's important but don't have the conversation or complete documents. Hierarchy of decision makers if no healthcare agent or AD. Share examples.
- Review TCP Starter Kits
- Choosing a healthcare agent
- Ways to "break the ice". Break out into groups if time.
- Video of family having the conversation
- Difference between palliative vs. hospice care
- Red folders
- Personal testimonial/story

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Advance Directives

Living Will

- Provides instructions for **future** treatment at end of life.
- Directs that life-sustaining treatment be withdrawn or withheld when person **(a) is in a terminal condition, or (b) in persistent vegetative state, or (c) end stage condition.**
- Does **not** guide EMS personnel
- Guides Inpatient treatment
- Does not need to be notarized in Maryland
- Generally is portable from state to state.

Healthcare Agent

- A person(s)(Agent) to make health care decisions for you when you are unable to make decisions for yourself.
- Able to consult with doctor, view medical records, make all decisions related to health care of patient.
- Is bound to make decisions according to wishes of the patient.

MOLST – Medical Orders For Life-Sustaining Treatment

- Medical orders for **current** treatment. It is intended to stay with patient as he/she moves into/out of various health care facilities and settings (e.g., assisted living, home with HHC, nursing home, hospital, hospice).
- Needs to be signed by a Physician, PA or NP.
- **Does** guide EMS personnel.

Financial POA

- A person who will conduct business on your behalf if you should become unable to do so (e.g., pay bills, sell property, etc.)
- Does NOT apply to making healthcare decisions - the Durable Medical Power of Attorney is required for that
- The same person can be your Financial POA **and** your Medical POA or they can be two separate individuals.

Advance Care Planning Checklist

- ❑ Use the Conversation Project Toolkit (theconversationproject.org)
  - ❑ Think about what you want and how you want to live
  - ❑ Plan when and how to talk to your loved ones
  - ❑ Decide who you want as a healthcare agent
- ❑ Talk to your healthcare agent
  - ❑ Tell them about your wishes and the responsibility of a healthcare agent
  - ❑ Obtain their agreement, and discuss any concerns or questions they have about supporting your wishes
  - ❑ Fill out the form "Appointment of Healthcare Agent" (FMH Advance Directive – Part A)
- ❑ Document your wishes in your Advance Directive (FMH Advance Directive – Part B)
  - ❑ Two people need to witness your signature and sign the document. Your Healthcare Agent cannot be a witness.
  - ❑ The document does not need to be notarized and you do not need an attorney.
- ❑ Store the original signed and witnessed documents in a safe place with other important documents , such as your birth documents and your will, and tell someone where you keep them.
- ❑ Keep a signed and witnessed copy of your Advanced Directive, Part A and Part B :
  - ❑ In a place where Emergency Medical Staff or friend could find it (on the side of the fridge, for example)
  - ❑ In the glove compartment of your vehicle
  - ❑ In your red folder on the side of your refrigerator
- ❑ Deliver a signed and witnessed copy of your Advanced Directive to:
  - ❑ Family members and friends who would be contacted or involved with your care
  - ❑ Your Healthcare Agent
  - ❑ Your Doctor(s), to keep with your records.
  - ❑ Any hospital where you receive care, for storage with your records.
  - ❑ Your clergy if you wish
- ❑ Put a card in your wallet that says you have an Advanced Directive, along with a person to contact in the event of an emergency and their phone number.

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ADVANCE CARE PLANNING
Your Life, Your Plan.

What is **Advance Care Planning** and why should I do it **now?**

Advance Care Planning is making decisions about the type of care you would like if you are ever unable to speak for yourself. ***Now is the time*** to have conversations and complete documents that identify your wishes, values, and beliefs. This caring act will relieve loved ones and healthcare providers of the stress and heartache of guessing what you would want.

What is an Advance Directive and why do I need one?

An Advance Directive is a legal document in which you can specify what actions should be taken for your health if you are no longer able to make decisions for yourself. It includes two parts: **Selection of Healthcare Agent(s)** and a **Living Will.**

PART 1: SELECTION OF HEALTHCARE AGENT

This section of the Advance Directive assigns a person(s) to assist the medical team to make healthcare decisions for you when you are unable to make decisions for yourself.

