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Advance Care Planning: Counseling in the Wake of CMS Reform

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Abstract

Advance directives, in the form of living wills and durable powers of attorney, have been in the medical ethics nomenclature and standard of practice for four decades, with newer physician orders in the form of POLST orders being added in the last two decades. While these advance directives facilitate the potential ability for patients to articulate preferences for future care, they have unfortunately had a major impediment in being queried and documented. Part of this had to do with the actual initiation of the discussion, and in large part due to financial constraints on the part of physicians for their time. Now with CMS regulations that took effect in January 2016, providers may take part in advance care planning discussions with their patients and be reimbursed for their time. This paper proposes a flexible EMR-based intervention grounded upon two aspects of advance directive discussion - the Values History and the Family Covenant-to facilitate a values-based discussion that also considers the dynamics of the family on future healthcare decision-making. The framework of this EMR template will be described, as well as methods by which this can be incorporated into the patient's health care visit. This EMR template provides physicians with a clinically relevant, ethics-based intervention that will promote discussion and there by benefit patients comprehensively in advance health care planning.

Introduction

Advance care planning (ACP) is an important part of adult preventative health maintenance. Advance directives are an important asset in ACP, as they allow for written declarations by a patient to set out what future treatments they accept or refuse. The living will is accepted by all states except Michigan by statute, and allows a patient to make such a declaration directly in case of future incapacity, while a Durable Power of Attorney for Health Care (allowed in all states) channels decision-making through a trusted loved one to make decisions on the patient's behalf if the patient becomes incapacitated. Yet while advance directives help frame future healthcare planning, there is not a general published guideline by the US Preventive Task Force regarding the use of advance directives based upon empirical data. In the past, there is been a great deal of resistance by physicians regarding discussing advance directives with patients due to their projected concerns regarding how patients or family members might respond to such decisions, as well as their own personal biases. In a primary care survey, 19.7% of patients had completed advance directives while 43.8% had discussed the topic of advance directives - but only 4.3% of these discussions had occurred with family doctors [1]. In another study of 310 patients, less than 1% reported an end-of-life conversation with a physician during their routine care [2]. Age and infirmity positively affect these interactions. Prevalence of advance directive discussions by primary care physicians in the elderly in another study ranged from 21% in the general elderly population, to 69% with terminally ill patients, and 81% with patients with mild to moderate Alzheimer's disease. In another study, physicians who had been in practice many years, and who had more experience both personally and professionally with advance directives were more likely to discuss them with patients who are infirmed, with multiple medical problems - 97.5% of physicians felt comfortable discussing advance directives yet only 43% of them did so with appropriate patients [3]. Advance directive discussions must be process-oriented, with a discussion

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of patient values that serve as a foundation of articulating their future life-sustaining treatment preferences [4]. Some have already called for a methodology of embedded templates in to medical records to facilitate discussion of advance directives [5].

With the advent of the Electronic Medical Record (EMR), the stage was set for new opportunities to allow for reminder systems as well as regimentation of documentation to facilitate requests for an execution of advance directives. One intervention used a reminder system within the EMR to set parameters of chronic illness that ultimately assisted in improved documentation rates of advance directives by over six-fold [6]. On the other hand, another study showed that the EMR can ultimately result in multiple, duplicative locations for advance directive documents, and that standardization for advance care planning documentation is necessary [7]. In this paper will set out a means by which standardized queries can be used for patients with capacity to inquire about their willingness to discuss advance directives, as well as the values and preferences that act as their foundation.

During the formulation of the Affordable Care Act, one aspect originally included was to provide for reimbursement of primary care physicians to discuss advance directives. However, this provision of the act was excluded due to the inflammatory public debate framed around "death panels", which accused the healthcare system of coercing patients into executing an advance directive that would cut off treatment prematurely to save cost [8]. In a fortunate turn of events, CMS has wisely reinstated the opportunity for physicians to be reimbursed for counseling regarding advance directives as of January 1, 2016 [9].

CMS and ACP

CMS has embraced the usage of reimbursement with CPT codes 99497 and 99498, which will allow for the first 30 minutes, and each additional 30-minute time segment respectively, that is required for "explanation and discussion" on advance care planning [9]. This discussion can take place with both physicians as well as allied care health providers such as social workers, etc., and allow for reimbursement with Work Relative Value Units (wRVUs) of 1.5 and 1.44, CPT codes 99497 and 99498 respectively [9]. Further, these discussions can take place within the context of an additional module of the annual wellness visit with a notation that this is billed under modifier 33 (with no deductible is applied).

