



Webinar Transcript

**MEASURING
ADVANCE CARE PLANNING
OUTCOMES**

Torrie Fields, MPH
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MEASURING ADVANCE CARE PLANNING OUTCOMES

DAVE SIMISON: Welcome! Five Wishes is pleased to present today's Practice Community webinar: Measuring Advance Care Planning Outcomes. I'm Dave Simison, the Vice President of Operations here at Five Wishes. It is now my pleasure to introduce Kathleen Taylor, our Five Wishes Healthcare Programs Director, who will facilitate our webinar today.

KATHLEEN TAYLOR: Thanks, Dave. And thank you for joining us for our webinar today: Measuring Advance Care Planning Outcomes. We host these informative webinars about quarterly, and we focus on topics that you tell us are the most relevant through your feedback.

And for anyone new, the Five Wishes Practice Community is for any healthcare professionals that use any components of the Five Wishes Program. Our primary goal with the Practice Community is to empower all of you who do the work of advance care planning to foster truly meaningful, effective and compassionate advance care planning conversations, and we do this by highlighting best practices and innovations and thought leadership.

The Practice Community serves a purpose in our national nonprofit Aging with Dignity's mission to educate and advocate. By providing sessions like these, we continue to pull in experts and offer guidance to assist all of us in providing the best care for the most vulnerable that we serve.

For the Practice Community we also provide mentoring and guidance for questions that you might have about advance care planning. If you think mentoring would help you, please email your questions and

concerns to us at PracticeCommunity@FiveWishes.org. We hope you find today's webinar useful.

At Five Wishes we work with thousands of healthcare organizations, and we frequently hear about the challenges and frustrations in measuring advance care planning outcomes, and even defining what to measure. There have been plenty of published research articles conducted to measure advance care planning outcomes, and there's also been plenty of journal articles that either support or question that research. So, it's a topic of a lot of debate currently. At the end of the day, I think we all want to establish that the work we're doing in advance care planning is enhancing the quality of care that we provide, and we want to be able to support the case for continuing to do it.

And measurement, to me, is one of the most important things that we can do, and I'll talk about a few reasons why. First of all, measurement is a way of ensuring that the activities that we're conducting — the advance care planning actions [and] interventions that we're doing — that we're doing those well, that we have skilled facilitators, that our processes are working, that we're having conversations across the life span, that we're discussing what's most important, really engaging in shared decision making as people experience changes in their health, and eliciting the right information in advance care planning conversations. So, we want to make sure that we're doing the thing that is advance care planning in the most effective ways.

Another reason it's important is, measurement ensures that advance care

“Measurement is a way of ensuring:

- *that the activities that we’re conducting — the advance care planning actions [and] interventions that we’re doing — that we’re doing those well.*
- *that advance care planning is a contributing factor to high quality and value of care.*
- *that leaders and managers can be empowered to meaningfully advocate for the time, resources, training and support required to do advance care planning well in all care settings.*
- *that the people we serve have beneficial experiences and good outcomes from engaging in advance care planning. ”*

planning is a contributing factor to high quality and value of care. If it’s not, we shouldn’t do it. But it probably is, especially if you’re doing it well.

Another reason is, measurement ensures that leaders and managers can be empowered to meaningfully advocate for the time, resources, training and support required to do advance care planning well in all care settings.

And another reason, lastly, is that measurement ensures that the people we serve have beneficial experiences and good outcomes from engaging in advance care planning.

So, it’s a big deal, and it’s also really challenging to do. And we are so lucky to have with us to talk about this today,

probably the preeminent expert in measurement. We have Torrie Fields with us today. Torrie is a skilled strategist, economist and population health researcher, and a passionate advance care planning advocate. She has over fifteen years of experience working with payers, employers, purchasers and providers to design and implement high-value and data-driven healthcare programs that improve the lives of people with serious illness and the lives of their families.

She serves as a strategic advisor and faculty with several different organizations, and has been directly involved in the design of many of the value-based care and payment models that you might be familiar with. We feel extremely lucky to count Torrie as a friend to Five Wishes, and we thank you for being here. Welcome, Torrie.

TORRIE FIELDS: Oh, thank you so much for having me! I must admit that this is my favorite topic. So, I will premise this conversation by saying that these slides are a little bit text heavy. We’re going to make this fun, and these are going to be takeaway slides for you so that you can get a little bit of a sense or an understanding of the framework by which we can really think about measuring advance care planning. So don’t be afraid by the words on the slides. They’re really just takeaways for you.

But to start, as Kathleen was saying, I have had the supreme opportunity to use my public health and population health expertise and apply it to value-based payment and to measurement and incentive programs for health insurance companies, for state agencies, and for the federal government in really trying to think about and address, where do services like advance care planning fit? We know that we need

them, we know that they are public health initiatives, but how do we make things like that more sustainable over time?

