Advanced Care Planning Discussions and Documentation in Primary Care

Tanya Litchmore-Porter

A Project Report Submitted to
the Faculty of The School of Nursing at
The University of North Carolina at Greensboro
In Partial Fulfillment
Of the Requirements for the
Doctorate in Nursing Practice

Greensboro
2024

Approved by:

Tanya Litchmore-Porter	Project Team Leader
Cheryl Wicker	Project Team Co-Leader
Wanda Williams	DNP Program Director

Table of Contents

Abstract

Background: As the life spans of Americans are increasing, so is the number of people who are living longer with multiple chronic comorbid conditions. Advanced care planning is, therefore, important because it is a process that helps patients discuss and communicate their future treatment and end-of-life preferences with their providers if they lose their capacity to make decisions or communicate their wishes and preferences. Primary care settings are ideal for integrating advanced care planning into routine care and health maintenance. ***Purpose:*** This project aims to increase advanced care planning discussions and documentation in a primary care clinic through a workflow that identifies patients without advance directives and educates staff and providers about appropriately documenting and billing for advanced care planning discussions. ***Methods:*** Under the framework of the Transtheoretical Model, this quality improvement project implemented different interventions to increase advanced care planning discussion rates. A live PowerPoint presentation was conducted with the clinic staff on appropriately identifying patients without advance directives documents. Additionally, information was provided on how to document and bill advanced care planning discussions. Advanced care planning current procedural terminology code billing frequencies were tracked pre and post intervention over three months. ***Results:*** Descriptive statistics was used to analyze the data because it was small; this also meant there would be no hypothesis testing. Four providers participated, and the project resulted in a slight increase in advanced care planning billing codes post intervention compared to pre intervention. The pre intervention phase revealed 3 documented advanced care planning billing codes 99497. There was no documentation for billing code 99498. The post intervention phase had 5 documented billing codes, including 99497. ***Recommendations and Conclusion:*** The project identified that timing can be a barrier

for providers in primary care clinics. As a result, this can affect the number of advanced care planning discussions and documentation conducted. A standardized system, such as utilizing support staff to engage in the advanced care planning process, can help increase those rates. Advanced care planning can increase revenue for primary care settings and the overall quality of care rendered during end-of-life.

Keywords: advance care planning, advance directives, primary care, end-of-life care

Background and Significance

Advance care planning is a process involving the discussion of patients' end-of-life wishes when they cannot do so on their own. It helps others know what type of medical care an individual wants. Advanced care planning consists of various components utilized when the patient is healthy enough to make those decisions about end-of-life care. These preferences are often put into an advance directive. This legal document goes into effect only if you are incapacitated and unable to speak for yourself, such as if you have a terminal disease or severe injury. According to McMahan et al. (2021), advance care planning (ACP) has garnered enthusiasm since several high-profile court cases in the 1970s and the Patient Self-Determination Act in 1990. Patients, surrogates, and clinicians consistently rate advanced care planning as necessary, especially among those who have experienced decision-making of severe illnesses. Although studies indicate an increasing interest in advanced care planning, the uptake in clinical practice remains low among many individuals with chronic illnesses. Many chronically ill patients do not have documented discussions on advance care planning in their electronic medical records. According to the Centers for Disease Control and Prevention (CDC, 2018), seventy percent (70%) of Americans are without an advanced care plan. Many factors, such as time and billing, can contribute to the low discussions of advance care planning in the primary care setting.

Advanced care planning is supported by the Medical Code of Ethics opinions 5.1 and 5.2. Opinion 5.1 states that although advanced care planning is usually applied to terminally ill patients, end-of-life decision-making applies to every patient served, including young, healthy, and all others (American Medical Association, 2018a). Opinion 5.2 speaks to advance directives and discusses the importance of documenting advance care planning discussions (American

Medical Association, 2018b). Advanced care planning positively impacts patients, family members, society, and the healthcare system. It helps to improve the patient's quality of life and decrease hospitalization, as well as reducing in-hospital death and healthcare costs as healthcare costs incurred at the end of life can be high (Gabbard et al., 2021; Zhu & Enguidanos, 2022). In contrast, due to its involvement in end-of-life care, advance care planning can be accompanied by unpleasant feelings.

Advanced care planning has various benefits, but many barriers still exist. How do we eliminate these barriers and increase advanced care planning discussions? A study by Sandoval et al. (2019) investigated various interventions to increase advanced care planning discussions, such as establishing advanced care planning as a priority across primary care practices. These interventions showed significant differences in advanced care planning discussions and documentation in pre and post intervention. Another issue affecting advanced care planning is documentation. Some organizations adopted an intervention tool to increase advanced care planning discussions and documentation called Vynca; this is a standardized workflow system where patients' end-of-life wishes are documented and can be viewed and amended at any time ("Vynca, Cone Health, and Triad Healthcare Network," 2019). Providers can easily view, make changes, and document patients' end-of-life wishes, which can help increase advanced care planning discussions and documentation rates over time. As the rate of chronic illnesses increases, the healthcare system must continue to provide patients with quality care, including engaging patients and loved ones in meaningful advanced care planning discussions. As mentioned above, advanced care planning offers many benefits for the patient, family, and the healthcare system.

Problem Statement and Purpose

This project aims to increase advanced care planning discussions and documentation in a primary care clinic through a workflow that identifies patients without advance directives and educates staff and providers about appropriately documenting and billing for advanced care planning discussions.

