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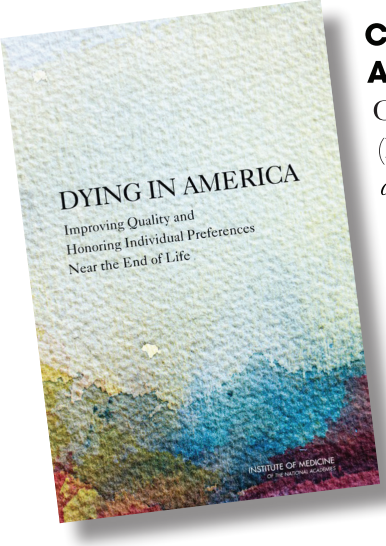
What Kind of Advance Care Planning Should CMS Pay For?

Thomas Harter, PhD *received a doctorate in philosophy from the University of Tennessee in 2010 and was a Bioethics Fellow in the Cleveland Fellowship in Advanced Bioethics from 2010-2012. Since joining the staff at Gundersen Health System (2012), he has worked to improve end-of-life care using the Respecting Choices model and the POLST (Physician Orders for Life-sustaining Treatment) paradigm. He is the Gundersen Health System co-chair of the institutional Ethics Committee and the alternate chair of the Institutional Review Board.*

Dr. Harter's contribution to BIO Quarterly *was originally published on the Health Affairs Blog, (March 19, 2015) and is re-printed here with his permission.*

Currently, Medicare does not offer a paid benefit for advance care planning (ACP). As a result, health care providers who want to assist Medicare enrollees with ACP do so voluntarily and neither they, nor their institutions, are compensated for their time and efforts. This is not only an unfair expectation on individual practitioners or health institutions, it is also medically and ethically unsound. Fortunately, two recent events have the potential to reshape the landscape of advance care planning in the U.S.



DYING IN AMERICA
Improving Quality and
Honoring Individual Preferences
Near the End of Life

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Cultural and Policy Evolution in Advance Care Planning

On September 17, 2014, the Institute of Medicine (IOM) published *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.* The report is built on two basic premises:

> Despite humankind's medical advances to lengthen life, death remains the inevitable outcome for all humans, and thus all people have a stake in improving end-of-life care; and Medical advances complicate the dying processes for many people in ways that medical training and health

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to Bio Quarterly are encouraged. Manuscripts may be original material or reprint with permission. Appropriate subject/topics include: issue analysis, cases, report of institutional activity or programs, legisative and policy commentary and book reviews. Please submit your article electronically to smithm24@ccf.org for consideration. Quarterly deadlines are the 15th of February, May, August and November.

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Sharon Darkovich,
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Bioethics Network of Ohio
25
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Serving Ohio Healthcare Ethics

● From the President

Sharon Darkovich, RN, MA, BSN, CPHQ

Hello everyone.

I hope you are all enjoying the Spring/Summer weather!

For those of you who attended BENO's 25th anniversary annual conference on May 1st, I trust that you found it enjoyable and enlightening. From the evaluations we received, it seems so. Thanks again to the Program Committee for a great conference! The Planning Committee for the 2016 conference (to be held on April 29) is already hard at work.

As we look ahead to the coming months, it is time for elections for BENO's Board of Trustees. I would like to thank our two out-going Board members, Anne Lovell and Karen Eubanks. It has been my privilege and pleasure to work with them over the past several years. They have been and are integral parts of BENO and the Bioethics Consultation Course, and their expertise and willingness to be part of these programs is truly appreciated.

I would also like to congratulate the graduates of the most recent Consultation Course who are identified later in this issue. Thank you for your interest and dedication to furthering bioethics in Ohio.

Because we will have openings for *three* Board members this summer, please send your application information to me at the e-mail address below as soon as possible if you are interested in running for the Board. Include your name, contact information and a brief paragraph regarding your qualifications and interest to serve in this capacity. Please also share this information with others at your respective institutions so they too can consider running for the Board.

