ACP Conversation Guide for Health Care Professionals

Honoring Choices® FLORIDA

A program of Community Hospice & Palliative Care in collaboration with Northeast Florida hospitals

Advance Care Planning – It's About the Conversation

Starting a conversation about end-of-life care can be difficult for all of us, even health care professionals. It is important to "normalize" the conversation and let each patient know that this is a routine part of developing a quality patient-provider relationship. Effective ACP is not just getting a document signed. It is a process of discussing goals of care, encouraging discussion with the chosen health care decision maker and family and educating the patient regarding his or her options.

Prepare Your Patient

The front office staff and MAs have an important role in introducing the topic:

"I see from your intake forms that you do not have an advance directive. The providers here feel that this is important planning for every adult."

"Your provider will be talking with you further about advance care planning. Let me give you some information to review."

Talking about ACP – Healthy Patients

Normalize the conversation:

"Mrs. Jones, I'd like to talk with you about something I discuss with all of my patients. It's called advance care planning."

"Have you given thought to the type of medical care you would want if you suddenly became too ill or injured to make your own health care decisions?"

"Have you given thought about who you would want to make these decisions?"

"Advance care planning ensures that you, your loved ones and your health care providers have a mutual understanding of your goals of care. When you are ready, it's important to document your preferences and give a copy to our office and your chosen health care decision maker."

Talking about ACP – Patients with a Serious Illness

Introduction:

"I think it would be helpful to talk about where things are with your illness. Is that okay?"

Assess patient's understanding and desire for information:

"What is your understanding of your illness and prognosis?"

"How much information about what may lie ahead would you like from me?"

Share medical information and prognosis:

Tailor what is shared based on the patient's preferences and proceed with scenarios that are relevant to the patient's diagnosis and progression.

Explore key elements of advance care planning:

"What are your most important goals as your condition worsens?"

"How much does your family know about your goals and wishes?"

"If you reach a point that you are unable to make your own decisions, who would speak on your behalf and make decisions for you?"

"Do you have that in writing?"

"Does that person know what care you want?"

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Closing the Conversation

Patient already has a written document:

"I recommend that you review your document to make sure it is up-to-date and talk again with your family and your designated decision maker to reinforce your wishes."

Patient does not have a written document:

"Please take this information home to review. I recommend that you put your wishes in writing and talk with your family about the care you would want if you were unable to make your own decisions. If you would like help with this, Honoring Choices Florida has people trained and they will help at no cost to you. You can call the number on the cover of the booklet or contact them through their website."

Billing Information

First 30 minutes	99497
Each additional 30 minutes	99498

CPT code 99498 cannot be used as a stand-alone code; 99497 must have been billed previously. There is currently no limit for the number of times 99498 may be used.

These codes may be used in both facility and non-facility settings and are not limited to a particular physician specialty. Additionally, if billed in conjunction with the Annual Wellness Visit using modifier 33, there is no additional co-pay to the patient.

MDs, DOs, PAs, NPs, clinical nurse specialists and nurse midwives are the only providers who can bill using these codes. ACP services may be furnished "incident to" the services of the billing practitioner and must include a minimum of direct supervision by the billing practitioner.

Time guidelines:

The provider must spend at least 16 of the 30 minutes indicated in each code descriptor face-to-face with the patient or the patient's family.

Documentation guidelines:

- Total time in minutes
- Details of discussion content
- Patient/Surrogate/Family "given the opportunity to decline"

Resources

We know time is a limited resource in a clinical setting. Honoring Choices® Florida, a program of Community Hospice & Palliative Care, offers tools to help guide you through advance care planning discussions with your patients. Our professionals can provide training to your clinical and office staff to become certified ACP facilitators. This training will provide them with the education necessary to guide patients through the conversation and to document their health care wishes.

Honoring Choices Florida is a proven model for advance care planning with a comprehensive framework for the ongoing planning beyond the initial conversation. Our website, HonoringChoicesFL.com, offers patient education materials, conversation guides and other resources to support your staff and your patients in having the conversation.

Billing guideline references can be found on the website under the "Health Professionals" tab in the CMS Advance Care Planning Billing document and in the Medicare Reimbursement FAQs document.

Contact us through the website or call 877.227.0050 with questions about facilitator training or to obtain the Honoring Choices Florida ACP document and educational materials for your patients and their families.