Review of Current Evidence

A literature search was done using different databases, including Cumulated Index in Nursing and Allied Health Literature (CINAHL) with Full Text, PubMed Full Text, and Google Scholar. Search terms included advance care planning, barriers, impact, benefits, interventions, documentation, and primary care. The inclusion criteria for the articles were that they should be in English and be viewable in full text; studies conducted in the U.S. included elderly patients 65 and over and were at least five years old. Exclusion criteria included articles, not peer-reviewed or scholarly and studies involving hospice and hospital patients. For this paper, I had to examine several articles that had information about the research topic of advanced care planning. The articles were appraised, and different themes were synthesized to answer the research question: barriers, benefits, interventions, and the impact of advanced care planning. Although some of the articles did not entirely focus on the research question, there were still sections in the articles that were related to the question. Articles were selected if they had information on the benefits, barriers, education, and patient outcomes. The current search yielded 27 articles. All the articles were published in the last five years.

Overview of Advance Care Planning (ACP)

Advanced care planning involves the care patients wish to have or not have during end-of-life. It acts as a guide for providers to ensure that patients are given the requested care. Over the past years, advanced care planning has become an increasingly important aspect of healthcare

(Dinescu, 2021). However, the rates of these discussions continue to be low, and incorporating meaningful interventions in the primary care setting can help to increase those rates. Advanced care planning discussions help the patient to transition smoothly to end-of-life care by limiting unnecessary treatment and stress for the patient and family.

Patient and Family Impact

Advanced care planning can positively impact the outcomes for the patient and family, which can result in reduced hospital death, decreased stress for the family, and increased use of hospice, which over time can improve the quality of dying, reduces avoidable distress, and increases patient satisfaction (Weathers et al., 2016; Schichtel et al., 2020; Gabbard et al., 2021). Of the 27 articles, only one, Enguidanos et al. (2017), mentions the timing of advanced care planning discussion as a factor that impacted patient outcomes. The study highlighted that older patients who completed advanced care planning during end-of-life care received more aggressive care, which doubled the rate of those who completed the advanced care planning earlier. Therefore, providers should encourage patients to start these discussions as early as possible. Improved patient outcomes are essential to healthcare, and advanced care planning discussions can help with that while patients get their preferred care. While the timing of the discussion can impact patient outcomes, Zwakman et al. (2018) and Jeong et al. (2019) studies also found decreased concerns about the future and easing families from making difficult decisions as another meaningful outcome of advanced care planning discussion.

Two studies mentioned that advanced care planning discussions could decrease costs. Zhu and Enguidanos (2022) found that about 25% of Medicare expenditures incurred were for care for patients in their last year of life. The average healthcare cost per capita in the last year of life was estimated at $80,000; about 44% of these costs were related to hospitalizations. Zhu and

Enguidanos (2022) also mentioned that with the initiation of an advanced care plan, studies have shown that having an advanced care plan was significantly associated with $673 lower hospital out-of-pocket costs, with a higher magnitude of savings among younger decedents. Decedents who completed advance directives three months or less before death had higher out-of-pocket costs ($1854 on average) than those who completed advanced directives more than three months before death, $1176 on average.

Healthcare Impact

How can advanced care planning discussions impact the healthcare system? Advanced care planning initiated in primary care leads to better outcomes, such as diminishing aggressive treatment at end-of-life and reducing the length of hospital admissions (Sherry, 2022). Advanced care planning helps older adults communicate better with healthcare providers and reduces hospitalization rates, reducing health resources (Weathers et al., 2016; Okada et al., 2022). Throughout the literature search, limited studies examined the impact of advanced care planning on primary healthcare.

Advanced care planning in Primary Care

In primary care, providers act as gatekeepers by coordinating the patient's Plan of care and ensuring that the patients receive quality care. Hence, researchers mention that advanced care planning should start in primary care because of its positive impact on end-of-life care. Glennon et al. (2019) note that family practice care is ideal for beginning the advanced care planning conversation between physician and patient due to preexisting relationships and understanding current healthcare concerns and future risks. During primary care visits or in good health, patients usually have a clearer mind to make the crucial decisions of advanced care planning compared to after or during the diagnosis of a severe illness when patients and families

are attempting to cope with the stress and emotions accompanying it. Some studies also emphasized that advanced care planning should begin early in adulthood, be revised throughout life if any changes occur, and not be delayed until hospitalization (Ludwick et al., 2022; Seecof et al., 2021). To facilitate providers getting reimbursed for advanced care planning discussions, Medicare started an initiative in 2016. Advanced care planning discussions remain low, and the benefit is not widely used (Jaklevic, 2021).

Documentation in Primary Care

In addressing advanced care planning discussions in primary care, attention should also be paid to documentation. The healthcare system did not have a standardized way of documenting advanced care planning discussions. In 2019, a formal process, VYNCA, was adopted by some organizations that ensured that these discussions were recorded to increase documentation rates. In a pilot study conducted by Seecof et al. (2021), an attempt was made to increase documentation using the telemedicine platform but suggested using another more feasible method to improve documentation in primary care for better outcomes. Standardized and accessible documentation is needed to enhance advanced care planning (Myers et al. & Huber et al., 2018). Three of the twenty-seven articles briefly mentioned standardized documentation. The new VYNCA system currently being used at the target practice for advanced care planning documentation was not mentioned.