- Agent is able to consult with doctor, view medical records, and give consent for treatment
- Agent is bound to make decisions according to your known wishes
- Does not afford agent the ability to conduct financial business on your behalf

PART 2: LIVING WILL

This section of the Advance Directive provides instructions for your future medical treatment when you cannot decide for yourself, including inpatient treatment and/or end-of-life care.

- Does not require an attorney or notary in Maryland
- Does not guide EMS personnel

Your Advance Directive must be signed by two witnesses who are both 18+ years old. Neither witness can include your Healthcare Agent(s), and neither witness can benefit financially or otherwise from your death.

When should I complete my Advance Directive?

You can complete your Advance Directive once you are 18 years of age. You should do so regardless of your current health conditions or need. Accidents, natural disasters, or health crises can happen at any time. ***It always seems too early until it's too late.***

Who should get a copy of my Advance Directive?

- Your Healthcare Agent(s)
- Hospital
- Doctors and specialists
- Family and/or loved ones that may be contacted

Where else should I keep a copy of my Advance Directive?

- In your Red Folder *(see other side for more information)*
- In your vehicle's glove compartment
- With your dated list of medications

What other forms do I need?

MOLST (MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT)

This form designates medical orders for current treatment. It is intended to stay with you as you move into and out of various healthcare facilities and settings (e.g., assisted living, home with HHC, nursing home, hospital, hospice). The MOLST Form must be signed by a treating Physician, Nurse Practioner, or Physicians Assistant.

- Does guide EMS personnel
- Replaces old DNR Form
- Does not expire but should be reviewed during transitions of care

FINANCIAL POWER OF ATTORNEY

This form designates an agent who will conduct business on your behalf if you should become unable to do so (e.g., pay bills, sell property, etc.). The same person can be your Financial Power of Attorney **and** your Healthcare Agent. This form must be completed by an individual with capacity to decide for themselves. It is generally recommended that this form be completed with an attorney present.

- Does not automatically apply to making healthcare decisions

What is the Red Folder and how do I use it?

The Red Folder is a place to keep important healthcare paperwork organized and in easy reach. In it we recommend including copies of your **Advance Directive,** the **MOLST form,** a current list of your **healthcare providers and medications,** and **a recent photo.** The folder is bright red for easy identification and has magnet strips on the back so you can attach it to your refrigerator. Emergency responders (including paramedics, firefighters, and police officers) are trained to look for this folder on refrigerators when responding to a medical crisis.

"An Advance Directive is a gift a person gives to their family and loved ones because it tells them what you want, so they don't have to struggle with these decisions at a very stressful time for all."

Rachel Mandel, MD
Vice President of Medical Affairs
Frederick Memorial Hospital

How can I get help with Advance Care Planning?

Appointments with licensed social workers are available free of cost to the community.

For questions, more information, or to set up a personalized appointment or presentation, please contact:

Michelle Ross, LGSW
240-651-4541
mross1@fmh.org
fmh.org/ACP

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FMH Red Folder Initiative

A community Social Worker at Frederick Memorial Hospital, Nicole Wetzel, created the Red Folder in 2015 when she realized that once a patient had created important documentation, there was no one standard place for it to be stored.

All Frederick County Ambulance Companies now look for the Red Folder on patient's refrigerators when they respond to 9-1-1 calls. If they don't have one, EMS will provide one!

Things to Include in the Red Folder:

- Advance Directive
- MOLST Form (Medical Order for Life Sustaining Treatment)
- Updated Medication list
- List of Doctors
- A recent photo

If you have a patient who is discharging to home with a code status of anything other than Full Code, please provide them a copy of their MOLST & a Red Folder!

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The Hello Game

COMMON PRACTICE

Commission on Law and Aging

Changing Lives Through Research, Education and Advocacy

Tool #7

The Proxy Quiz for Family or Physician

How well does your family, proxy, or doctor know your health care wishes? This short test can give you some sense of how well you have communicated your wishes to them. Consider this a tool to promote better conversation and understanding.

