HMSA Advance Care Planning Concepts

What is advance care planning?
Advance care planning (ACP) is a process of reflection, discussion, and communication that enables patients to plan for when they’re no longer able to make or communicate their decisions about medical treatment and other care.

ACP is:
- Patient-centered care.
- Based on fundamental principles of self-determination, dignity, and the avoidance of suffering.
- An expression of values, beliefs, and life goals that helps guide future care, including how decisions are made and by whom. This applies when there’s an accident, sudden illness, or loss of the ability to express preferences.
- Especially important for care in the months prior to death, as well as care during the final days or weeks of life.
- A process that all patients, and especially those who are at “high risk” for health deterioration, can benefit from.
- Helpful to assure peace of mind for those members who wish to avoid certain treatments no matter what the circumstances may be.

1. ACP should be a component of routine health care for those ages 55 or older, although it’s appropriate for all adults.

Goals for patients:
- Learn about the importance of ACP.
- Select a surrogate health care decision maker.
- Complete a basic written advance directive that identifies, among other things, choices for treatment if there’s a severe, neurologic illness from which recovery is unlikely, chronic progressive illness, or terminal conditions.

ACP typically begins in one of two ways:
1. As part of a visit by primary care providers (e.g., physician, nurse, patient representative).
2. As part of a community activity with a community facilitator (e.g., clergy, advocates for seniors, parish nurses, trust attorney, social worker, volunteer)

Documentation requirements
ACP should result in documentation of one or more of the following in the patient’s chart:
- Advance Health Care Directive (AHCD).
- Durable Power of Attorney for Health Care Decision-making.
- If the patient isn’t ready or comfortable with completing either document, the chart should document the patient’s current thinking about the two documents and key questions for further discussion.
2. **ACP becomes especially important** for patients with a chronic, progressive illness who:
   - Start to experience a decline in functional status.
   - Have co-morbidities.
   - Are experiencing more frequent hospitalizations and ER use
   - Are at risk for complications which could lead to a loss of ability to make their own health care decisions.

**Goals for patients:**
   - Understand the progression of their illness.
   - Become familiar with potential complications.
   - Learn about the benefits, burdens, and choices regarding life-sustaining treatments that may be faced with if their illness progresses.
   - The patient’s health care agent(s) and other loved ones should be involved in the planning process, to enable them to support the care plan, and be prepared to make substituted decisions if necessary.
   - A more specific written plan identifies goals of care when death, cognitive impairment, or functional decline is likely.

**Documentation requirements**

ACP for patients with chronic progressive illnesses should result in more specific documentation of one or more of the following in the patient’s chart:
   - AHCD.
   - Durable Power of Attorney for Health Care Decision-making.
   - If the patient isn’t ready or comfortable with completing either document, the chart should include documentation of the patient’s current thinking about:
     - Advance directive decisions.
     - Durable Power of Attorney for Health Care Decision-making.
     - Key questions for further discussion.
     - The progression of illness.
     - Potential complications.
     - Life-sustaining treatments that may be required if the illness progresses.

3. **ACP becomes particularly important for:**
   - Patients with early cognitive impairment for whom future loss of decisional capacity can be anticipated
   - Patients with advanced disease and frailty.
   - Patients whose death in the next 12 months wouldn’t be surprising.
   - Individuals living in long-term care facilities and at risk of complications and losing their decision-making capacity.

**Goals for the patient:**
   - Converting specific and timely life-sustaining treatment decisions into medical orders to guide the actions of health care providers and be consistent with the patient’s wishes (POLST).
   - Participate in focused discussion including their designated health care agents to make the following health care decisions:
CPR.
- Goals of care for situations where cardiopulmonary failure can occur including choices regarding intubation and artificial ventilation, life support, and ICU care
- Choices regarding whether or not to be hospitalized
- Artificial nutrition and hydration.
- Comfort care options, including hospice care.
- A specific written plan documenting these decisions to ensure they’re honored by health care providers throughout the continuum of care. The Provider Orders for Life-Sustaining Treatment (POLST) paradigm has proven most effective for accomplishing this goal.