The Board's functions include furthering BENO's mission of providing education regarding bioethics to the healthcare community. This is done by reviewing grant applications for the educational grants and working to provide high quality educational offerings through the annual conference and the Bioethics Consultation course.

Sharon Darkovich, BENO President
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WELCOME New BENO Members

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Sunni-Ali Islam
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Robin Imbrigiotta, MDiv
Mount Alverna Village
Parma, OH

Kathleen Bronson, MD, MS
CWRU & Cleveland Clinic
Cleveland, OH

Advance Care PLanning *continued from page 1...*

systems in America generally were not designed to address, making them ill equipped to balance complex patient needs in practice.

The IOM report finds that advance care planning is essential to improving the quality of end-of-life care. It also notes how traditional approaches to ACP—namely, having people complete advance directives on their own, such as living wills (LWs) or powers of attorney for health care (POAHCs)—have ultimately failed. Only about 25 percent of the general U.S. populace has documented its ACP preferences; even among people 60 and older, that rate only hovers around 50 percent.

The IOM report finds that advance care planning is essential to improving the quality of end-of-life care.

According to the IOM report, there are multiple reasons why these completion rates remain relatively low, including people's reluctance to converse with loved ones about death and dying and health systems' failure to standardize their internal ACP processes. The report also points to the typically poor quality of ACP conversations between patients and their loved ones or doctors in which vague or value-laden claims—such as "I don't want to die hooked up to machines"—are unexplored and taken at face value.

The IOM identifies a number of characteristics shared by most effective ACP approaches, such as understanding and treating advance care planning as a recurring discussion about someone's goals, values, and treatment preferences instead of seeing it as a one-time activity; including in ACP conversations those designated as power of attorney for health care; and accommodating diverse belief systems that can shape the treatment decisions people make at the end of life.

The second major event is the Centers for Medicare and Medicaid Services' (CMS) apparent willingness to begin considering reimbursement for advance care planning discussions between patients and providers. On October 31, 2014, CMS issued a final rule regarding revisions to its payment policies. This document contains two new practice billing codes, 99487 and 99497, which will officially recognize the efforts of physicians or other qualified health care professionals—those with education, training, and licensure—to engage in ACP with patients, including the explanation, discussion, and completion of standard advance directive forms.

There is still no actual reimbursement associated with these two codes (similar to when CMS initiated practice codes for palliative care). It appears that the usage of these two codes will help CMS determine whether or not to eventually reimburse for ACP — and for how much. It is not uncommon for CMS to use this kind of data when there is some uncertainty about how often a service like ACP is, or will be, used.

Respecting Choices

Both the IOM report and Medicare's new billing codes mark an evolutionary turning point for advance care planning in the U.S. Not only do these two events signify that ACP should be treated as a part of standard medical care, but the IOM report indicates what should be paid for under the new CMS practice codes. In particular, the IOM report states that the hallmark of good ACP is open, clear, respectful communication between the person doing the planning and his or her clinicians, loved ones, and health care agents. This implies that if CMS pays for ACP, the reimbursement should be based on ACP models that focus on this type of communication.

Both the IOM report and Medicare's new billing codes mark an evolutionary turning point for advance care planning in the U.S.

Advance care planning tools such as Physician Orders for Life Sustaining Treatment and living wills, can effectively communicate people's preferences when they can no longer make decisions for themselves due to long-term or acute mental declines. However, as the IOM describes, these tools are only as effective as the system in which they are implemented and used. One initiative highlighted by the IOM report for its successful incorporation of advance care planning into a broader health care system, is the La Crosse, Wisconsin-based Respecting Choices (RC).

continued...

RC was developed in the early 1990s as a community-wide collaboration among the four major health organizations in La Crosse: Gundersen Clinic, Lutheran Hospital, Skemp Clinic, and Franciscan Health System. While Respecting Choices is now exclusively owned and operated by Gundersen Health System, it continues to be used in all health care facilities in La Crosse, and the entire Gundersen system, which includes six hospitals and 27 clinics in 19 counties across the Wisconsin-Iowa-Minnesota tri-state area — a patient population of approximately 560,000. At Gundersen, operating costs for advance care planning are assumed by the organization. ACP conversations between clinicians and patients are not reimbursed by any traditional payers and ACP facilitators—those who are trained to assist persons with the advance care planning process—volunteer their time.