Patient Barriers

While advanced care planning can positively impact patient outcomes, barriers affect the rate of advanced care planning discussions and documentation. In a study conducted by Poveda-Moval et al. (2021), patients and family members agreed that the main barriers were fear of discussing their relative's end of life, lack of ability to carry out advanced care planning, and not

knowing who was responsible for initiating conversations. Three of the twenty-seven articles zoomed in on the issue of racial disparities that affect the rate of advanced care planning. Minorities are less likely than their Caucasian counterpart to participate in advanced care planning, which results in these patients receiving more aggressive and unnecessary treatments during end-of-life (Anderson, 2021; Jimenez et al., 2018; Maldanado et al., 2019). According to Maldonado et al. (2019) and Anderson (2021), some likely reasons are mistrust of the healthcare system, cultural practices, language barriers, health literacy, and lack of resources. Other barriers affecting minority patients include sexual orientation and gender identity. Valenti et al. (2021) mentioned that historically, homosexuals have been discriminated against, and their decision-making questions have been ignored. This results in low advanced care planning discussion rates among this group.

Provider Barriers

The main barriers reported by professionals were a lack of knowledge and skills to carry out advanced care planning, a particular fear of starting conversations about advanced care planning, not knowing what is culturally appropriate, and a lack of time for discussions due to busy clinic schedules (Fulmer et al., 2018; Maldanado et al., 2019). Enguidanos et al. (2017) and Jimenez et al. (2018) identified time as a gap and a deterrent to advanced care planning discussions.

Organizational Barriers

At the institutional level, some barriers identified were legalistic paperwork, systems for monitoring and accessing records, staff shortage, poor staff preparation, and lack of resources and time dedicated to advanced care planning (Jimenez et al., 2018). For some organizations, billing remains a barrier to advanced care planning discussions. According to Henage et al.

(2021), a practice began collecting billing data but discontinued because patients complained about incurring Medicare copays for advanced care planning services. Although barriers to advanced care planning continue to affect the rate of advanced care planning discussions negatively, studies are being conducted to address this issue.

Patient Interventions

Several articles provided meaningful information to address advanced care planning discussions and ways to increase those rates. In doing so, each area, such as the patient, provider, and organization, must be thoroughly investigated, and the right interventions must be implemented to sustain the lifelong continuation of advanced care planning discussions. According to Seiter (2021), advanced care planning can be challenging. Often, patients are provided with educational materials that they do not fully understand, are inconsistent, and do not offer encouragement, which may affect the continuation of advanced care planning after initial discussions. The study tried to implement new ways of providing information that would benefit the patients more. The study further stated that self-efficacy helps motivate change, so educational materials should be replaced with self-efficacy messages and resources. On the other hand, Seiter (2021) said that while self-efficacy resources can help, they often provide too general information. Instead, the resources should be more specific and easy to follow.

Some tools were developed to help with advanced care planning discussions. Although some of these tools have not been tested in research settings, they still benefit patients (Seidini et al., 2022). According to Seidini et al. (2022) and Seiter (2021), the Conversation Project is a written tool kit with value-based questions to help individuals start advanced care planning conversations. Seidini et al. (2022) further examined another tool kit, PREPARE, an advanced care planning website with videos introducing individuals to advanced care planning and

preparing them for decision-making. These interventions help individuals who might find the educational materials cumbersome and difficult to understand an opportunity to start engaging in advanced care planning discussions.

In contrast, different tools are used to engage the sexual, gender, and racial minority groups. Anderson (2021) states a pilot workshop focused on black churches as the trusted community brokers and stakeholders between formal healthcare organizations and faith-based communities helped increase the advanced care planning rate among African Americans. This workshop provided education about advanced care planning using the Let's Talk about advanced care planning toolkit. On the other hand, according to Maldonado (2021), to increase advanced care planning discussion rates among Hispanics, emphasis should be placed on providing culturally sensitive educational materials in Spanish. Another intervention is to offer the patients the choice to include family members and respect their input. In a qualitative descriptive study by Valenti et al. (2021), four areas were identified to assist with advanced care planning among sexual and gender minorities. The first area is training clinicians on sexual orientation and gender identity and providing educational materials to patients distinguishing between palliative and hospice care. The second area is recognition, providing sexual orientation and gender identity information in the electronic medical record and asking patients how they want to be addressed. Another approach is to ask about the patient's relationships, support persons, and the family of choice.

Valenti et al. (2021) also looked at acceptance as the fourth area of improvement. In acceptance, it is essential to acknowledge the patient's relationship and preferences and to prepare a clinical area that is welcoming and inclusive. Lastly, dyadic interventions include communicating with a support person or partner throughout the illness, encouraging the support

person or partner to ask questions and voice concerns, and communicating on time. These interventions improved advanced care planning discussions among this group, leading to better outcomes.

Provider Interventions

Although the emphasis is often placed on patients' involvement in advanced care planning, the providers are also an essential part of the process. According to Sandoval et al. (2019), Fulmer et al. (2018), and Seecof et al. (2021), offering site-level educational sessions to clinicians and staff will help to facilitate advanced care planning discussions. Fulmer et al. (2018) and Sandoval et al. (2019) also stated that having a formal system, giving provider incentives, and reimbursing these critical conversations are also important.

Organization Interventions

A study was conducted by Sandoval et al. (2019) that investigated various interventions to increase advanced care planning discussions. One of the interventions was establishing advanced care planning as a priority across primary care practices. Other interventions included normalizing advanced care planning discussion, standardizing workflows for scanning advanced care planning forms into electronic records, and developing an obvious indicator of advanced care planning in the electronic record. Additionally, creating electronic reminders if advanced care planning forms are absent, identifying the standard and preferred forms, and ensuring standardized advanced care planning forms are readily available also helped to increase advanced care planning discussions. For advanced care planning discussions and documentation to rise, several interventions are necessary, such as identifying appropriate patients for advanced care planning discussion before the visit, creating a monthly automated electronic report, and reviewing performance regularly with stakeholders. Sandoval et al. (2019) further showed that

with these interventions, there was a significant increase in post intervention advanced care planning discussions compared to pre intervention advanced care planning discussions. Although advanced care planning interventions can benefit patients, families, and healthcare staff, there seems to be a lack of high-quality randomized controlled trials that evaluate advanced care planning interventions (Johnson et al., 2017).