INSTRUCTIONS:

Step 1:
Answer the 10 questions using the **Personal Medical Preferences** test which follows.

Step 2:
Then, ask your health care proxy, family member, or close friend to complete **the Proxy Understanding of Your Personal Medical Preferences** test. The questions are the same. Don't reveal your answers until after they take the test. They should answer the questions in the way they think *you* would answer. (Try the same test with your doctor, too.)

Step 3:
GRADING – Count one point for each question on which you and your proxy (or you and your doctor) gave the ***same*** answer. Their proxy score is rated as follows:

Points	Grade	
10	*Superior*	… You are doing a great job communicating!
8 – 9	*Good*	… Need some fine tuning!
6 – 7	*Fair*	… More discussion needed.
5 or below	*Poor*	… You have a lot of talking to do!

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Step 1: Personal Medical Preferences

Complete this questionnaire by yourself.

1. Imagine that you had Alzheimer's disease and it had progressed to the point where you could not recognize or converse with your loved ones. When spoon-feeding was no longer possible, would you want to be fed by a tube into your stomach?
   a. Yes
   b. No
   c. I am uncertain

2. Which of the following do you fear *most* near the end of life?
   a. Being in pain
   b. Losing the ability to think
   c. Being a financial burden on loved ones

3. Imagine that…
   - You are now seriously ill, and doctors are recommending chemotherapy, and
   - This chemotherapy usually has very severe side effects, such as pain, nausea, vomiting, and weakness that could last for 2-3 months.

   Would you be willing to endure the side effects if the chance of regaining your current health was less than 1 percent?
   a. Yes
   b. No
   c. I am uncertain

4. In the same scenario, suppose that your condition is clearly terminal, but the chemotherapy might give you 6 additional months of life. Would you want the chemotherapy even though it has severe side effects (frequent pain, nausea, vomiting, and weakness)?
   a. Yes
   b. No
   c. I am uncertain

5. If you were terminally ill with a condition that caused much pain, would you want to be sedated, even to the point of unconsciousness, if it were necessary to control your pain?
   a. Yes
   b. No
   c. I am uncertain

Step 2: Proxy Understanding of Your Personal Medical Preferences

To be completed by your named health care proxy, family member, close friend, or physician.

Instructions: Answer the following questions in the way you think *"N"* (Name : _____) would answer.

1. Imagine that ***N*** had Alzheimer's disease and had progressed to the point where he/she could not recognize or converse with loved ones. When spoon feeding was no longer possible, would he/she want to be fed by the insertion of a tube into the stomach?
   a. Yes
   b. No
   c. ***N*** would be uncertain

2. Which of the following do you think ***N*** fears *most* near the end of life?
   a. Being in pain
   b. Losing the ability to think
   c. Being a financial burden on loved ones

3. Imagine that ***N*** …
   - Is now seriously ill, and doctors are recommending chemotherapy, and
   - This chemotherapy usually has very severe side effects, such as pain, nausea, vomiting, and weakness that could last for 2-3 months.

   Would ***N*** be willing to endure the side effects if the chance of regaining his/her current health was less than 1 percent?
   a. Yes
   b. No
   c. ***N*** would be uncertain

4. In the same scenario, suppose that his/her condition is clearly terminal, but the chemotherapy might give 6 additional months of life. Would ***N*** want the chemotherapy even though it has severe side effects (frequent pain, nausea, vomiting, and weakness)?
   a. Yes
   b. No
   c. ***N*** would be uncertain

5. If ***N*** were terminally ill with a condition that caused much pain, would ***N*** want to be sedated, even to the point of unconsciousness, if it were necessary to control the pain?
   a. Yes
   b. No
   c. ***N*** would be uncertain

Institute for Healthcare Improvement

conversation ready

End-of-Life Care Conversations: Medicare Reimbursement FAQs

The changes in Medicare reimbursement policy that went into effect January 2016 provide an opportunity for more clinicians and patients to engage in conversations about preferences for care at the end of life. However, many people are confused about where to start. Whether you are uncertain about the new rules for CMS reimbursements or about starting those conversations with patients, this document will help you understand this new landscape for end-of-life care conversations.