While physicians play an integral role in advance care planning conversations, it is simply impractical to expect them to have the time, training, or comfort level to discuss in depth a person's values, beliefs, and goals of care, address how that person's medical information fits with that worldview, and then ensure that person's medical choices are documented and communicated. Recognizing this limitation, the RC model relies on trained ACP facilitators to:

- Uncover gaps in their understanding about their individual medical situations then working with medical providers to help bridge those gaps.
- Engage patients about their values, beliefs, preferences, and goals.

- Help people communicate with their chosen health care agents and other loved ones about those values and goals of care.
- Help patients document their elected health care agents and goals of care using a tool such as a living will or powers of attorney for health care.
- Ensure that documented plans are easily retrievable by those who may need access including health care agents, loved ones, and medical providers.

Facilitators are trained then certified by Respecting Choices to conduct ACP in three distinct stages: when adults are relatively healthy, when they are beginning to suffer the effects of a chronic or life-limiting illness, and when they are near the end-of-life. RC facilitators who work with relatively healthy adults include nurses, social workers, physicians, and community volunteers without medical training. Facilitators who conduct ACP with ill people usually have some knowledge, training, and experience working with adult patients in this population. RC facilitators are assigned to work with populations that fit their level of training. Facilitators will only engage with people who say they want to create an advance care plan.

One reason the Respecting Choices model was explicitly discussed in the IOM report is because outcomes data is available to measure the program's impact. In 1995 and 1996, two years after the community-wide implementation of the RC model, Drs. Bernard Hammes and Brenda Rooney conducted The La Crosse Advance Directive Study (LADS 1), a retrospective study of 540 decedents in La Crosse. This study found that 85 percent of decedents had an advance directive and that 95 percent of these directives were documented in their medical records. When this study was repeated in 2007 and 2008 (LADS II), the numbers of decedents with advance directives that were also documented in their medical records rose, respectively, to 90 percent and 99 percent. What is perhaps most impressive, and most important, about the high percentage of people in La Crosse with advance care plans are the rates at which these plans are followed by health care providers. As noted in the LADS II study, eight patients were found to receive medical treatment inconsistent with their documented preferences in LADS I. LADS II found no cases of patients receiving treatment inconsistent with their documented treatment preferences.

Another measure of the RC model's success is its apparent economic impact on utilization and health care expenditures in the last two years of life. According to the Dartmouth Atlas for Health Care, Gundersen's 2010 utilization score was 0.40. This score—which is a ratio of the number of days patients spent in the hospital and the number of physician encounters they experienced as inpatients during the last two years of a person's life compared to a baseline score of 1—is lower than institutions in the National average (1.0), and even institutions in the 10th percentile (0.62). Gundersen's average Medicare expenditures per person over the last two years of life in 2010 were $48,771. This too sits well below institutions in the 90th percentile ($102,939), the National average ($79,337), and even the 10th percentile ($58,866). This impact is attributable to reducing wasteful spending related to providing unwanted care to patients at the end of life.

Respecting Choices has been implemented in many health systems and organizations throughout the United States—including Kaiser Permanente of Northern California—and in Canada, Australia, Singapore, and Germany. Well known statewide ACP programs such as Honoring Choices Wisconsin, Honoring Choices Minnesota, Honoring Choices Virginia, and Honoring Choices Florida are also based on the RC model. Randomized controlled trials of implementations nationally and internationally by ACP researchers such as Detering, Lyon, Kirchhoff, and in der Schmitten further demonstrate the success of the RC model and the ACP facilitation process.

