

Wellforce Clinical Webinar Series

Serious Illness Conversations

Presented by: Tamara Vesel, MD, Chief of Palliative Care, Tufts MC

October 21, 2021

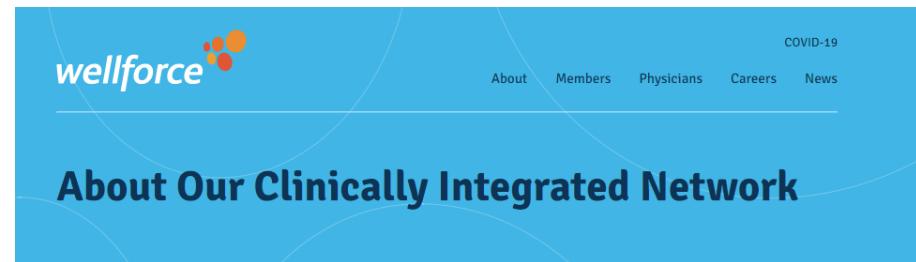
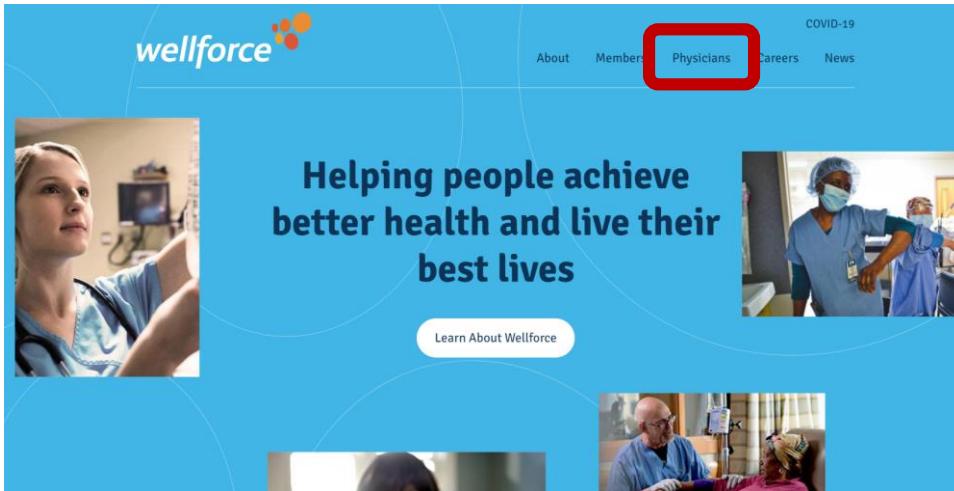
Zoom Participation and Etiquette



This Webinar is brought to you by the Wellforce Clinically Integrated Network:

*A distinctively different population health and value-based care contracting entity that builds upon the best of **Lowell General PHO** and **New England Quality Care Alliance (NEQCA)**.*

Visit Our New Site to Learn About the Wellforce Clinically Integrated Network: wellforce.org/physicians/clinically-integrated-network



We Are *The Physicians' Network*

Our Network was formed in July, 2021 by envisioning what it would take to create a distinctively different population health enterprise. We built upon the legacy of two long-standing, high-performing organizations – Lowell General Physician Hospital Organization and New England Quality Care Alliance (NEQCA) to launch a new Network that is well-positioned for future success.

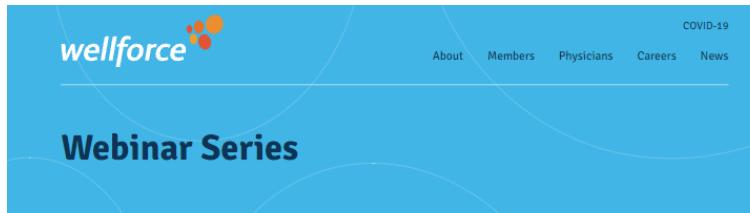
Mission and Vision

Our Network's mission is to bring together private practice and employed physicians, community-based and academic care providers, and primary care and specialists to

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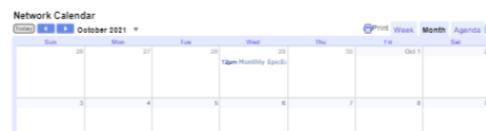