With primary care physicians turning to their Electronic Medical Records (EMR), it would be facilitative to construct some form of ready-made text template that would then allow for patients to articulate the necessary aspects of advance care decision-making that could then help the physician in future times of patient incapacity. As noted in the advance care planning guideline from Michigan, the relevant topics that one should be covering in the advance care planning process include healthcare values, proactive conversations with family, identification of a surrogate decision-maker, inclusion of cultural sensitivity, and, where applicable, POLST orders [10]. Despite the bias that patients don't want to hear about advance directives, patients have indicated that they are readily willing and able to have such discussions [11]. What follows is a proposed EMR template that can readily be used as a free text or quick text template that can be utilized within the framework of any commercial electronic medical record. It is founded upon ethical and logistical principles grounded within two constructs in primary care medicine: *The Values History* and the *Family Covenant*.

The Values History was originally developed in the late 1980s as a means by which to identify a patient's philosophical, social, cultural, and religious values and how these values play a role in the selection of life-sustaining treatment in the face of terminal illness without hope of recovery or irreversible coma/persistent vegetative state [12]. The Family Covenant is a prospective physician family agreement that articulates a framework of decision-making for the dissemination of information as well as whom within the family is allowed to have access and who may serve as primary and secondary decision-makers [13,14]. These two advance care planning documents allow for a nuanced, ongoing discussion that will facilitate future healthcare in the face of incapacity with a more meaningful articulation of how one's decisions are grounded within the values of the patient and then applied to future circumstances of incapacity. As one's values can have a powerful role for both the patient and the family in making healthcare decisions, it is best to frame the decision regarding the Living Will and the Durable Power of Attorney for Healthcare by having an in-depth discussion on those aspects of one's life that would ground these two legal documents. To sign a piece of paper without having such a discussion would be no more meaningful than signing a legal contract without reading its stipulations, and understanding its meaning. This discussion must take place not as a singular event but as a process of discovery for the healthcare provider in understanding those aspects of life, philosophy, and spirituality that are important to the healthcare of the patient.

It is also possible that while these undercurrents of values are present, there has not been an attempt by the patient to overtly examine their own bases for making healthcare decisions. It is unfair for a physician (and their patient) to thrust a sheet of paper and say "sign this" as the patient may not understand why they would

wish to sign such a piece of paper and what the implications of their signature may be for their own future. Advance care planning requires of the physician to be sensitive and diligent to the needs of the patient regarding prospective healthcare decision-making, and cannot rush nor dally in their endeavor.

Given the new CMS guidelines regarding advance care planning, physicians now have an opportunity to be reimbursed for these efforts. Prior to this point, physicians had a valid complaint that this effort was time intensive, non-reimbursed activity. Very importantly, as there is been an increasing schism between outpatient healthcare providers and inpatient hospitalists, those outside of the hospital have less "skin in the game" to broach what is a sensitive area of discussion. Further, previous research has shown that physicians are reluctant to initiate these discussions because of their own reservations, but also how it may adversely impact the patient and their family.

The Advance Care Planning Template

The Advance Care Planning Template consists of two sections, one addressing planning efforts attempted in the past, those they would consider in the future, medical surrogacy, and quality of life general values. Section 1 first addresses whether the patient has any form of advance directive whether informal or formal, i.e., one that has been fashioned by oneself, versus one that is recognized by the jurisdiction in which they live (Figure 1).

Next, the provider proceeds to ask whether they have an established living will as per their jurisdiction as well as a healthcare proxy/healthcare surrogate/durable power of attorney for healthcare (DPA-HC). This offers an opportunity for the provider to engage the patient in education regarding both documents, their defined use, how they can be executed, and the utility of having loved ones serve as surrogates. The next query specifically requests whether the patient would like to have that op-

Advance Directive Counselling

Do you have an **advance directive**?: Y N

Do you have a **living will**?: Y N

Do you have a **healthy proxy**?: Y N

Would you like an opportunity to write your values and preferences regarding advance care planning?: Y N

Do you have a trusted person who you want to make decisions on your behalf in the event of your disability or incapacity?: Y N

Do you have a trusted person whom you DO NOT want to be allowed to make decisions on your behalf in the event of your disability or incapacity?: Y N

Quality of life General Values

Which of the following two statements is the most important to you?

I want to live as long as possible, regardless of the quality of life that I have experience. Y N

I want to preserve a good quality of life, even if this means that I may not live as long. Y N

Why?

Figure 1: Basic queries on advance directives.

Quality of life value queries

1.) I want to maintain my capacity to think clearly Y N

2.) I want to feel safe and secure Y N

3.) I want to avoid unnecessary pain and suffering Y N

4.) I want to be treated with respect Y N

5.) I want to be treated with dignity when I can no longer speak for myself. Y N

6.) I do not want to be an unnecessary burden on my family. Y N

7.) I want to be able to make my own decisions. Y N

8.) I want to be experience a comfortable dying process. Y N

9.) I want to be with my loved ones before I die. Y N

10.) I want to leave good memories of me to my loved ones. Y N

11.) I want to be treated in accord with my religious beliefs and traditions. Y N

12.) I want respect shown for my body after I die. Y N

13.) I want to help others by making a contribution to medical education and research. Y N

14.) Other value Y N

15.) Other value Y N

16.) Other value Y N

Which 5 values are MOST important to you?