Overview of Vynca

As part of an effort to increase advanced care planning discussions and documentation, a standardized workflow system where patients' end-of-life wishes are documented and can be viewed and amended at any point in time was developed and implemented, called Vynca, Vynca, which is based in Palo Alto, California, provides comprehensive advance care planning technology solutions that enable healthcare organizations to deliver high-quality end-of-life care consistent with an individual's preferences. The company helps patients, families, and healthcare providers have meaningful conversations about future care preferences, ensures that wishes are documented accurately, and provides real-time access to this critical information throughout the care continuum. Through this partnership, Vynca will support the digital completion of advance directives and make them electronically available to hospitals, clinics, and doctors' offices across the Cone Healthcare system. This initiative was started in 2019, over three years ago, and it is still underutilized by some healthcare facilities (“Vynca, Cone Health, and Triad Healthcare Network,” 2019). Additionally, the Vynca system is a form of electronic health record that stores the advance care documents and makes it easy for the providers to access and view the patient's end-of-life wishes. There was no information about the Vynca system in the CINAHL or PubMed databases. Despite the information found in the documentation, none of the articles spoke explicitly about the new standardized documentation system.

Conceptual Framework and Theoretical Model

This Doctor of Nursing Practice project will use Lewin's change theory to assess, implement, and improve how a primary care clinic conducts advance care planning discussions and documentation. According to Raza (2019), change behavior involves how humans accept, embrace, and perform change, which is the core of modern change management. This process can best be explained and executed using Lewin's change theory: unfreeze, change, and refreeze. In the first step, unfreezing, Lewin identifies human behavior to change as a quasi-stationary equilibrium state. This state is a mindset, a mental and physical capacity that can be almost absolutely reached (Raza, 2019). In this first stage, an assessment was done to determine what needs to change. At the primary care clinic, stakeholders voiced their concerns about issues surrounding a decrease in the discussion and documentation of advanced care planning. There was an understanding of why the change was necessary. Management got involved and was supportive. Addressing this issue would positively impact the entire practice.

In the freezing stage, the second step, change, involves implementing your change. Organizational change, in particular, is notoriously complex, so executing a well-planned change process does not guarantee predictable results. Therefore, you must prepare a variety of change options, from the planned change process to trial and error. Examine what worked, what didn't, and what parts were resistant with each attempt at change. During this evaluation process, information flow and leadership are two essential drivers of the successful and long-term effectiveness of the change implementation process (Raza, 2019). The principal investigator did a live PowerPoint presentation on identifying patients in VYNCA without Advance directives and how to document appropriately for the implementation. Laminated cards with information on how to bill correctly were also issued to staff. The results showed a slight increase in billing

code 99497 from three pre intervention to five post intervention. Additional educational sessions can help to increase advanced care planning discussion rates.

The third stage, refreeze, is to sustain the change implemented. The goal is for the people involved to consider this new state as the new status quo so they no longer resist forces trying to implement the change. The latest change transforms the group norms, activities, strategies, and processes. The previously dominant behavior tends to reassert itself without appropriate steps to sustain and reinforce the change. Formal and informal mechanisms must be considered to implement and freeze these new changes. One or more measures or actions should be implemented that will be strong enough to counter the cumulative effect of all resistive forces to the change (Raza, 2019). The clinic aims to transition into conducting advanced care planning discussions more consistently so that this can become a new way of life for the practice. Some examples of doing so involve incorporating the recent changes into the culture by identifying change supports and barriers and developing and promoting long-term ways to sustain the change.

Methods

This quality improvement project will focus on interventions that can help increase discussion and documentation rates of Advanced care planning in a primary care clinic. The project will be implemented utilizing the Plan-Do-Study Act translational framework. The framework is commonly used to test a change by planning it, trying it, observing the results, and acting on what is learned.

Design

The quality improvement project used multiple interventions based on the Plan-Do-Study-Act (PDSA) methodology.

Methods Model

The quality improvement model I will use to conduct my DNP project is the Plan-Do-Study-Act (PDSA).

Phase 1 of the cycle is the **Plan**, where the change to be implemented is discovered. The planning phase is also where the question you want to be answered is stated (Institute for Healthcare Improvement, 2022). Advance care planning involves having discussions with patients before a terminal illness and determining what type of care the patients wish to have if they can no longer make those decisions. Although studies have found advanced care planning beneficial, the rates remain low. Many factors can contribute to the low rates of advanced care planning. Studies have also shown that with the right interventions, those rates can increase. The question to be answered here is whether the rate of advanced care planning discussions and documentation will increase by removing barriers such as billing and addressing documentation in the Vynca system. The team included the principal investigator, clinical advisor, provider champion, and stakeholders at the clinical site. The budget included out-of-pocket costs for thank you cards and information cards on billing that were laminated.

Population

The population involved in this project included physicians, nurse practitioners, and clinical staff currently working at a primary care family practice that conducts advanced care planning for Medicare patients.