So, a lot of my work has really centered at the intersection of payment and measurement, which is why this is my favorite topic. I also have the opportunity to hold a number of roles with the Coalition to Transform Advance Care, the Center to Advance Palliative Care, and the Center for Healthcare Strategies on their Better Care Playbook. And what our team is working on right now is working to build out palliative care benefits at the state level in a partnership with the National Academy for State Health Policy.

So, there are a lot of activities going on as it relates to people with serious illness, and I'm really passionate about, how can we think about this more broadly and make sure that advance care planning is really everywhere for everyone? I am a two-time cancer survivor, and I did not know what advance care planning was when I was diagnosed at 19 years old, and I was led through my care without really knowing what was available to me. And so now I find it to be my moral obligation to pay it forward and help others understand what's available to them and how to speak up and think about their care [and] be more active participants.

So, I'm hoping to give you a little bit of a framework in terms of answering some of these questions that we often hear about when it comes to advance care planning.

Why should we focus on measurement? Kathleen shared some already. And often times people ask me specifically, as the finance person, what is the return on investment or the anticipated impact for advance care planning? How should we think about it as it relates to payment?

"The thing that gets me really excited about advance care planning is that it is for everyone. It can be approached as a population-level, or even a wellness activity. And there are a lot of opportunities to really apply advance care planning to larger population frameworks, such as age-friendly health systems that a lot of health systems are really looking to undertake, and state master plan fund aging that are trying to support communities that are aging in place."

I'm going to give just a little overview and background on some of the challenges when it comes to collecting data as it relates to advance care planning. And that is related to our challenges with reimbursement. And I'm hoping to then be able to give some of my thoughts in terms of where the field is going and where we can start to think about advance care planning in a more population health framework.

So to start, the thing that gets me really excited about advance care planning is that it is for everyone. It can be approached as a population-level, or even a wellness activity. And there are a lot of opportunities to really apply advance care planning to larger population frameworks, such as age-friendly health systems that a lot of health systems are really looking to undertake, and state master plan fund aging that are trying to support communities that are aging in place.

Advance care planning is a really interesting reimbursement code already because CMS

has taken the stance that advance care planning is a preventive service, which means that it is being performed in advance of a crisis. Now, they aligned that for people over 65 with the annual wellness visit, expecting or anticipating that a primary care provider would have an annual conversation with their patient and update their advance care plan. What an ideal world CMS thinks that we live in!

However, what we have today is an understanding that advance care planning does need to be done when somebody has a serious illness. However, what I have seen the tension being, especially coming from a payer, is that, how do we think about giving everybody the opportunity for advance care planning in advance of the crisis?

The challenge, though, is that a lot of publications have come out related to the impact of advance care planning, and those publications have largely been in the context of cost. And we don't necessarily know what's on somebody's advance care plan in order to determine whether their cost should be higher or lower. And that gives us an opportunity to really think about this from the consumer-empowerment

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perspective, and to think about where advance care planning fits as a requirement for care.

So, as I said, these slides are a little bit text-heavy, because this becomes complicated over time. One thing that we have learned, or I have learned, in developing policies and payment models for people with serious illness, is that we need to offer or have a continuum of care delivered to people with serious illness, and that always starts with the initial kernel of advance care planning. We need to understand somebody's health care wishes in order to determine what they need, and how to refer them to additional services.

So that's really the crux of all of these other models, including palliative care services, concurrent care, and hospice services. Advance care planning is an underpinning of those things.

KATHLEEN TAYLOR: And Torrie, I was actually going to highlight that as well, because it occurs to me that advance care planning — you could go horizontally across this very top dark blue row, and advance care planning is appropriate in all of these care services across, as I said in the beginning, across the life span, and across the care continuum. So yeah, we could have that going through each of these models.

TORRIE FIELDS: Exactly. In the definition of the model or the service, advance care planning is repeated in every single one of these models. Which means that you need to start with advance care planning and do it repeatedly over time to better determine how people get access to which service, and when.

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A Continuum of Care is Needed for People with Serious Illness