> ***CMS's willingness to consider reimbursing for advance care planning sends a strong message to medical providers that ACP should now be considered a standard of care.***

CMS's willingness to consider reimbursing for advance care planning sends a strong message to medical providers that ACP should now be considered a standard of care. The IOM's recognition that traditional modes of advance care planning have failed to effectively guide treatment decisions for incapacitated patients—and the report's focus on innovative programs like Respecting Choices—sends a strong message to payers, including CMS, that advance care planning should be covered when it occurs as part of models that have demonstrated effectiveness in both completion and compliance of care plans.

Bioethics Educational Opportunities

The first statement of the **Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants** is, "Be Competent." It goes on to state, "Continuing education and training are essential to maintain these competencies and to foster professional development." Below is a sampling of bioethics continuing education opportunities during the rest of the year.

July 23-25 Conflict Resolution and Bioethics Mediation for Healthcare. Sponsor: the Alternative Resolution Dispute Institute. Visit: adrinst.com/healthcare_training.htm.

July 24-25 11th Annual Treuman Katz Center for Pediatric Bioethics Conference – The Delicate Triangle: Responsibilities and Challenges in the Provider-Patient-Parent Relationship. Visit: seattlechildrens.org/pediatric-bioethics-conference.

August 3-7 28th Annual Summer Seminar in Health Care Ethics. Sponsor: the Department of Bioethics & Humanities, University of Washington School of Medicine. Visit: uwcme.org.

August 7-8 Transplant Ethics: Dilemmas and Discussions. Sponsor: the Mayo Clinic College of Medicine. Visit: ce.mayo.edu (search "transplant").

September 18 2nd Annual Symposium of the Clinical Ethics Network of North Carolina "Saying No: Exploring the Ethical Dimensions of Refusals in Healthcare." Visit: cennc.org/

October 15-16 International Neuroethics Society's Annual Meeting. Visit neuroethicssociety.org/.

October 22-25 17th Annual Meeting of the American Society for Bioethics and Humanities. Visit: asbh.org.

November 2 2nd Annual Interprofessional Forum on Ethics and Religion in Health Care – Maintaining Dignity, Respect and Familial Cohesion as our Loved Ones and Patients Age. Sponsor: the Institute for Jewish Continuity and the University of Maryland Schools of Dentistry, Medicine, Law, Nursing, Pharmacy, and Social Work. Visit: law.umaryland.edu/mhecn (click on Conferences).

November 13-14 27th Annual MacLean Conference on Clinical Medical Ethics, The University of Chicago Law School. Visit: macleanethics.uchicago.edu/events/maclean_conference/2015_conference_program/.

● New Guidelines Aim to Resolve Conflicts in Treating Critically Ill Patients

Douglas White, MD, MAS *co-chaired an international task force that recently published a policy statement on "Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units." Dr. White is Chair for Ethics in Critical Care Medicine at the University of Pittsburgh Medical Center. He delivered the Jim Barlow Memorial Lecture at BENO's annual conference on May 1, 2015. Reprinted here is the Press Release for this task force's policy statement and guidelines.*

Who should decide what life-prolonging medical treatments the intensive care patient should receive: the clinician or the patient's family? The answer in almost all circumstances should be "both," according to the authors of a new policy statement from the American Thoracic Society aimed at providing guidance for crucial decision-making for the care of patients with advanced critical illness while preventing conflicts between medical staff and family caregivers.

"Neither individual clinicians nor families should be given unchecked authority to determine what treatments will be given to a patient," explained Douglas White, M.D., M.A.S., UPMC Chair for Ethics in Critical Care Medicine, associate professor in the University of Pittsburgh Department of Critical Care Medicine, and co-chair of the committee that produced these guidelines. "Clinicians should neither simply acquiesce to treatment requests that they believe are not in a patient's best interest, nor should they unilaterally refuse to provide treatment. Instead, if conflicts arise between clinicians and patients' families, a fair process of dispute resolution should be undertaken, in which neither individual can unilaterally impose his or her will on the other."

The statement has been published in the June 1st issue of the *American Journal of Respiratory and Critical Care Medicine* (available online<http://iz3.me/R9IO2zN4SMA1>) and is a new resource for an estimated 80,000 health professionals. It was supported by the Society of Critical Care Medicine, the American Association of Critical Care Nurses, the American College of Chest Physicians and the European Society of Intensive Care Medicine.