Setting

The project occurred at a Cone Health affiliate primary care clinic in Graham. The practice has been in the Graham community for over 30 years. It is committed to providing quality healthcare services to the community and surrounding areas. There are currently four

providers: two nurse practitioners, one nurse practitioner who completed the doctor of nursing practice program, one medical doctor, and an osteopathic doctor. Some of the services offered at the facility include chronic disease management, diagnostic services, Department of Transportation (DOT) physicals, adult immunizations, such as flu shots, lab tests onsite, pediatric care, women's health, and preventative care.

During phase 2, **Do (implementation)**, the change is tested. The interventions are implemented, and you then describe what happened, what data was collected, and what observations were made. Also, when will the data be collected to determine whether the intervention works? (Institute for Healthcare Improvement, 2022).

Intervention

A primary care clinic in Graham was having issues with advanced care planning discussions and documentation, and the office manager was not satisfied with the low advanced care planning rates that the clinic was recording. The principal investigator proposed a plan to increase the rate of advanced care planning discussions and documentation and presented it to the office manager. The office manager was receptive and got the medical director involved. The principal investigator asked a nurse practitioner at the clinic to take on the role of a provider champion to help with the smooth transition of the project. The office manager got the remaining staff on board as this would require everyone's efforts to make this a success. During the literature search, several interventions were highlighted, and the principal investigator, in collaboration with the clinic, decided to use some of these as interventions for the clinic. One of the interventions was to identify appropriate patients for advanced care planning discussions and documentation before the visit (Sandoval et al., 2019). Another intervention was to offer site-level educational sessions to clinicians and staff to help facilitate advanced care planning

discussions (Sandoval et al., 2019; Fulmer et al., 2018; Seecof et al., 2021). The principal investigator, office manager, and provider champion communicated through telephone calls, emails, and text messages several times. After approval from The University of North Carolina in Greensboro IRB team and the Cone Health IRB team, the principal investigator contacted the office manager to discuss a suitable date and time for the clinic interventions. The principal investigator visited the clinic in June 2023 to implement the project interventions. This quality improvement project included a live PowerPoint presentation about documenting in VYNCA, which the office manager and the Registered Nurse (RN) attended.

The clinic was busy that day; therefore, only two staff members could attend the presentation. The principal investigator provided paper copies of the PowerPoint presentation to the office manager and R.N. A few extra copies were also provided. The presentation also provided information for Certified medical assistants (CMAs) to review Medicare patients' charts at each visit and identify those without an advanced directive to initiate discussions. The principal investigator gave providers additional details in the form of laminated cards with billing information on advance care planning and how to do this appropriately. The presentation took thirty minutes and included a question-and-answer session. The staff members shared their appreciation for the essential information provided. A follow-up was done, and the staff members who were absent at the presentation received the information during their routine staff meeting a week later.

IRB Approval

Due to this quality improvement project being a non-human subject, the project did not have any sections or interventions that could provide physical, psychological/emotional, social, and economic risks. The data collected were de-identified by the office manager and given to the

principal investigator. Paper copies were stored in a locked cabinet and shredded immediately after the data was copied. Electronic data will be stored for two years using a password-protected one drive. The project information will only be shared with the clinic and not outside the clinic.

Data Collection

The project implementation started in June 2023. Aggregate advanced care planning current procedural terminology (CPT) billing code data were de-identified by the office manager and given to the primary investigator (PI). The aggregate billing data were collected over three months, March through June 2023, before implementation and is to be compared with after-implementation data over three months, July through September 2023. It is proposed that the project will conclude in April 2024.

Phase 3 of the cycle is the **study,** which involves reviewing the results from phase two to make changes. It also involves summarizing and reflecting on what was learned. Did the interventions bring about meaningful results? Should you add or take away anything from the study? (Institute for Healthcare Improvement, 2022).

Data Analysis

Before the principal investigator implemented the interventions, a meeting was set up with the statistician to determine the best way to analyze the data collected. After the data collection, it was decided that the best way to analyze was to use descriptive statistics because the data was small; this also meant that there would be no hypothesis testing. The Excel software incorporated the quantitative data in a bar chart that showed pre intervention data compared to post intervention data over three months. A tabular data layout also showed the number of providers and advanced care planning billing codes documented pre and post intervention over

three months. The interventions are working; there was a slight increase in the post intervention data compared to the pre intervention data.

Results

This quality improvement project focused on increasing the advanced care planning discussions and documentation rate within a primary care office in Graham, North Carolina, between June 2023 and April 2024. Outcomes measures show a slight rise in advanced care planning, a noted change over time. The site staff comprised Nurses, Nurse practitioners, Physicians, and certified medical assistants. A total of two staff members participated in the live PowerPoint. The information from the presentation was disseminated to the rest of the staff members during their routine staff meetings. The March to June 2023 pre intervention phase revealed three documented advanced care planning billing codes 99497 from 1 provider. There was no documentation for billing code 99498. The post intervention stage, July to September 2023, had five documented billing codes 99497 from three providers. There was no documentation for billing code 99498; see Table 1. There was no hypothesis testing due to the small sample size.