	Advance Care Planning	Palliative Care Consultations	Palliative Care Services	Concurrent Care Services	Hospice Services
Eligibility Criteria	Any beneficiary	Serious illness, with unmanaged pain and symptoms	Serious illness, with expectation of ongoing decline	Terminal illness, with prognosis < 6 months, physician attestation of prognosis	Terminal illness, with prognosis < 6 months, forego disease-related treatments , physician attestation of prognosis
Definition of Model or Service	Face-to-face service to discuss the patient's health care wishes if they become unable to make their own medical decisions. Can be performed in any setting	Pain and symptom management; advance care planning; care coordination. Can be performed via telemedicine or in-clinic.	Pain and symptom management; advance care planning; care coordination. Delivered longitudinally by an interdisciplinary team.	Pain and symptom management; advance care planning; care coordination with end-of-life treatments. Delivered longitudinally by an interdisciplinary team in conjunction with hospice care team. Available 24/7.	Pain and symptom management; end-of-life care planning; care coordination. Delivered longitudinally by an interdisciplinary hospice care team. Available 24/7.
Payment Model	99497 & 99498 CPT Codes; can be coupled with annual wellness visit for \$0 co-payment	Fee-for-service payments for advance care planning, E&M visits made by a physician or advanced practitioner, social work visits	Fee-for-service payments for advance care planning, E&M, home or domiciliary codes for visits made by a physician or advanced practitioner, social work visits	Only covered as part of a CMMI or private payor model. In testing under VBID Hospice and Kidney Care Choices. Tested through MCCM.	Per diem payments based on setting. Global bundled payment covering all aspects of beneficiary's end of life care
Requirements or Intersection with End-of-Life Care	50% of the time ACP is billed as part of annual wellness visit. 50% of time ACP is billed as specialty visit, where co-payments are applied, and ACP considered a specialty.	Currently not required and underutilized. However, when PC consult completed, beneficiaries accessed goal-aligned care more often.	When delivered by hospice care providers, main goal is de-treating and de-prescribing.	Has demonstrated longer length of stay on hospice when concurrent care is allowed, especially in black and underserved populations.	Currently under review for carve-in to MA and for consumer protections/hospice reform by Rep. Blumenauer (D-OR)



"...there's very little consistency with where (advance care planning) fits in different healthcare organizations... It can belong all the way across the care continuum, kind of like primary palliative care... but one of the only ways we're going to be successful with that is if we help organizations figure out how to tie this in to some kind of organizational strategic imperative. And if it doesn't get tied in, you probably will not have an easy time getting the resources and the measures of using those resources."

KATHLEEN TAYLOR: And one more thing that I'll add about that is we — and you and I have talked about this — we hear from, as I mentioned, so many different healthcare systems, hospitals and care providers, and one of the consistent things that we hear is that there is difficulty in finding what people feel is the appropriate ownership of advance care planning. It is owned by different departments: palliative care; sometimes the cardiac — I've had cardiac floors owning advance care planning; we've had chaplaincy services that kind of own advance care planning; social work; discharge; admissions...

So, what we find is that there's very little consistency with where it fits in different healthcare organizations. And that is something that I think cuts both ways. It's difficult to advocate for how many resources you need to do this well if you don't

have the leadership buy-in from a strong department that owns it. But the benefit of it not really belonging anywhere is that it can belong everywhere. Just like you're talking about with this slide. It can belong all the way across the care continuum, kind of like primary palliative care, when we talk about the point of that. And I would love to see that it does, but one of the only ways we're going to be successful with that is if we help organizations figure out how to tie this in to some kind of organizational strategic imperative. And if it doesn't get tied in, you probably will not have an easy time getting the resources and the measures of using those resources.

TORRIE FIELDS: It's fascinating that you say this, because I worked in the health insurance space for about 15 years, and in looking at it from that perspective, we had the exact same challenge, saying, where do these services fit when they are cross-cutting? And I was an actuary at the time, so it partially fit into Finance, and it partially fit into Quality, which created and required a very strong partnership between clinical leadership in our organization and financial leadership in our organization. And that alignment really is something that must be driven from the top.

So, for the leaders on this webinar, there is a responsibility to say, okay, how do we set this up in a way where it is sustainable and where it can really scale?

To this point, there has also been some real opportunity in starting to think about and discern between what advance care planning is and what serious illness communication is, or goals-of-care conversations that are completed over time.

One of the challenges for reimbursement for advance care planning, as I shared, is

that it was set up to be a preventive service. So that is different from serious illness communication, and anticipates that these are decisions for future care when you are someone who is well. And it is something where you can have conversations with a colleague or a friend or a clergy member, that doesn't necessarily need to include a clinician as part of advance care planning.

When we start to think about medical decision making, that's when we move into serious illness communication, where there does need to be some partnership between a person, their family, the community, and the healthcare delivery system. And that's something that wasn't always necessarily accounted for in the reimbursement structure for advance care planning today, and is why you're hearing a lot of the impetus or the push to advocate for some of these bigger care models, because advance care planning is really the kernel that lives within all of those different care models for people with serious illness.

Back to what Kathleen was saying in the introduction, there have been a number of publications related to return on investment of advance care planning. However, those return on investment or impact evaluations have assumed that somebody's advance directive would actually reduce the care that they receive. And we're not certain what is on somebody's advance directive, so I'm not certain that I can put my money behind saving money [from] advance care planning.

However, what we do know is that it allows for a conversation to begin and for decisions to be considered and for decisions to be documented for future caregivers. So, it may not be that advance care planning doesn't work, but maybe we're measuring the wrong things.

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So, you look at something like *Clear, Simple and Wrong*, or *What's Wrong with Advance Care Planning?*, and some of those things are really that we're measuring the impact of utilization of services rather than somebody's empowerment around decision-making.