Supporting our physician community

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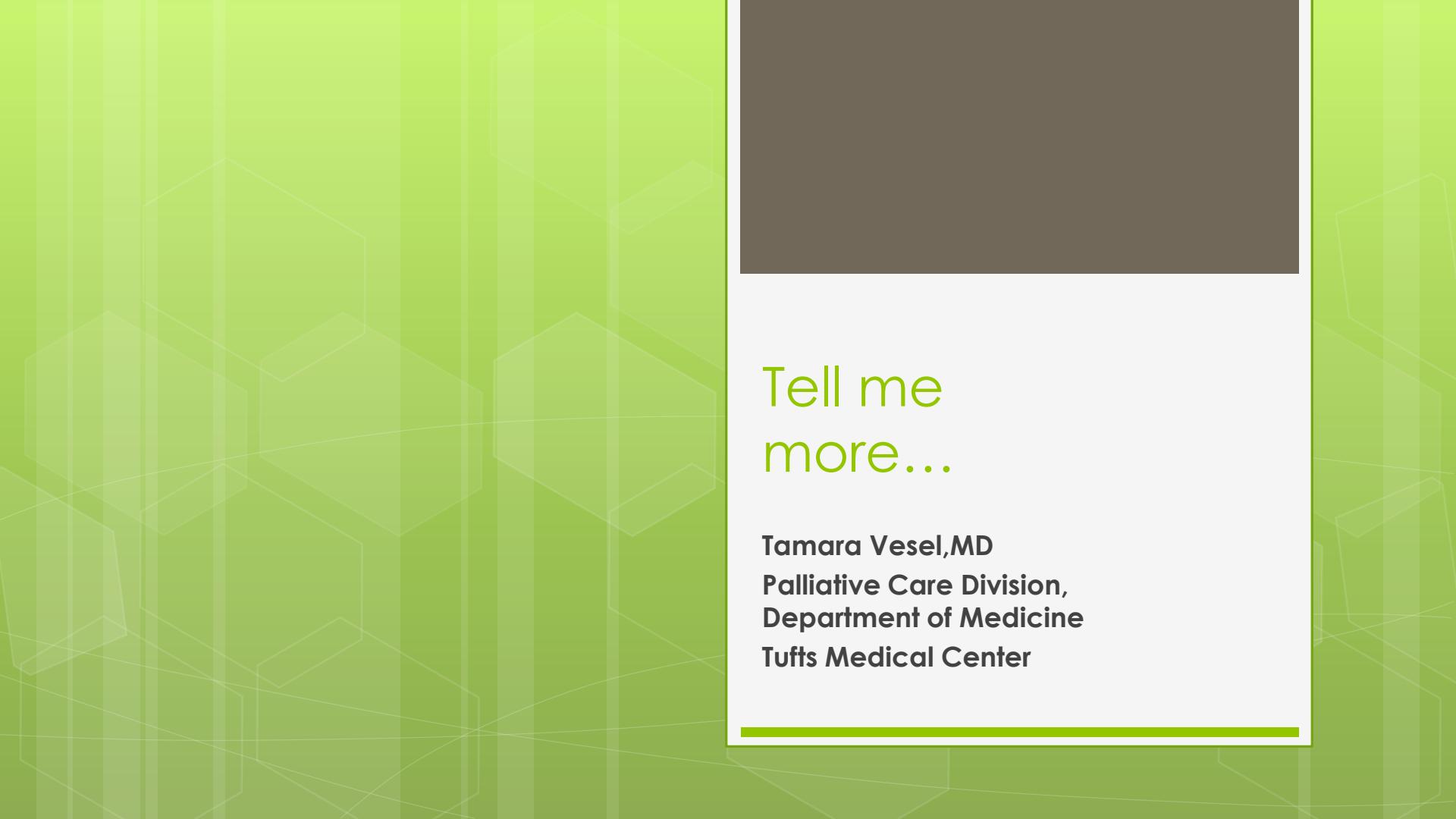
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Agenda

- Welcome and Introductions
- Goals of Care/Serious Illness Discussions
 - *How to have them, when to have them*
 - Q&A
- Advance Care Planning Visit
 - Coding and Billing
 - Q&A