Before getting started, check to see if a local coverage determination has been made, and check with your local billing expert to ensure your practice is compliant with their recommendations. Make sure that the new reimbursement codes have been added to your system's billing apparatus. These codes may not be available until your facility approves them for use.

1. Do these new codes need to be used in the context of an illness?

No. In fact, any medical management must be billed separately.

2. What are the new advance care planning (ACP) codes from CMS that became active in 2016?

99497 – ACP, 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

99498 – Each additional 30 minutes (list separately in addition to code for primary procedure)

3. How much time must be spent to use the new codes?

More than half of each interval must be used. For example:

- Use 99497 if you meet or exceed 16 minutes.
- Use 99497 + 99498 if you meet or exceed 46 minutes.

4. Does the conversation have to be in-person to use the new codes? Does it have to be with the patient?

The conversation has to be in-person (you cannot use the code for telehealth), but it doesn't have to be with the patient. It can be with a surrogate or family members.

5. What are the documentation requirements?

- Total time in minutes
- Patient/surrogate/family "given opportunity to decline"
- Details of content (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)

6. What costs might patients incur from these codes?

When a provider discusses advance care planning with a patient at his/her Annual Wellness Visit, there is no cost to the patient. However, if the provider has an ACP conversation at other times, Part B cost sharing applies and the patient may be responsible for copay/coinsurance.

7. How much do payers reimburse for these codes?

99497 = 1.5 RVUs
99498 = 1.4 RVUs

8. Are there limits to the number of times that the new codes can be used?

There are no limits to the number of times the codes can be used. ACP can be readdressed as needed with a change in condition. Each time they are used, 99497 should be used for the first 30 minutes and 99498 should be used for each additional 30 minutes.

9. Which health care providers can be reimbursed for having ACP discussions with patients under the new rule? Can physicians charge for the codes if another staff member engages the patient in the ACP discussion?

Physicians (MDs and DOs), nurse practitioners (NPs), and physician assistants (PAs) (i.e. those who are authorized to independently bill Medicare for Current Procedural Terminology (CPT) services) are the only providers who can use these codes.

"Incident to" rules apply in the outpatient setting. This means that a provider can use these codes if they perform an initial service and a non-billing team member (e.g., registered nurse, social worker) helps deliver part of the service, with ongoing direct supervision and involvement of the billing provider. Example: The physician starts an ACP conversation, then says, "I'd like to introduce you to our nurse who will talk with you about choosing a surrogate medical decision maker and discuss with you how you might have a conversation with that person," then debriefs afterwards with the patient. Work with your local billing expert regarding "incident to" rules.

10. How can physicians bill for these conversations for non-Medicare patients?

If the patient has private insurance, find out if ACP conversations are covered. Otherwise, you can use "counseling and coordination of care" codes, but only in the context of a serious illness.

Coalition to Transform Advanced Care

During advanced illness, employees and employee caregivers have significant needs, including planning for a health crisis, caregiving, and support for grief and bereavement. Each year, millions of employees must navigate between caring for their ill loved ones, their household duties and workplace responsibilities, leading to emotional distress and billions in lost productivity to employers.

The mission of the Employer Committee of the *Coalition to Transform Advanced Care* (C-TAC) is to empower employers to take positive steps toward supporting employees on all levels, including caregiving responsibilities, advanced illness planning and individual care planning, advanced illness issues and grief and bereavement.

The single most powerful intervention for employers is training for supervisors to help employed caregivers to balance work and caregiving. There are many individuals and organizations already tackling this issue in unique and innovative ways. However, it is clear that more must be done to meet the needs of working caregivers.

To that end, the **C-TAC Checklist for Employers** puts forward four categories of action items your organization can use to assist employee caregivers. C-TAC recognizes that organizational capacity to accomplish these goals varies greatly and has built flexibility into the checklist. Even small steps can make a large difference to those dealing with advanced illness and caring for loved ones.