As I said — again, busy slides here — but some general overview on reimbursement for advance care planning that makes this a little bit difficult to evaluate. As I shared previously. Oh, go for it Kathleen...

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KATHLEEN TAYLOR: Oh, I'm sorry, I didn't mean to interrupt you there. We've had a really good question come through, though, that fits in with what you've got right here in this portion. There's this — it's wonderful that Medicare has this as an avenue, and then as you're talking about some of the caveats with that — but I'm curious if you've heard about there being reimbursement for advance care planning, again, across the life span, everyone over 18. I know that private insurers do frequently pay for that, but we're not seeing that as, you know — Medicare tends to drive and shape the models because it's such a big payer, and because it's usually the bulk of how most healthcare systems are getting reimbursed, it tends to drive the way they do care.

So, is that something that you see on the horizon, having advance care planning conversations reimbursed by more and more payers for people across the life span?

TORRIE FIELDS: Absolutely. CMS already reimburses for advance care planning using these two codes [99497, 99498]. So, those codes are available for any insurance company to reimburse for. So that's the first thing. What we have heard over the past couple of years, as you were sharing, is that some insurance companies on the commercial market have either decided not to "turn on" or pay for those codes, or have different rules in place that make it difficult to be reimbursed for services. This is an administrative problem.

So, this is something that is a state-by-state problem that needs to be fixed on the commercial insurance market, where commercial insurance companies should be paying for advance care planning today under CMS rules. So, this is something to

A Note on Advance Care Planning Reimbursement

- Advance Care Planning is currently reimbursed using two time-based CPT codes (99497, 99498)
- Originally designed to be an addition to a risk-adjusted encounter or time-adjusted Evaluation & Management code.
- Specifically designed to augment or extend an Annual Wellness Visit, Advance Care Planning is considered a Preventive Service when used in this way. No co-pay is applied when ACP is performed by a person's Primary Care Physician performing the Annual Wellness Visit and Advance Care Planning on the same day.
- Considered a core component of all palliative care and hospice services.
- CMS did not impose a limit on the number of times the code may be billed. Practitioners should time your patient and family meetings and bill the correct/accurate number of units that you used. These must be contiguous minutes of patient counseling, not charting.
- 50% of the population accesses ACP through the Annual Wellness Visit, while 50% access ACP when faced with a serious illness, seeking support from a specialist.
- Because 50% of ACP is delivered by a specialist, some patients may receive a bill for co-pay or co-insurance if billing is not correct.
 - Remember to apply the correct modifier (-33) so that advance care planning can be counted as preventive, even when patients already have a serious illness.
 - If modifier is not applied, some patients can receive an up to 20% copay. It is encouraged to have a script or a plan to discuss with the patient, hopefully before the visit.



advocate for at the state level if your health plan does not reimburse for advance care planning.

Now, there are a number of challenges with the advance care planning codes, that have some changes that we're seeing being explored. One of the things that is specific to the advance care planning codes is when a co-pay applies. So, for advance care planning to be considered a preventive service, it must be coupled with an annual wellness visit, and it must be performed on the same day by somebody's primary care physician performing the advance care planning visit and the annual wellness visit. And it's in those circumstances where the co-pay becomes zero.

My research partner, Susan Enguidanos, found that, in review of those advance care planning codes, 50% of the population

accesses advance care planning through the annual wellness visit, but 50% access advance care planning when faced with a serious illness and they're seeking that support from a specialist, which means that the co-pay then applies.

And so this becomes a challenge for the under-65 population — Kathleen, to your question — because if more people who are under 65 are seeking advance care planning from a specialist, then they would be charged upwards of a 20% co-pay for that. And this is something that we are actively advocating to change, because CMS has already ruled that advance care planning is a preventive service — it just doesn't seem to be configured that way.

KATHLEEN TAYLOR: Which doesn't mean you can't do it with these folks. We're talking about reimbursement right now,

but I want to make sure that when we talk about measurement we also talk about — measurement doesn't always have to be tied to reimbursement.

TORRIE FIELDS: Absolutely.

KATHLEEN TAYLOR: But you can still do, and should do, advance care planning with patients where there isn't a formal reimbursement structure like this.

TORRIE FIELDS: Right. And this is something that, in terms of what must be measured, there are some things that are even more unclear here, where even if you are seeking reimbursement for advance care planning, the coverage determinations are made locally, and so reviewers have different understandings of what counts for advance care planning documentation. They have some parameters around that, around what they have stated needs to be documented, but it just gets more and more murky as you keep looking.

When looking at this, CMS, in their *Medicare Learning Network* newsletter, identified these specific documents as what "counts" as advance care planning documents. And this will be important a little bit later in the conversation, because CMS has also been shifting some of this and these requirements to insurance companies, that are starting to open up some of these expectations on providers.

The major billing and payment issues are that, number one, advance care planning reimbursement is not enough if it's completed as a standalone activity. It's not a serious illness conversation. It is something that was designed to be coupled with another visit. So, it's not something that should be considered standalone from the payment perspective.