Serious Illness Discussions

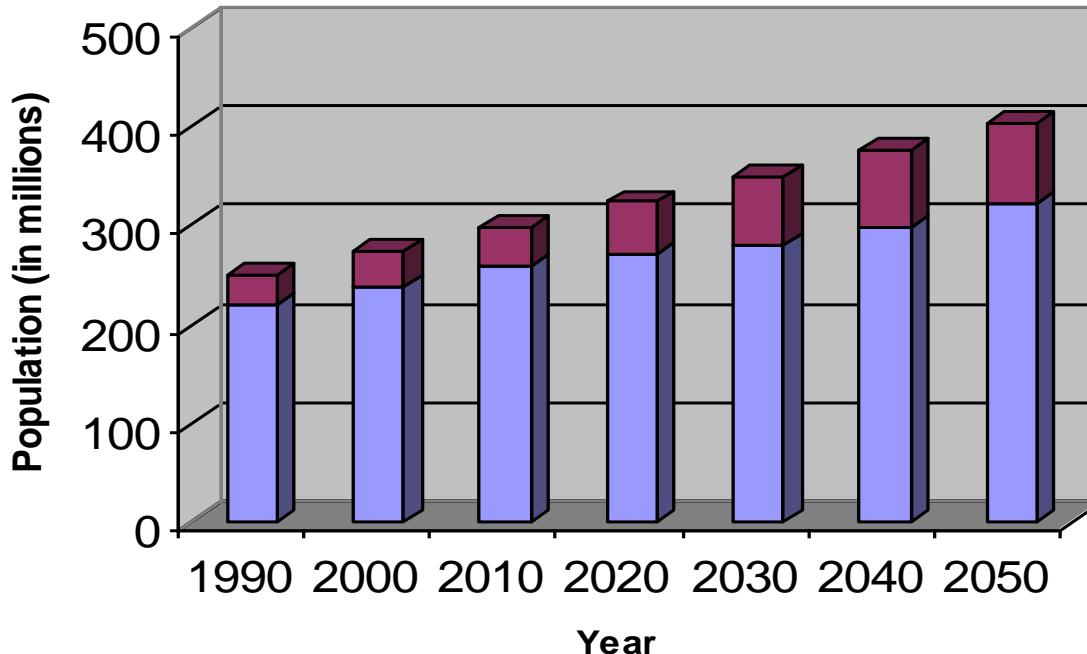
Dr. Tamara Vesel, MD Chief of the Division of Palliative Care, Tufts Medical Center