When a clinician is asked by the family of a critically ill patient to administer invasive interventions that the clinician believes will not benefit the patient, "such disagreements can present particular challenges, since they bring into conflict important interests of patients, clinicians and society," Dr. White said. "The cases are difficult because there are generally no clear, substantive rules to appeal to and because ICU patients are especially vulnerable because of their overwhelming illness and lack of ability to seek out another doctor if they disagree with the plan."

> ***Families need to be given a voice regarding what treatments are consistent with the patient's values and preferences and physicians' professional integrity also needs to be respected***

The guidelines emphasize that conflicts in the ICU can and should be prevented through early and intensive communication between the patient's family and the health care team. When conflicts cannot be resolved with ongoing dialogue, the policy statement recommends early involvement of expert consultants, such as palliative care and ethics consultants, to help find a negotiated agreement. If a dispute remains unresolvable despite intensive communication and negotiation, the committee recommends a fair process of dispute resolution, involving a review of the case by a multidisciplinary ethics committee within the hospital, ongoing mediation, a second medical opinion, offering family the option to seek to transfer the patient to an alternate institution, and informing the family of their right to appeal to the courts.

"Families need to be given a voice regarding what treatments are consistent with the patient's values and preferences, and physicians' professional integrity also needs to be respected, meaning that they should not be compelled to administer treatments that violate good medical practice," Dr. White said.

The policy statement also outlines innovative procedures for two additional situations. When families request treatment that is truly futile, meaning that it simply cannot accomplish its physiologic aims, the clinician should refuse to administer the treatment and should clearly explain the rationale behind the treatment decision. In addition, for situations in which medical urgency does not allow compliance with the longer dispute resolution process, the committee has provided expedited steps that, nevertheless, ensure a fair process.

"These guidelines provide clinicians with a framework to manage treatment disputes with an emphasis on procedural fairness, frequent communication, expert consultation and timeliness," said co-chair Gabriel T. Bosslet, M.D., assistant professor of clinical medicine at the Charles Warren Fairbanks Center for Medical Ethics at Indiana University. "We hope that states will adopt laws similar to these guidelines, so that all sides in a particular dispute can have the resources they need to come to a resolution."

Co-authors of the guidelines include Thaddeus M. Pope, Hamline University Law School; Gordon Rubenfeld, M.D., Sunnybrook Health Sciences Center; Bernard Lo, M.D., University of California, San Francisco; Robert Truog, M.D., Harvard Medical School; Cynthia Rushton, Ph.D., R.N., Johns Hopkins University; J. Randall Curtis, M.D., University of Washington; Dee W. Ford, M.D., Medical University of South Carolina; Molly Osborne, M.D., Portland VA Medical Center, Oregon Health Sciences University; Cheryl Misak, M.A., University of Toronto; David H. Au, M.D., VA Puget Sound Health Care System, University of Washington; Elie Azoulay, M.D., Ph.D., Saint Louis Teaching Hospital and Paris 7 University; Baruch Brody, Ph.D., Baylor College of Medicine; Brenda Fahy, M.D., University of Florida; Jesse Hall, M.D., University of Chicago; Jozef Kesecioglu, M.D., Ph.D., University Medical Center-Utrecht, the Netherlands; Alexander A. Kon, M.D., University of San Diego; and Kathleen Lindell, Ph.D., R.N., University of Pittsburgh.

● High Praise for BENO's Annual Conference

***Ali Jahan, MD**, was one of 135 participants at BENO's most recent annual conference held on May 1, 2015, when the Bioethics Network of Ohio celebrated its 25th anniversary. Dr. Jahan is the Medical Director of the Intensive Care Unit at Mercy Regional Medical Center in Lorain, OH, and he has a long-standing interest in bioethical issues, especially as they impact critically ill patients. Marty Smith, BIO Quarterly's editor, recently interviewed Dr. Jahan about his experience at the 2015 conference.*

Why did you attend BENO's annual conference this year?