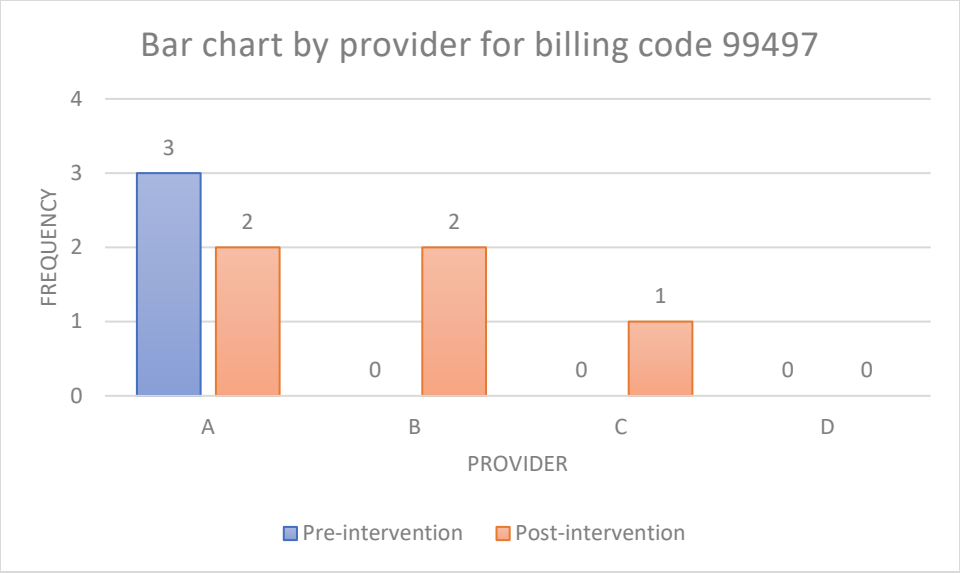
The participants who participated in the practice interventions were clinical staff who conducted advanced care planning on Medicare patients. Figure 1 demonstrates the statistical findings of each provider's advanced care planning billing codes before and after the intervention. Provider A did 5 advanced care planning billing codes, 3 (99497) pre intervention and 2 (99497) post intervention. There was no documented billing code for provider B pre intervention, but that increased to 2 post intervention. It was similar for provider C with no documented billing code pre intervention, but post intervention saw 1. Provider D had no documented billing code for pre and post-intervention. There was no change in billing code

99498, which remained at 0 for all providers pre and post intervention. The most significant barrier mentioned was time availability. The other barriers included changing staff and educating new staff members. One strategy implemented to overcome the time barrier was to have the CMAs view the chart to identify patients without advance directives and inform the providers instead of having providers search through the charts. Another strategy was providing educational materials to new staff members to document and bill advanced care planning appropriately.

Table 1 shows billing codes documented per provider:

Provider	Pre intervention billing code 99497	Pre intervention billing code 99498	Post intervention billing code 99497	Post intervention billing code 99498
A	3	0	2	0
B	0	0	2	0
C	0	0	1	0
D	0	0	0	0

Figure 1 shows a bar chart for the providers for billing code 99497.



Discussion

Advance care planning is an essential element in providing primary care. The Centers for Medicare and Medicaid Services have signaled the importance of provider-led discussions on patient values and preferences related to end-of-life care by creating a reimbursement system for such discussions. However, few primary care providers are currently incorporating advanced care planning in their practice. This quality improvement project sought to increase the number of advanced care planning discussions and documentation through provider and staff education and awareness. This project aims to increase advanced care planning discussions and documentation in a primary care clinic through a workflow that identifies patients without advance directives and educates staff and providers about appropriately documenting and billing for advanced care planning discussions. Coding was addressed during the staff live PowerPoint presentation intervention, and several laminated cards on appropriate billing were disseminated. The staff was open to the new change and actively participated.

Relevance of Conceptual and Theoretical Framework

Lewin's change theory was used to guide the advanced care planning interventions implemented at the primary care clinic and was shown to be useful in guiding practice change. The project followed the steps, and as a result, a problem was identified: low rates of advanced care planning. Interventions were implemented, and the site has adopted the new change. Similarly, the plan-do-study-act model also served as a helpful guide to implement this project. The clinic identified a problem, and interventions were implemented to address the issue. The results were small, but this still represented a positive change. To sustain and increase the advanced care planning discussion rate, the quality improvement project suggested additional education for all staff members, including clinical and non-clinical staff. Although the findings were small, they did show a positive outcome for the clinic.

Interpretation

Regarding advanced care planning frequency, the structure of the project intervention showed a slight increase in the number of advanced care planning discussions. However, the intervention yielded no impact on the outcome measure of the number of visits coded with advanced care planning code 99498. The sample size was small; therefore, no hypothesis testing was done. Both pre and post intervention tallies found eight advanced care planning codes utilized. Four providers participated in the project. The pre intervention phase revealed 3 documented advanced care planning billing codes 99497. The post intervention phase had 5 documented billing codes, including 99497. The lack of change in the outcome for billing code 99498 may have been because proper coding with advanced care planning code 99498 requires an additional 30 minutes of discussion of advanced care planning. The patient visits were typically 20-45 minutes, which, if appropriately coded, would leave very little, if any, remaining time for other activities during the visit. This echoes findings from the literature that lack of time

and billing are some of the barriers to advanced care planning discussions (Fulmer et al., 2018; Maldanado et al., 2019). The literature also suggests that providing advanced care planning education to staff may help reduce the provider barrier of time (Sandoval et al. 2019; Fulmer et al. 2018; Seecof et al. 2021).

Limitations

The small data size was a limitation as it meant no hypothesis testing could be done. At times, the clinic tends to get busy. Therefore, only two staff members were present during the PowerPoint presentation. No provider could attend the presentation; the office manager provided the information in a staff meeting later. An alternative to getting full staff participation would have been to conduct the PowerPoint presentation during the lunch break when most staff members were available.

Unintended Outcome

This project attempted to address advanced care planning discussions through a staff education intervention with an expected outcome of an 80% participation rate. However, the staff participation rate fell short of the projected goal; this resulted from a busy day at the practice. Unintended staff changes could also have affected the outcomes of this project. Continually checking in with the clinic and providing additional education could help to increase advanced care planning rates.