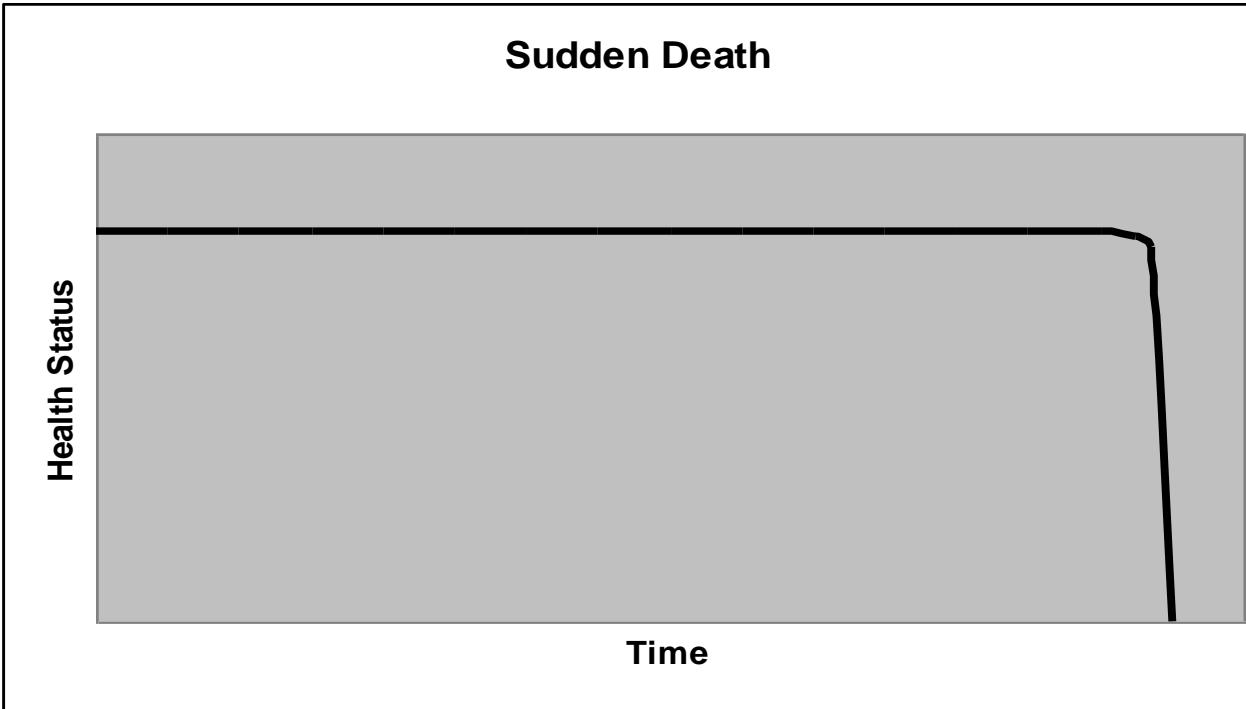
**Tell me
more...**

**Tamara Vesel,MD
Palliative Care Division,
Department of Medicine
Tufts Medical Center**

Americans are living longer



What patients want

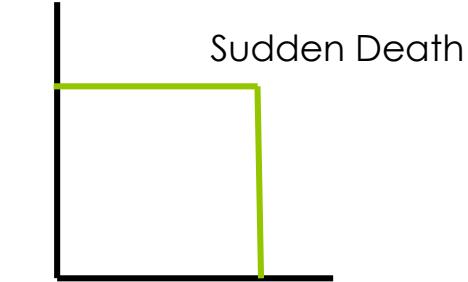


What do patients with serious illness want?

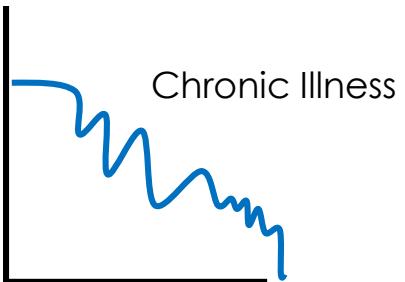
- Pain and symptom control
- Avoid prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Singer et al. JAMA 1999;281(2):163-168.

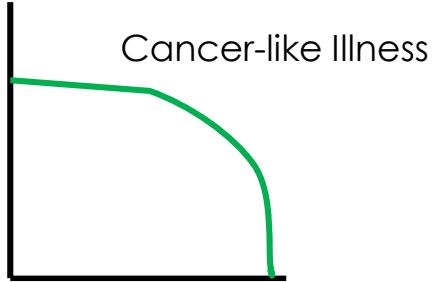
What they get...



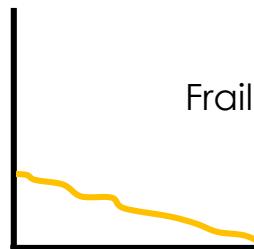
Sudden Death



Chronic Illness



Cancer-like Illness



Frailty

Adapted from Lunney, 2003

What do hospitalized patients get?

- Physical suffering
- Poor communication regarding goals of medical care
- Care discordant with patient and family preferences
- Financial, physical, and emotional burdens on family

Teno et al. JAMA 2004;291:88-93.



"There's no easy way I can tell you this, so I'm sending you to someone who can."

● ADVANCE DIRECTIVES

- Only can be done *in ADVANCE* when a patient has capacity.
- Kicks in only if patient is:
 1. Incapacitated AND
 2. Diagnosed with a qualifying condition
 - Terminal
 - PVS
 - End Stage

Advance Directives

1) Living will

document that specifies what types of medical treatment are desired.

2) Power of attorney

document in which you name a person to be a **proxy** to make all your health care decisions if you become unable to do so. Before a medical power of attorney can be used to guide medical decisions, a person's physician must certify that the person is unable to make their own medical decisions.

