



Transforming End-of-Life Care

Reaching New Heights of Patient Engagement through Advance Care Planning

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In the News...

- Recognizing the value of meaningful discussions among physicians, patients and caregivers, the Centers for Medicare & Medicaid Services (CMS) has established a separate payment and payment rate for advance care planning services provided to Medicare beneficiaries by physicians and other practitioners. Previously, CMS had provided coverage for advance care planning as part of the "Welcome to Medicare" visit available to all Medicare beneficiaries. However, Medicare beneficiaries may not have needed these services when they first enrolled. Establishing separate payment for advance care planning codes in recognition of practitioner time to conduct these conversations provides beneficiaries and practitioners greater opportunity and flexibility to utilize these planning sessions at the most appropriate time for each patient. CMS is also finalizing payment for advance care planning when it is included as an optional element of the Annual Wellness Visit. See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf>
- On October 30, 2015, CMS released the final 2016 Medicare Physician Fee Schedule, including two CPT codes to reimburse for advance care planning. The HCPCS codes became effective January 1, 2016. HCPCS Code 99497 is for advance care planning 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 healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate. The Final CY 2016 work RVU for this code is 1.50. The second HCPCS code is 99498 defined as advance care planning 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 healthcare professional; each additional 30 minutes (List separately in addition to code for primary procedure). The RVU for this code is 1.40. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-2.html>

IPRO Awarded CMS Special Innovation Project: Transforming End of Life Care

Quality care at the end of life should involve honoring a person's preferences, values, and beliefs; be based on evidence-based medicine; and allow for informed medical decisions made collaboratively and deliberately among the individual, family/caregiver, and healthcare professionals.

This fundamental belief is the basis for the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project newly awarded to the IPRO-led Atlantic Quality Innovation Network, the Medicare-funded Quality Innovation Network-Quality Improvement Organization for New York, South Carolina and the District of Columbia. AQIN is partnering with a nationally recognized expert in this area, Patricia Bomba, MD, F.A.C.P., Vice President & Medical Director, Geriatrics/Excellus BlueCross BlueShield & MedAmerica Insurance Company; and Chair, MOLST Statewide Implementation Team & eMOLST Program Director. AQIN will provide outreach and education to Medicare beneficiaries and their families/caregivers in the Long Island region of New York State, emphasizing the importance of advance care planning, including strategies to communicate end-of-life wishes to family and healthcare professionals.

IPRO will also collaborate with the hospitals, skilled nursing facilities, home health agencies, hospices, emergency medical services and physician practices within the target region to provide training and technical assistance for a community based adoption and implementation of NYS Medical Orders for Life-Sustaining Treatment (MOLST), New York State's Physicians Orders for Life-Sustaining Treatment (POLST) Paradigm Program, designed to improve the quality of care people receive at the end of life. This initiative will include use of the eMOLST Registry, a secure web-based application that allows enrolled users to complete the MOLST form electronically. The project will also promote the MOLST Chart Documentation Form for documentation of effective communication of patient wishes. The AQIN project aligns with the National Quality Strategy and CMS Quality Strategy triple aim to improve health, improve care and lower costs using innovative techniques to achieve the following goals:

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- Make care safer by reducing harm,
- Strengthen person and family engagement,
- Promote effective communication and coordination of care, and
- Work with communities to promote best practices of healthy living.

For more information on the project please contact Carolyn Kazdan, MHSA, NHA, Quality Improvement Specialist at IPRO, Carolyn.kazdan@area-1.hcqis.org or 518-320-3590 or visit the AQIN Transforming End of Life web page at <http://atlanticquality.org/initiatives/transforming-eol>

CDC Offers Free Online Course on Advance Care Planning for Public Health and Aging Services Professionals

The Centers for Disease Control and Prevention (CDC) is addressing advance care planning as a public health issue, emphasizing its potential for prevention of unnecessary suffering and support of an individual's healthcare decisions and preferences. The CDC has developed an online course specifically tailored to public health and aging services professionals. The course addresses the need to evaluate state-based comprehensive cancer plans to assure that end-of-life issues are addressed appropriately. The top priorities listed on the CDC website are to...

- Identify a chronic disease point person within each state health department to coordinate or be the liaison for end-of-life activities with relevant issues (e.g., aging and cancer);
- Collect, analyze, and share end-of-life data through state surveys such as CDC's Behavioral Risk Factor Surveillance System (BRFSS);
- Incorporate end-of-life care into state comprehensive cancer control plans;
- Educate the public about hospice and palliative care availability; and
- Educate the public about the importance of advance directives and healthcare proxies.

Information about the CDC's free interactive online self-paced course, which offers select continuing education credits, can be found on the CDC website at www.cdc.gov/aging/advancecareplanning/index.htm

Spotlight on Success: Implementation of MOLST Within the Skilled Nursing Facility

"I'm a fan of MOLST—it's clear, detailed and convenient."

So says Jacob Berelowitz, LMSW, CCM, Director of Social Services at Queens Boulevard Extended Care Facility. His facility adopted MOLST about two years ago and has been very satisfied with the results. "The transition allowed us to move from a multi-document Do Not Resuscitate (DNR) (The DNR consent form and the DOH Non-Hospital DNR Order) to one clear, well thought-out MOLST form that not only provides a document that is valid across healthcare settings, but also addresses other life sustaining interventions and eliminates the need for many of our ancillary forms. It provided a wonderful opportunity for us to reinforce our staff's knowledge of advance directives and best practices."

According to Berelowitz: "Perhaps the best part is that the MOLST facilitates meaningful discussion and effective communication about the plan of care between the resident and medical staff, allowing the resident and family to be very specific about medical intervention preferences, particularly when approaching palliative care. We have also had positive feedback from residents and families about not having to continually complete new forms on every medical facility admission. As we enjoy the benefits of using the MOLST, we look forward to advancing to the next stage of advance directive communication; adopting the digital eMOLST once its use becomes widespread in our region's medical facilities."

Patient/Beneficiary Engagement

The United Hospital Fund Next Step in Care website (www.nextstepincare.org) features easy-to-use guides to help family caregivers and healthcare providers work closely together to plan and implement safe and smooth transitions for chronically or seriously ill patients. The materials—available in English, Spanish, Chinese and Russian—highlight careful planning, clear communication, and ongoing care coordination.

For additional information, tools and resources please visit <http://qio.ipro.org/care-transitions/overview>.

For questions or more information please contact...

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