The four categories of caregiving support listed below are merely guidelines, presented in the order intended to best break down barriers and yield results. Still, even accomplishing a few of the many suggestions listed here will be invaluable to organizations and employees. The four categories are:

- Informal Resources
- Individual Care Planning
- Administrative Support
- Evaluation and Metrics

"The efforts of C-TAC promote the best-practice delivery of health care, while empowering individuals to make informed choices for themselves and their family members, thus limiting the distractions that interfere with their overall well-being and the productivity in their work."

-J. Brent Pawlecki, MD
Chief Health Officer,
The Goodyear Tire & Rubber Company

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http://www.gundersenhealth.org/respecting-choices

GUNDERSEN HEALTH SYSTEM®
Where Caring Meets Excellence

- Leading the nation with its innovative program – Respecting Choices
- 96% of People who die in La Crosse have an advance directive.
- National average is 30%
- La Crosse spends less on health care for patients at end of life than any other place in the country according to the Dartmouth Health Atlas.
- Moved to “What assistance does the individual need to plan ahead for future healthcare decisions?”
- Goals are to assist patients in understanding the progression of their illness and specific life sustaining treatments and alternatives if required.
- Provided by trained professional facilitators – Social Workers, Nurses, Parish Nurses, physicians and clergy

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ACP SW Pilot Results

- Pilot: April 2015 – October 2015 – had CT Social Worker focused (part time) on patients transferring to SNF's – high readmission rates
- At start of pilot, only **1%** of inpatients without ADs were counseled about or executed an AD. This increased to **70%** during pilot.
- Patients admitted with AD already completed went from 20% to 25% by October.
- The data from two SNF patient groups was analyzed; one with new Advance Directives (Case) and one group without (Control)
- The two groups were inpatients at the same time
- We evaluated the following metrics for the two groups:
  - Encounters for the six months before and after the index hospitalization
  - Utilization and charge per case for each group for six months before and after the index admission date
  - Readmission rate for each group
  - Hospice Referral rate for each group

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Utilization Rates

Case (108)	Encounters	Avg LOS IP	Avg total costs	Avg Total Charges	Total Charges
6 mos Pre	220	166	$9,016	$11,290	$2,483,890
6 mos Post	97	135	$6,722	$8,321	$807,130
% Change	-56%	-19%	-25%	-26%	-66%

Control (100)	Encounters	Avg LOS IP	Avg Total Costs	Avg Total Charges	Total Charges
6 mos Pre	146	159	$5,966	$7,843	$1,145,040
6 mos Post	94	124	$5,454	$7,403	$695,888
% Change	-36%	-22%	-9%	-6%	-39%

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Readmission Rates: 30 d

	IP/OBS Admits	No. of Readmissions	Readmission Rate	Cost per readmission
Case	56	7	12.5%	$5,600
Control	47	10	21%	$7,651

These are encounters, not unique patients
The hospice patients were excluded
Total cost for Case group: $39,200
Total cost for Control group: $76,510