Lastly, phase 4, **Act**, is based on what you learned from the test. It determines what modifications you should make, adopt, adapt, or abandon (Institute for Healthcare Improvement, 2022). Based on the results of this project, it is clear that the practice is trying to increase the rate of ACP. However, for advanced care planning to become a routine and consistent part of the

practice, further education and follow-up are needed to ensure that it is committed to continuing advanced care planning discussions and making it a part of the clinical culture.

Conclusion

The project's title was Advance Care Planning Discussion and Documentation in the Primary Care Clinic. The project's purpose was to increase the rate of advanced care planning discussions and documentation using different interventions, such as a workflow, and educating staff and providers on how to document and bill advanced care planning. Advanced care planning remains essential as it helps to identify patients' preferred wishes and helps to avoid unnecessary hospitalization, which could be costly. The staff was receptive to the interventions implemented. The project saw a slight increase in the billing code 99497 from 3 to 5 over three months. Timing can be a barrier, but a standardized system, such as utilizing support staff to engage in the process and staff education, can help address this issue. Future projects can focus on interventions that can assist the clinic in routinely engaging in advanced care planning. Educating staff and providers can help address barriers and help staff feel more confident to conduct advanced care planning discussions.

Recommendations for Future Project

Future projects may wish to include an even broader multilevel approach when crafting interventions. Suppose more primary care providers integrate advanced care planning conversations into the routine care of their patients. In that case, more advance directives will be generated, potentially decreasing healthcare decisions that lead to higher spending yet have a relatively small effect on prolonging life.

Relevance for Clinical Practice

The lessons learned from this Doctor of Nursing Practice project led to the following recommendations for clinical practice. Developing and maintaining a workflow that supports advanced care planning in the clinic (tailored to the individual practice) is essential, as well as using interdisciplinary team members to work collaboratively on advanced care planning. Educating electronic health record users to document advanced care planning appropriately, upload Advance Directives and label them correctly, and communicate with users in other settings whenever possible so that advanced care planning notes are accessible to other providers.

Additionally, educational sessions targeting staff and providers may effectively address some of the barriers to advanced care planning detailed in the literature. This quality improvement project demonstrated that the involvement of the whole care team, not just providers, may be an essential element in advanced care planning. Clinical staff has multiple opportunities to educate and remind patients to influence their likelihood of engaging in advanced care planning activities. Clinical staff members may also be able to influence provider activities regarding advanced care planning by identifying patients who may benefit from advanced care planning discussions and helping providers incorporate this aspect of patient care more smoothly into current workflows. Education and awareness for all staff on advanced care planning is essential, as patients may come to clinical and non-clinical staff with questions about documents used in advanced care planning. Future projects may benefit from other means of introducing advanced care planning education and discussions, such as phone calls, mailed letters, patient communication portals, or in-person invitations at preceding appointments.

Sustainability

The organization plans to continue using the educational materials and the process designed to improve advanced directive documentation and enhance patient awareness. The next steps involve informing the practice about the project results and ways to continue improving and routinely conducting advanced care planning.

Dissemination Plan

The dissemination plan aims to raise awareness of the work completed and the importance of continued work around advanced care planning. The project aimed to increase advanced care planning discussions and documentation in a primary care clinic through a workflow that identifies patients without advance directives and educates staff and providers about appropriately documenting and billing for advanced care planning discussions. First, the project and findings will be presented to the University of North Carolina School of Nursing in Greensboro at a poster presentation on April 12, 2024. Key university members will be present for the presentation, as well as upcoming students who may develop and implement projects in the future to continue improving advanced care planning processes. The Doctor of Nursing Practice project was presented via PowerPoint to the project site on February 26, 2024, to help the clinic implement more ways to improve and sustain advanced care planning discussions. Key members involved with advanced care planning processes for the health system will receive the information. Some stakeholders will be the office manager, providers, front desk workers, and other staff members.

Summary

Primary care is an excellent place to start advanced care planning because the patients are familiar with their providers and may feel more comfortable discussing their wishes. However, some barriers might affect the rate of advanced care planning. The project aimed to increase the

rate of advanced care planning through various interventions. The project implementation took place over six months, where pre intervention data was compared to post intervention data over three months. The project saw a slight increase in the billing code 99497. There was, however, no change in billing code 99498 pre and post intervention. Educating staff and providers can positively affect the rate of advanced care planning. The more advanced care planning discussions are done, the more revenue it will generate for the practice. Future projects may wish to include an even broader multilevel approach when crafting interventions.

I have abided by the UNCG academic integrity policy on this assignment.

T Litchmore-Porter March 23, 2024

References

American Medical Association. (2018a). *AMA code of medical ethics opinion 5.1 advance care planning*. https://www.ama-assn.org/delivering-care/advance-care-planning

American Medical Association. (2018b). *AMA code of medical ethics opinion 5.2 advance directives*. https://www.ama-assn.org/delivering-care/advance-directives

Anderson, G. T. (2021). Let's talk about ACP pilot study: A culturally responsive approach to advance care planning education in African-American communities. *Journal of Social Work in End-of-life & Palliative Care, 17*(4), 267–277. https://doi.org/10.1080/15524256.2021.1976354

Centers for Disease Control and Prevention. (2018). *Give peace of mind: Advance care planning.* U.S. Department of Health and Human Services. https://www.cdc.gov/aging/advancecareplanning/