Documentation requirements

ACP should result in more specific documentation of one or more of the following in the patient’s chart:
- POLST (More information at www.kokuamau.org/professionals/polst).
- AHCD.
- Durable Power of Attorney for Health Care Decision-making.
- If the patient isn’t ready or comfortable with completing these documents, the chart should include documentation of the patient’s current thinking about:
  - CPR.
  - Goals of care for situations leading to cardiopulmonary failure, including whether or not to hospitalize
  - Artificial nutrition and hydration.
  - Comfort care options.
  - Advance directive decisions.
  - Durable Power of Attorney for Health Care.
  - Key questions for further discussion.
  - The progression of illness.
  - Potential complications.
  - Life-sustaining treatments that may be required if the illness progresses.

Practice care team members performing ACP counseling with video decision aides

Practices may bill 99497 and 99498 when practice team member performs ACP counseling with video decision aids. Note: E/M billing regulations don’t permit E/M visits on the same day unless the visit is a separate occasion for a different condition and satisfies medical necessity for a separate visit. It’s highly unlikely that two ACP visits in the same day will meet these criteria.

Importance of ACP

According to the 2013 U.S. Census estimates, there are almost 220,000 people over the age of 65 in Hawaii (15.6 percent of the population), and almost 45 million nationally (14.1 percent). The population 85 years of age is estimated at 35,000 for Hawaii and over six million nationally. As this population ages, physical function decreases, pain increases, and cognitive ability can decrease. Older adults become increasingly depressed or have complex medication regimens. As people age, it’s important to consider choices for end-of-life care and create an ACP. Assessing functional status and pain, medication review, and ACP can help ensure that older adults receive comprehensive care that prevents, to the extent possible, further health status decline while preparing for the eventual end of life care needs in a patient and family-centered way. (qualitymeasures.ahrq.gov/content.aspx?id=38855)
As people age, consideration should be given to their treatment wishes in the event they lose their ability to direct and manage their own care. There’s a large discrepancy between the wishes of dying patients and the end-of-life care they actually receive. Advance directives are widely recommended as a strategy to improve healthcare compliance with patient wishes at the end of life and ensure appropriate use of health care resources. There’s expert consensus on the need for advance directives and a regulatory mandate, but only 15 percent to 25 percent of adults complete advance directives, usually after a serious illness or hospitalization. It’s been found that most adults would prefer to discuss advance directives while they’re well, preferably with a doctor who has known them over time. Most say they look to their doctors to initiate the discussion.

(qualitymeasures.ahrq.gov/content.aspx?id=38855)

Evidence for ACP
Advance directives and outcomes of surrogate decision making before death. Silveira MJ, Kim SY, Langa KM.

Source:
Veterans Affairs Center for Clinical Management Research and Division of General Medicine, University of Michigan, Ann Arbor, USA. mariajs@umich.edu

Abstract
METHODS:
We used data from survey proxies in the Health and Retirement Study involving adults 60 years of age or older who had died between 2000 and 2006 to determine the prevalence of the need for decision making and lost decision-making capacity and to test the association between preferences documented in advance directives and outcomes of surrogate decision making.

RESULTS:
Of 3,746 subjects, 42.5 percent required decision making, of whom 70.3 percent lacked decision-making capacity and 67.6 percent of those subjects, in turn, had advance directives. Subjects who had living wills were more likely to want limited care (92.7 percent) or comfort care (96.2 percent) than all care possible (1.9 percent); 83.2 percent of subjects who requested limited care and 97.1 percent of subjects who requested comfort care received care consistent with their preferences. Among the 10 subjects who requested all care possible, only five received it, however, subjects who requested all care possible were far more likely to receive aggressive care as compared with those who did not request it (adjusted odds ratio, 22.62; 95 percent confidence interval [CI], 4.45 to 115.00). Subjects with living wills were less likely to receive all care possible (adjusted odds ratio, 0.33; 95 percent CI, 0.19 to 0.56) than were subjects without living wills. Subjects who had assigned a durable power of attorney for health care were less likely to die in a hospital (adjusted odds ratio, 0.72; 95 percent CI, 0.55 to 0.93) or receive all care possible (adjusted odds ratio, 0.54; 95 percent CI, 0.34 to 0.86) than were subjects who had not assigned a durable power of attorney for health care.

CONCLUSIONS:
Between 2000 and 2006, many elderly Americans needed decision making near the end of life at a time when most lacked the capacity to make decisions. Patients who had prepared advance directives received care that was strongly associated with their preferences. These findings support the continued use of advance directives. 2010 Massachusetts Medical Society.