****The Case group had fewer readmissions with less expense per admission**

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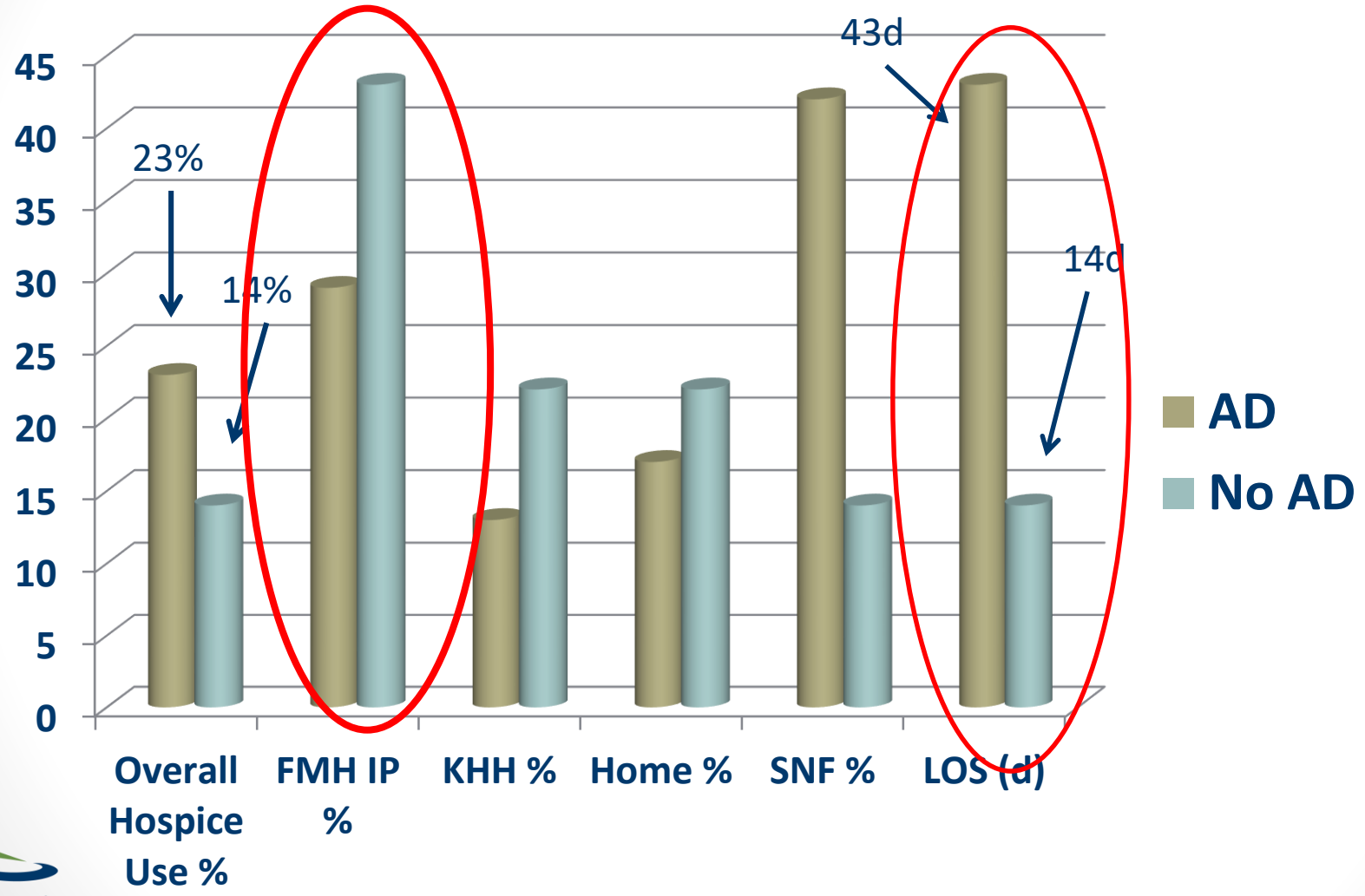
Impact of AD on Hospice Use