It's also — when it's delivered by a specialist, it's considered a specialty, and so a lot of health systems — some health systems, maybe not a lot — have actually stopped allowing for reimbursement because of the disproportionate co-pay that gets applied when someone seeks advance care planning.

Also, social workers and nurses are often the ones performing advance care planning as part of their scope, but they are unable to bill independently for advance care planning services.

KATHLEEN TAYLOR: That's something that's really, I think, irksome to anyone who's been doing this for a while and who's highly skilled, because the reimbursement requirements are disconnected from the concept of us having the most skilled professionals conducting the conversation. The list of who are the — what are they called, authorized professionals, what is the terminology? I think that's it. There's a list of clinicians that are allowed to do this, but it's not a list of who's the most skilled in advance care planning. And if someone

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outside of those disciplines is extensively trained and very good at this, it doesn't matter according to the reimbursement rules. And I will just say — I'm going to keep putting a flag in this — it doesn't mean that these people shouldn't be doing advance care planning. It just has to do with the reimbursement. And there are some other creative, some other ways to think about the value of having your most highly skilled facilitators doing advance care planning. Even if they can't bill for it, there's still reasons to do it that way, which I know we're going to get to later.

TORRIE FIELDS: Yeah, that's right. These are really — when you're looking at advance care planning and why the results are inconclusive when you're looking at the overall publications that we have today around the cost and utilization for advance care planning, it's very difficult to even measure who has received it, and where they're receiving it. And there are so many other things that really give context, that tell us that we need to measure something different — not that the services should be performed differently.

And you look at this, and chaplains are not even able to bill at all, so when you look at this, it's not that they are not doing it, it's that they are unable to account for the work that they do — and may even have more time.

KATHLEEN TAYLOR: And because electronic medical records are in many ways billing machines, these things get tied to codes. When people are pulling data about advance care planning, often they are looking for billing codes, which is leaving out a lot of advance care planning conversations and activity that may have occurred in ways that could not be captured by those

"When people are pulling data about advance care planning, often they are looking for billing codes, which is leaving out a lot of advance care planning conversations and activity that may have occurred in ways that could not be captured by those codes, so that's to me a huge consideration in measurement. What looking at billing codes tells you is how many times you use those billing codes. It doesn't give us much information about quality or the nature of those activities."

codes, so that's to me a huge consideration in measurement. What looking at billing codes tells you is how many times you use those billing codes. It doesn't give us much information about quality or the nature of those activities.

TORRIE FIELDS: Exactly. So, you know, where do we go from here, now that we feel really beaten down by fee-for-service advance care planning codes? Well, we have started documenting when we perform advance care planning through those codes, but we've also started to educate insurance companies and CMS about where advance care planning fits, as we talked about.

So, when you find that 50% of the population is accessing advance care planning through primary care and 50% of them are not, you need to change your strategy. And so CMS has actually started coming out with federal and state level requirements that are related to equity and related to quality measurement. And the

"CMS has actually started coming out with federal and state level requirements that are related to equity and related to quality measurement. And the first one that changed was last year. This affects Medicare Advantage plans. And this is their quality measurement framework — their HEDIS framework..."

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first one that changed was last year. This affects Medicare Advantage plans. And this is their quality measurement framework — their HEDIS framework. And HEDIS is a way for health insurance companies to demonstrate the quality of care that they provide for their population. And in return, those Medicare Advantage companies get more money from CMS if they are higher quality. How cool is that? I really like HEDIS.

The one thing I really like about HEDIS is that they are squarely focused on advance care planning, and the HEDIS measures that changed in 2022 — I'll share a little bit more about them in a second — but they have expanded documentation for advance care planning, and have also incentivized these health plans to start demonstrating

how many people in their population are receiving advance care planning. They're not required to document through those reimbursement codes. So, just something to think about. They can be creative as to how they create that data set to determine who gets the advance care planning services in their population.

That, coupled with Managed Medicaid in the states — Medicaid agencies are now requiring their Managed Medicaid plans to deliver things like advance care planning or caregiving services or personal care services to their populations. And so for those insurance companies that have Medicaid and Medicare beneficiaries, advance care planning is in both of their measurement frameworks. So, they need to have a way to document and deliver advance care planning to their populations. And again, that's not tied to the reimbursement codes. They just need a solution.

The additional piece to this which is really interesting is what changes are being made to hospitals and health systems. And there are two programs that are related to hospitals and health systems: the Medicare Shared Savings Program and the Accountable Care Organization Programs, both of which are different payment structures, and they have requirements for advance care planning as part of their measurement portfolios from CMS.

So, while some of the publications may seem "inconclusive" about what the impact is, CMS has demonstrated that this is a standard quality measure across their population for anybody over 65.