3) Health Care Proxy

DNR- Do not resuscitate

- In hospital

MOLST form in MA

- Out of the hospital

Conversation Tools

- <https://theconversationproject.org/>
- <https://www.vitaltalk.org/>
- <https://www.capc.org/>
- Serious Illness Conversation Guide-Ariadne lab
- <https://www.bioethics.northwestern.edu/programs/epec>
L
- <https://www.aacnnursing.org/ELNEC>

Four Fundamental Principles for Better Communication

- **Principle 1: “Ask-Tell-Ask”**
- **Principle 2: When you are stuck, ask for more information: “Tell me more”**
- **Principle 3: Respond to emotion (NURSE)**
- **Principle 4: Assess the patient’s coping style**

Goals of care Conversation

- Elicit patient's and/or surrogate's understanding of the patient's condition
- Get permission to share news
- Elicit what is most important to the patient in the context of the illness
- Explore your patient's values as they influence care options, or guide surrogate decision-makers to explore the values and goals of the patient

My own wisdom ☺

- If you don't know what to say- remember kitchen table conversation with your mom/grandma
- Low hanging fruit
- What keeps you awake at night?
- Bells curve of Being present

Thank you

- tvesel@tuftsmedicalcenter.org

Discussion/Questions

Advance Care Planning Visit

Donna Campbell, Risk Adjustment Manager

Advance Care Planning Documentation and Coding Guidelines

- Voluntary Advance Care Planning (ACP) is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care.
- CPT has established two time-based codes (99497, 99498) for Advance Care Planning
- When reporting these codes, no active management of problem(s) is undertaken during the time period reported.
- CMS has not issued specific guidelines, but suggested the following as examples of appropriate documentation:
 - An account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter;
 - Documentation indicating the explanation of advance directives (along with completion of those forms, when performed);
 - Who was present; and the time spent in the face-to-face encounter.

Advance Care Planning Documentation and Coding Guidelines

- If ACP is billed with the Welcome to Medicare Visit (IPPE) or Medicare Annual Wellness Visit (AWV), cost-share is waived. Append the modifier -33 to the claim.
- If Advance Care Planning is billed with non-AWV visits, no modifier is used and cost-share will apply.
- There are no limits to how frequently ACP can be reported for a given beneficiary in a given time period. However, when the service is billed multiple times for a single beneficiary, CMS expects to see documentation which supports the need for multiple conversations – such as a change in health status and/or wishes regarding care.
- ACP **can** be provided via telehealth (either video or audio-only).
- For more information, please see the Medicare Learning Network [Advance Care Planning Fact Sheet](#)

ACP: CPT Codes and Medicare Allowables

CPT Code	Description	Notes	Medicare Allowable Reimbursement: Metro Boston (non facility)	Medicare Allowable Reimbursement: Rest of Mass (non facility)
99497	ACP 30 minutes	Minimum face-to-face time is 16 minutes* (*per CPT guidance, a unit of time is attained when the halfway point + 1 minute has been passed)	\$93.94	\$88.48
+99498	ACP each add 30 minutes	Add this code when you have spent at least 46 minutes in face-to-face time.	\$80.75	\$76.46

Discussion/Questions

Upcoming Events

Mark Your Calendar!



EpicEdge Community Info Sessions

Program Overview and Billing sessions for Wellforce Private Practices interested in the EpicEdge Community Offering. Learn more [here](#).

Billing Overview:

Monday, October 25: Noon - 1:00 p.m.

Program Overview:

Thursday, October 28: 5:30 p.m. - 6:30 p.m.

Mark Your Calendar!



IEP for Home Seminar Series

LEARN HOW TO SET YOUR CHILD UP FOR SUCCESS AT SCHOOL

The *IEP for Home* seminar series provides detailed psychoeducation to parents about the skills that all children need to build. The series also will address the issue of parents-as-teachers, given the prevalence of remote learning during the COVID-19 era.



Seminar topics include:

1. Positive relationships
2. Sleeping
3. Eating
4. Movement
5. Schedules
6. Rules
7. Friendships
8. Homework

Seminars are scheduled on the following Wednesdays from 7-8 p.m.

OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE
6	3	1	5	2	2	6	4	1

Join the seminar via ZOOM: tinyurl.com/IEPForHome

Meeting ID: 914 4931 0430

IEP for Home Seminar Wednesday, November 3 7-8 p.m.

Mark Your Calendar!

Risk Adjustment Coding Webinar:
A deeper dive into Vascular
conditions for risk coding

Thursday, November 18
Noon-1 p.m.

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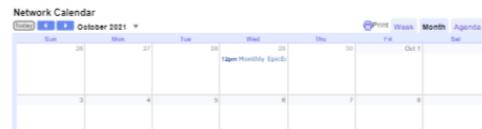


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