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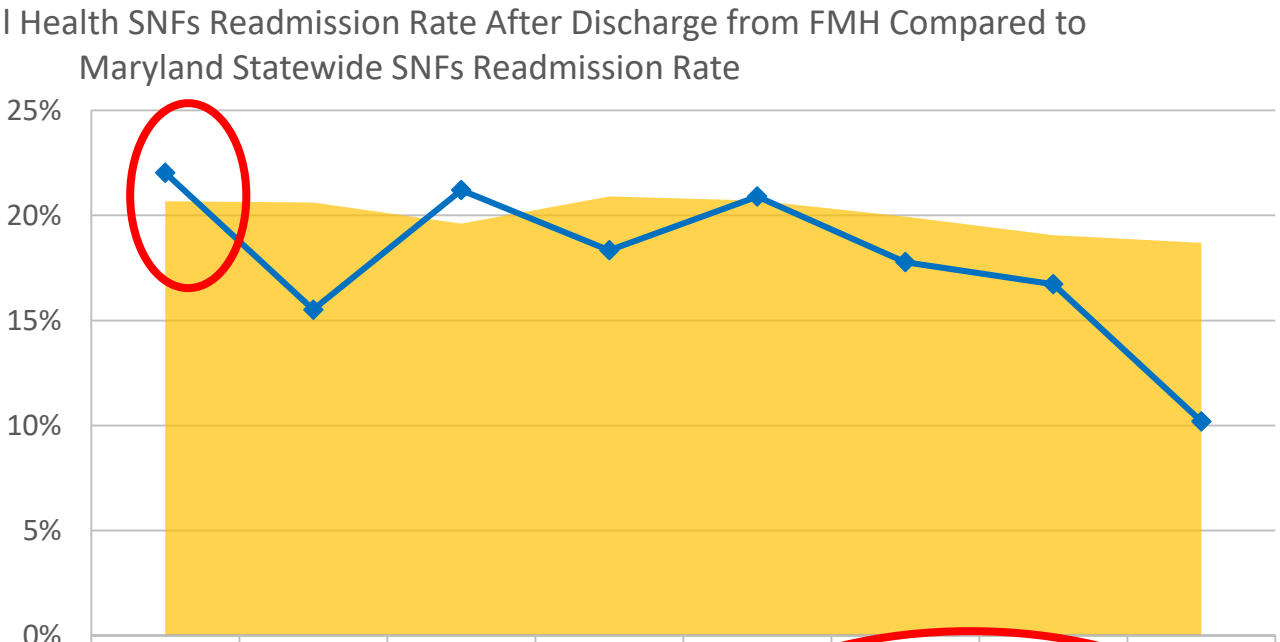
Frederick SNFs Readmission % Compared to Statewide Rates



	Q1-2014	Q2-2014	Q3-2014	Q4-2014	Q1-2015	Q2-2015	Q3-2015	Q4-2015
Maryland Statewide SNFs Readmission Rate	20.68%	20.61%	19.61%	20.91%	20.71%	19.94%	19.07%	18.70%
Frederick Regional Health SNFs Readmission Rate	22.03%	15.52%	21.21%	18.34%	20.90%	17.78%	16.73%	10.20%

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VHQC Office: 804-289-5320

It All Comes Together Where It Counts…At the Bedside

- Senior Leadership supported a full time ACP Social Worker
- Respecting Choices Facilitator training
- The Advance Directive IT Multidisciplinary Group made it possible to reliably file this paperwork in the EHR so that the clinicians had access
- IT collaborated with the Social Worker to set up an EHR based assessment, tracking and documentation tools
- The **ACP Social Worker** has a 45% Advance Directive completion rate
- The ACP Social Worker has an ACP conversation/completes AD with 91% of patients that she is referred *9% are patients with dementia or inability to understand/complete.
- 41% of patients who die at FMH has an Advance Directive (17% in 2015)

Task	2017	CYTD 2018	Total
ACP Conversation	718	248	966
AD Completed	306	125	431
Referrals	854	198	1052

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Pearls and Pitfalls

Keys to Success

- Multidisciplinary committee
- Physician champions
- Senior Leadership support
- Engaged and passionate committee members
- In a healthcare setting must be able to provide data to show improvement
- The Conversation Project Community Calls
- Be open to new ideas

Lessons Learned

- Need someone with event planning experience
- Be ready to take your show on the road – presentations, materials
- Health fairs – need something to draw attendees to your table

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Open discussion

- How have you shifted the way you approach this work over time?
  - WHAT: To keep it fresh, sustain momentum
  - WHO: To reach new or hard-to-reach audiences?
    (moving beyond "*low hanging fruit")*

Open discussion

- Any other lessons learned on this journey that could help other groups bring their work to the next level?

- Any unique things people really appreciate?

Monthly Community Calls

Date and Time	Topic
Wednesday, August 15th , 3:00-4:00pm ET	Special interest: Conversation Sabbath
Wednesday, Sept 19th, 3:00 – 4:30 pm ET	Virtual Speaker Training
Wednesday, Oct 17th , 3:00 – 4:00 pm ET	Community Highlights to Prep for Alzheimer's Awareness Month
Wednesday, Nov 21st , 3:00-4:00pm ET	Special interest: Ensuring equity, reaching diverse communities

We want your feedback!

After this call you will be redirected to a Survey Monkey form.

Please take a few moments to answer questions that will ask you to rate the overall effectiveness of this call.

THANK YOU!