KATHLEEN TAYLOR: And Torrie, are these — the Medicare Shared Savings and Accountable Care ACOs — is this where we're seeing the ability to reimburse for

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advance care planning conversations with inpatient populations?

TORRIE FIELDS: Yes.

KATHLEEN TAYLOR: Yeah. Okay. That came in as a question, so I wanted to clarify that.

TORRIE FIELDS: Great. So a little bit about HEDIS. As I shared, advance care planning was added as a new HEDIS Measure for 2022, so just last year. And this is our opportunity to educate insurance companies, but also to educate our providers who are delivering advance care planning about what the value really is currently to CMS from a quality perspective.

So, providers can be reimbursed for having discussions regarding advance care planning with Medicare Advantage beneficiaries. That's actually something — Kathleen,

to your point — that's something that all Medicare Advantage Plans have to do. So if you're talking to a commercial insurance company that has a Medicare Advantage plan, they must pay for advance care planning. It's a quality measure.

In addition, they've really defined who is a person who needs advance care planning at baseline. They've said people 66-80 who have advanced illness or frailty or who are receiving palliative care, and any adults over 81, they need to have advance care planning every year.

So, this is the requirement on Medicare Advantage Plans from CMS right now. In exchange — go for it...

KATHLEEN TAYLOR: Well, I'm just— my brain is just attaching this to the earlier question about advance care planning across the life span. So, if we have a, let's say an Aetna that has a Medicare Advantage plan, they must provide this as a service for people not only under that plan, but anybody who's purchasing a commercial insurance plan or a private insurance plan from them — correct?

TORRIE FIELDS: They are not required to measure advance care planning for any of their commercial beneficiaries, however, they are required to reimburse for advance care planning for their population.

KATHLEEN TAYLOR: Thank you.

TORRIE FIELDS: Absolutely. And this is something where it gives you a little bit of a framework. And the incentives to the insurance companies are that, if you select the advance care planning measure for these populations, you don't have to report other measures, including colorectal screenings, breast cancer screenings, mammograms, things like that for this population, because

More Sophistication in Measurement through HEDIS

Code	Definition	Code System
99483	Assessment of and care planning for a patient with cognitive impairment	CPT
99497	Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) Provided by the physician or other qualified health care professional	CPT
1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)	CPT II
1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan (DEM) (GER, Pall Cr)	CPT II
1157F	Advance care plan or similar legal document present in the medical record (COA)	CPT II
1158F	Advance care planning discussion documented in the medical record (COA)	CPT II
S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)	HCPCS
Z66	Do not resuscitate	ICD10

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they have been carved out of some of the other measures.

So, there is an incentive on the health plans to get better at identifying who really should have these advance care planning conversations so that they are not subjected to other screenings or other requirements that may not be the best use of their time.

The other thing that the HEDIS measures did was gave us a little bit more sophistication in terms of how we document advance care plans. So, the Medicare Advantage organizations were also given these requirements, including additional codes. So as you see, these are CPT codes that are more specific to what happened in that conversation of advance care planning, and what was the result.

So, they're really looking to start to tie some of the goals of care to the advance

care planning conversations to ensure that documents can be found in the medical record, or that they understand if somebody has cognitive impairment or not. Really interesting.

However, as Kathleen was saying, the challenge with advance care planning is that we don't have something that measures overall societal impact. What I like to take an approach for is really the socio-ecological model of healthcare communication or of behavior change. And that is really premised on the fact that we need to look at and measure things in different ways, depending on the impact of the service that we're providing. And advance care planning is a really interesting conundrum in this way.

What does advance care planning do overall for our population? Advance care planning fits in the equity portfolio. It addresses

equity through access to information, resources and services. And so, one of the best ways that we can do to measure that is the result of advance care planning being a referral to another service.

So, instead of thinking of advance care planning as something that may change utilization or change cost, we can think about advance care planning as something that provides access. So, provides access to more knowledge; it also provides access to more services. And that allows us to deliver a further continuum of care.

From the community perspective, what advance care planning does is address access and inclusion through shared decision-making and shared accountability. And that can occur in the healthcare setting, but it doesn't need to. Advance care planning is something that definitely can be performed as part of just your community offering, and actually should be over time.

And from the interpersonal level, it fosters trust through connection and authenticity. And some of the ways that we can measure that are really around personal empowerment and self-sufficiency, and how people feel in terms of being heard and understood by both their healthcare delivery system and by their healthcare proxy.

So this gets to this individual level of why we need to do advance care planning early and over time, so that we can measure self-efficacy and self image through exploration of values and values-based decisions, which is what advance care planning really is.

I'll just share very quickly that for me advance care planning really hits close to home. I lost every person on this slide during COVID. My family is not in healthcare. They do not know how to navigate the system. But we have a network of caregivers who

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understood one another's values. And while our values were very different, we all felt empowered, and each one of us got the things that we wanted in the end.