Why?

Figure 2: Specific queries on quality of life values.

portunity to engage in a discussion on a written advance directive. If the patient wishes to not have that discussion at that point, it can be noted into the medical record, as well as some indication as to whether the patient will accept written materials such as the forms as well as question-and-answer informational materials. Next, the patient is requested to identify a person allowed to make decisions on their behalf in the case of future incapacity - a surrogate decision-maker or durable power of attorney for healthcare. This can also include a discussion on other family members who can serve as a backup to that person selected as a DPA-HC agent, or those persons who can be consultants to represent the patient's substituted judgment and best interests in a future time of patient incapacity.

As part of both the Values History and the Family Covenant, the patient then is asked to articulate whom they would *wish not to be included* in future healthcare decision-making at a time of incapacity (that is, a proxy negation) [12]. This could be done due to a variety of personal and values-based differences between the patient and that family member - but acts to delineate those persons that the patient believes cannot serve to best reflect the patient's values, and does not speak in their best interests at a time of surrogate decision making in the future. This effort can best be thought of as a "reverse durable power of attorney" in that this person has been identified as someone who does not serve the patient's best interests for whatever reason the patient wishes to clarify or identify, or even if they wish not to do so. The next query addresses the patient's general values towards quality of life, specifically asking the patient as to which they value more how long they wish to live or how best they wish to live. Interestingly, past empirical research is shown that fewer than 10% of respondents wish to live as long as possible, and rather, the overwhelming majority of patients wish to have a high quality of life while they are sentient [15]. The second part of the template addresses quality of life value queries as well as a relative ranking of these values by the patient (Figure 2).

These values, although framed within a context of yes or no questions, are intended to stimulate narrative aspects of respect, communication, benefit, and other aspects of healthcare ethics intrinsic to end-of-life. It is by no means all-inclusive, but is a starting point for discussion. In this discussion, the patient is asked to identify their three (up to five) most important values, as well as why they are important to them in terms of future healthcare. It also gives one an opportunity to identify other values as well. Those values that address respect and communication (1, 4, 5, 7, 11, 12, and 13) are intended to frame that aspect of the discussion that reflect the need for the patient to pass on to their family and their provider what things they do or do not want, and to have them carried out. Those values that emphasize patient concerns regarding avoidance of pain to themselves, comfort, and a desire to avoid family-based burden (2, 3, 6, 8, 9, and 10) facilitate discussion revolving around beneficence-based responsibilities in fulfilling values regarding the patient's as well as the family's benefit as deemed by the patient. The discussion section regarding ranking pertains to the fact that oftentimes persons will see all of these statements is important, however by having the discussion on ranking, it allows for persons to weigh them relatively for themselves, their families, and their providers so that there can be a better understanding of why treatment would wish to be entertained, or refused in the future.

This template has been successfully integrated into an EMR (All scripts Enterprise 15.1) at the author's clinic, as well as throughout the author's department's clinical sites. Face validity was checked with medical peers, with feedback on the utility of the template as very positive. Further, anecdotal feedback from patients resulted in universal positive responses about the helpfulness of clarifying their values and getting them known for themselves, their family, and documented in the EMR. Future work with the template will incorporate a formal evaluative component by survey, and perhaps also by focus groups. Template use allows for the discussion to take place in a manner consistent with CMS on advance care decision-making, and does so such that requisite meaningful use information can be collected with the template. This template is offered to all persons who use EMR's, who have discussions on advance directives in ACP, as well as to patients who wish to address their advance directives. To date, the author has successfully used this template to have meaningful discussions with many of his patient's and to document their values and preferences regarding life-sustaining treatment, as well as eliciting the execution of, and EMR scanning of, advance directives for the patient's future benefit. The template is available for all physicians, residents, social workers, and nurse practitioners. It must be noted, that for resident use, the attending physician who is precepting the resident must be present for this conversation in order to bill for it through current Medicare rules.

Conclusion

Importantly, due to the political fracas of unfounded, irrational fears of "death panels" that resulted in this aspect of CMS coding and billing being made separate from the Affordable Care Act, it frees it from any contemporaneous concerns regarding the potential repeal of the ACA. As a standalone aspect of healthcare, it can hopefully now be safeguarded as a liberty-based interest

of patients to have their future healthcare discussed by their physicians per their own request and allowance. With the current coding strategies now per CMS guidelines, one can have this discussion (whether 30 minutes or 60 minutes) by having the modular code added onto the patient's billing for a visit for other health reasons, or embedded within a preventative health visit. It is hoped that the opportunity afforded by the new CMS guidelines will allow for physicians to feel less encumbered about the need for having these discussions with their patients, and that any reticence by physicians based on their own personal values or those projected upon their patients can be overcome.

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