I initially learned about this year's conference through one of our mutual colleagues, Margot Eves. She suggested that the conference would be a way for me to become intimately involved with bioethics. I had attended my first BENO conference in 2014. I not only enjoyed the "networking" aspect of that meeting but truly thought the topics were thought provoking and very informative in a dynamic fashion (not "boring"). So I decided to attend the conference again this year and I was definitely not disappointed!

Which Breakout Sessions did you attend?

I attended "Anatomy of an Ethics Consult Note: Developing Competencies." The reasons I attended this session were twofold. One, I feel that this is an area related to ethics consultation where my hospital and I can do a better job. My thinking was that if I had more concrete information or guidelines to present to my colleagues at Mercy about writing ethics chart notes, this would be very helpful. The second reason was because of the presenters. Since I have the pleasure of working with them [Margot Eves and Cristie Cole], I knew their format would be very dynamic, interactive and truly an enriching educational and training experience – which it was!

The other Breakout Session I attended was "Advance Care Planning: Past, Present, and Future." The reason I attended this session was primarily due to the concerns my colleagues and I have in regards to the new Ohio advance directive forms. I thought this would be a great opportunity to gain information and knowledge from authorities on this topic.

Which presentations were most helpful for your practice?

In addition to the breakout sessions, I learned an enormous amount of clinically relevant information from Dr. Doug White's plenary presentation which provided direction on how to manage requests for potentially inappropriate treatments. [Readers are directed to the article in this issue of *BIO Quarterly* by Dr. White]. This is a day-to-day challenge when caring for critically ill patients and even though I feel that I do a good job in managing these situations, it's always good to hear how others are approaching and responding to these difficult cases.

Comment on any "networking" opportunities you had to meet and talk with other attendees.

The networking opportunities at BENO conferences are tremendous. The best example that I can give you for this year was the opportunity to talk with Dr. White. For me, it is helpful to not only have "access" to my current fantastic ethics colleagues, but it is important for me to meet other critical care physicians who share the same interest in ethics as I have.

Will you likely attend next year's conference?

Not only will I attend next year's conference but because I truly thought this was THE BEST conference I've ever attended, it has motivated me to request to be a presenter on next year's program if the opportunity exists.

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Certificates Awarded for BENO's Ethics Consultation Course

BENO offers a year-long Ethics Consultation Course aimed at enhancing core competencies necessary for practicing proficiently as a clinical ethics consultation team member. Educational methods used during this course include didactics (four full days), mentoring, small peer group interactions, three independent projects, and reading assignments. A team of four BENO faculty provide the didactics, facilitate large and small group discussions, mentor participants, and guide project completion.

BENO's Board of Trustees and the course's faculty congratulate the most recent "graduates" who completed course requirements in 2014-2015 and who received their Certificates of Completion in May 2015:

Adedoyin Adetoro, MD, Adena Health System
Lisa Balster, LSW, Hospice of Dayton
David Berzon, MD, Hillcrest Hospital
Henry Blair, MD, Hillcrest Hospital
Heather Ciesielski, PhD, Cincinnati Children's Medical Center
Jennifer Discher, PhD, Mercy St. Anne Hospital
Rebecca Joseph, RN, CHPN, Genesis Hospice
Joseph Karnitis, MD, Promedica Fertility Center
Victoria Kumorowski, JD, LLM, MJS, DMin, Genesis Healthcare System
Julie Landoll, LSW, Mercy Willard Hospital
Amy D. Marcum, MA, BCC, St. Rita's Medical Center
Julia Miller-Lemon, NP, Hillcrest Hospital
Asma Mobin-Uddin, MD, Nationwide Children's Hospital
Susan Stone, DDIV, BCC, Hillcrest Hospital
Cindy Tuma, RN, St. Rita's Medical Center

A new group of participants began their year-long course on April 30, 2015. For information about enrolling in the 2016-2017 course (likely to begin April 28, 2016), contact course Registrar and faculty member Anne Lovell at Anne.Lovell@cchmc.org.