Advance care planning does that for families, and that's what it needs to measure. It prepares people like my parents to interact with and navigate the healthcare delivery system. It empowers people like

Consumer Empowerment, Patient Experience & Self-Sufficiency

Clinical and community interventions focused on advance care planning have been successful in measuring:

- Self-empowerment, including a person’s and caregiver’s level of confidence in decision-making
- Beneficiaries feeling more heard and understood as part of their care
- Increased referrals to necessary and available services
- Self-Sufficiency related to disability and physical health

Table 4. ACP Engagement Survey (34-Item) Results From 220 Participants^a

Domain	Paired No.	Mean (SD) score		Score difference (after – before)	P value
		Before game	After game		
Knowledge (2 items)	210	3.63 (1.15)	4.01 (0.96)	0.38 (1.24)	<.001
Contemplation (3 items)	196	3.24 (1.13)	3.36 (0.98)	0.12 (1.12)	.16
Self-efficacy (12 items)	173	3.64 (1.01)	4.18 (0.81)	0.54 (0.98)	<.001
Readiness (17 items)	164	2.86 (1.09)	3.19 (0.90)	0.33 (0.98)	<.001
Total score (34 items)	144	3.19 (0.92)	3.59 (0.73)	0.40 (0.74)	<.001
ACP Engagement Survey 4-item ^b	195	2.95 (1.17)	3.29 (0.98)	0.33 (1.03)	<.001

Van Scoy, 2016

Table 3. Rates of ACP Behavior Among 220 Participants

ACP behavior ^a	Participants, No./total No. (%)
Completed new advance directive	91/220 (41)
Updated, reread, or completed new advance directive	106/220 (48)
Talked to loved ones	176/220 (80)
Talked to clinician	43/220 (20)
Discussed game	154/220 (70)
Reviewed resources	122/219 (56)
Funeral planning ^b	14/212 (6)
Financial or insurance planning ^b	20/212 (9)
Other behavior	14/212 (6)
≥1 ACP behavior	214/219 (98)
≥3 ACP behaviors	145/215 (67)

Abbreviation: ACP, advance care planning.

me and my aunt to understand the best decisions for them on a very personal level, and it enables beneficiaries to develop shared plans over time.

And what was even more important was that it allowed for us to be on the same page, and to advocate for what we wanted, and to ask for help, and to navigate even when resources were limited during COVID. And advance care planning can hold space for that. So, it’s more than just a document, and can be used in a lot of different contexts, which also is something that needs to be the framework for measurement.

And one of the best ways that I have seen has come from community evaluations of advance care planning. So, Lauren Van Scoy from the University of Pennsylvania Hershey evaluated an advance care planning game called the Hello Game by an organization

called Common Practice, and they evaluated advance care planning performed in churches with African Americans around consumer empowerment and action toward care. And what they did was actually look at different domains of advance care planning engagement, rating increases in knowledge, self-contemplation, self-efficacy, readiness, and action.

So, you see on the right, some of the actions that people took toward their care. And on the bottom, you’ll see how people’s knowledge or their self-efficacy really changed. And these are things that can be performed in the community, these types of evaluations, relatively easily, with some sort of basic scales and surveys.

So, in terms of thinking about measuring the impact of advance care planning, one thing to do is to really divorce advance care

planning from just serious illness, and look at advance care planning as a population measure, and as the first step to a standard of care overall for people.

So, we should be expecting that everybody is getting advance care planning and that that number is going up, and that 100% of the population that you see in the HEDIS measures are receiving advance care planning.

We do need to go beyond coding to make sure advance care planning is occurring and that it has impact. So, I would encourage the Practice Community to think about how you start collecting the advance care planning conversations that are performed that are not being reimbursed, because that's important in and of itself to collect.

Measurement and evaluation approaches then can collect data for activities in the community, and we need to start publishing on those things. And there are already tools that can be used for some of this evaluation, and the publications from Lauren Van Scoy have some of those scales in them that can be used.

There are also new measures for hospice and palliative medicine that can be extended to other communities or populations that evaluate somebody's feeling heard and understood, or their overall experience of care. And that is based on a community survey called the CollaboRATE tool that can be delivered across multiple settings and multiple languages.

So, I would encourage you to really look at advance care planning as something that can support the overall patient experience and overall patient empowerment, or self-empowerment.

"We do need to go beyond coding to make sure advance care planning is occurring and that it has impact. So, I would encourage the Practice Community to think about how you start collecting the advance care planning conversations that are performed that are not being reimbursed, because that's important in and of itself to collect."

KATHLEEN TAYLOR: And as Dave mentioned in the beginning, we'll connect with you Torrie, and when we send the follow-up email, we'll send a link to how to access that CollaboRATE survey that you mentioned, and investigate further into that. Thank you.

TORRIE FIELDS: Awesome. We are participating in partnering with U.S. Aging and the Coalition to Transform Advance Care on an initiative to start expanding advance care planning as part of services with AAAs and other community-based organizations. And so, there will be a couple of sessions in October at the C-TAC summit related to advance care planning, and how we can measure it a little bit differently in order to address health disparities.

Alright. With that, thank you very much.

KATHLEEN TAYLOR: Oh, thank you, Torrie! And we have had — I'll say this is really interesting — we've had quite a few questions come up that have to do with billing. So, it's interesting to me that we're trying to talk about a larger theme of measurement, and what tends to bubble up for people, because there's been so much

attention to it lately, are the intricacies of billing, and the qualified professionals and who can really have the conversation, if the physician introduces it, and what's the difference in the codes... And we will try to address those individually in some follow-up emails, but I didn't want to get too far into billing intricacies during this webinar because we're talking about measurement.

I do want to ask a question of my own to get your help with. When we work with healthcare providers, what we mostly hear that they are measuring — the typical provider is measuring, and these are the standard ones:

- They're measuring number of completed advance directives in the EMR. I'm not saying these are good or bad, but I just want to talk about some considerations with these.
- They're measuring, some people are measuring the number of conversations that are conducted and noted or coded with an F Code or something in the EMR.
- Billing, of course, for advance care planning during the Medicare annual wellness visits, which we've talked plenty about.
- Some, particularly non-profit hospitals, are measuring community engagement in advance care planning, and when you just talked about the study with the game, that's a great community engagement initiative.
- And then, I would say even the more advanced measures are people trying to connect utilization patterns and correlate them or connect them with the presence of an advance directive.

I just want to mention those and ask, what are your concerns or considerations for those, since that seems to be where people are putting their energy right now? And

it's important, I think, to address the real practical considerations, so that people can leave this webinar with an idea of, how can I do this better, and how can I measure what actually has to do with the quality of our care and the experience of the people that we're serving? So, given that that's where most people are aiming, what should we be thinking about differently?

TORRIE FIELDS: I think, in thinking about these different measures that are being collected, what strikes me is that we need to define the denominator. So, the number of completed advance directives makes a lot of sense, but how are you measuring that, and what's the expectation over time? And I think that that's what was really exciting to me about some of these payer-based quality measurement requirements, because they're expecting that a subset of this population, 100% of those patients are getting advance care planning. And so I am interested in knowing, what's the percentage that you expect getting a completed advance care planning document, so that I would understand the context of that number?

So, if you're talking about number of conversations being completed, and they're being performed in the community, what's the percentage of your population who is seriously ill, or older, or fits into that area where you're really wanting to ensure that people are getting advance care planning conversations really quickly, and you're closing that gap quickly over time? Otherwise, counting the number of conversations doesn't really put it into context or help us understand if we have improved or changed.

KATHLEEN TAYLOR: Right — or if those conversations resulted in people feeling truly prepared and empowered to make

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decisions in real time. And the other thing with counting the number of advance directives — I understand that's a really easy data point to extract, and sometimes that's the big challenge for health systems, is, what data can they get their hands on? What's the burden of retrieving the data or doing a survey? And that needs to be considered.

But my issue with completed advance directives — I'm not saying don't measure it — but completed advance directives, that's not always — that's not our goal of advance care planning

TORRIE FIELDS: Well, having them completed is — it doesn't document the process. And that's really — the slide that I was sharing that says, what did people do? Self-contemplation, or contemplation of these things, is an activity in and of itself, and that can take a lot of time. And so, we don't know, and should not force people into making decisions too quickly, otherwise they're really not making their own decisions. So, in terms of thinking about it that way, measuring somebody's action, rather than completion, helps you understand if they are actually changing, or if there's a behavior change, which is really what we're trying to measure with advance care planning.

KATHLEEN TAYLOR: That makes sense. We're about at the end of our time. We could go on and on about this, there's so much rich information. And you've done an incredible service for everybody who's listening to this webinar, Torrie. Thank you so much — so much — for everything you've done and all that you've shared with us.

Again, we will — if there were resources mentioned, we will send links and information about that in a follow-up email to everybody who's registered for the webinar. If you had an individual detailed question about billing, which there were a few, I apologize that we didn't address that on the webinar, but we will just get back to you in an email with some more information about that. So, thank you for being a participant and asking those questions, and we will get back to you.

And that's about it. And with that, thank you again Torrie, and I'm going to pitch it back to Dave to close us.

DAVE SIMISON: Well, thanks again. As a reminder, this presentation was recorded, and will be available to view within seven business days. You'll find it, along with all of our other recorded webinars, by visiting

the Five Wishes webinar page at FiveWishes.org/webinars. Please feel free to share the Five Wishes Webinar page with your teams and your colleagues. And on behalf of all of us at Five Wishes, thank you to our speakers, and to you our participants and attendees. Have a wonderful afternoon.

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This Five Wishes Practice Community Webinar was recorded live on September 27, 2023. To learn more about the Five Wishes Program for Healthcare or to participate in future live Webinars, please visit us at FiveWishes.org/Healthcare.