Dinescu, A. (2021). Advance care planning. *Clinical Geriatric Medicine*, *37(*4), 605–610. https://doi.org/10.1016/j.cger.2021.06.001

Enguidanos, S., & Ailshire, J. (2017). Timing of advance directive completion and relationship to care preferences. *Journal of Pain Symptom Management*, *53*(1), 49–56. https://doi.org/10.1016/j.jpainsymman.2016.08.008

Fulmer, T., Escobedo, M., Berman, A., Koren, M. J., Hernandez, S., & Hult, A. (2018). Physician's views on advance care planning and end-of-life care conversations. *The Journal of American Geriatrics Society*, *66*(6), 1201–1205. https://doi.org/10.1111/jgs.15374

Gabbard, J., Pajewski, N. M., Callahan, K. E., Dharod, A., Foley, K. L., Ferris, K., Moses, A., Willard, J., & Williamson, J. D. (2021). Effectiveness of a nurse-led multidisciplinary

intervention vs. usual care on advance care planning for vulnerable older adults in an accountable care organization. *JAMA Internal Medicine, 18*(*3*), 1–9. https://doi.org/10.1001/jamainternmed.2020.5950

Glennon, C. A., Thomas, W., Black, K., Herrig, M., Ishikawa, J., & Reedy, I. (2019). Educating healthcare employees about advance care planning. *Asia-Pacific Journal of Oncology Nursing*, *6*(4), 343–348. https://doi.org/10.4103/apjon.apjon_27_19

Henage, C. B., McBride, J. M., Pino, J., Williams, J., Vedovi, J., Cannady, N., Buno, L. R., Chatman, T., Busby-Whitehead, J., & Roberts, E. (2021). Educational interventions to improve advance care planning discussions, documentation and billing. *The American Journal of Hospice*, *38*(4), 355–360. https://doi.org/10.1177/1049909120951088

Huber, M. T., Highland, J. D., Krishnamoorthi, V. R., & Tang, J. W. (2018). Utilizing the electronic health record to improve advance care planning: A systematic review. *The American Journal of Hospice and Palliative Care*, *35*(3), 532–541. https://doi.org/10.1177/1049909117715217

Institute for Healthcare Improvement. (2022). *How to improve: Model for improvement*. Retrieved October 14, 2022, from https://www.ihi.org/resources/how-to-improve

Jaklevic, M. C. (2021). Despite big buildup, few benefit from Medicare's advance care planning coverage. *Journal of the American Medical Association, 325*(23), 2333-2334. https://doi.org/10.1001/jama.2021.8402

Jeong, S., Barrett, T., Ohr, S. O., Cleasby, P., David, M., Chan, S., Fairlamb, H., Davey, R., & Saul, P. (2019). Study protocol to investigate the efficacy of normalization of advance care planning for people with chronic diseases in acute and community settings: A quasi-

experimental design. *Journal of BioMed Central, 19*(286). https://doi.org/10.1186/s12913-019-4118-x

Jimenez, G., Tan, W. S., Virk, A. K., Low, C. K., Car, J., & Ho, A. H. (2018). Overview of systematic reviews of advance care planning: Summary of evidence and global lessons. *Journal of Pain and Symptom Management*, *56*(3), 436-459 https://doi.org.10.1016/j.jpainsymman.2018.05.016

Johnson, S. B., Butow, P. N., Kerridge, I., Bell, M. L., & Tattersall, M. H. N. (2017). How well do current measures assess the impact of advance care planning on concordance between patient preference for end-of-life care and the care received: A methodological review. *Journal of Pain Symptom Management*, *55*(2), 480–495. https://doi.org/10.1016/jpainsymman.2017.09.008

Ludwick, R., Bakerjian, D., Zalon, M., Melander, S. D., & Crist, J. D. (2022). Advance care planning at life milestones. *Nursing Outlook*, *70*(3), 451–457. https://doi.org/10.1016/j.outlook 2022.02.011

Maldonado, L., Goodson, Mulroy, M. C., Johnson, E. M., Reilly, J. M., & Homeier, D. C. (2019). Wellness in sickness and health (The WISH Project): Advance care planning preferences and experiences among elderly Latino patients. *Journal of Clinical Gerontologist, 42*(3), 259–266. https://doi.org/10.1080/07317115.2017.1389793

McMahan, R. D., Tellez, I., & Sudore, R. L. (2021). Deconstructing the complexities of advance care planning outcomes: What do we know and where do we go? A scoping review. *Journal of the American Geriatrics Society*, *69*(1), 234–244. https://doi.org/10.1111/jgs.16801

Myers, J., Cosby, R., Gzik, D., Harle, I., Harold, D., Incardona, N., & Walton, T. (2018). Provider tools for advance care planning and goals of care discussions: A systematic review. *American Journal of Hospice and Palliative Care, 35*(8), 1123–1132. https://doi.org/10.1177/1049909118760303

Okada, H., Kiuch, T., Okuhara, T., & Kizawa, Y. (2022). Effect of advance care planning discussions with trained nurse in older adults with chronic disease in Japan. *Annals of Palliative Medicine*, *11*(2), 412–422. https://doi.org/110.21037/apm-21-2161

Poveda-Moral, S., Falco-Pegueroles, A., Ballesteros-Silva, M. P., & Bosch-Alcaraz. (2021). Barriers to advance care planning implementation in health care: An umbrella review with implications for evidence-based practice. *Journal of Worldviews Evidence Based Nursing, 18*(5), 254-263. https://doi.org/10.111/wvn.12530

Raza, M. (2019). *Lewin's 3 stage of model explained*. Retrieved November 10, 2022. From https://www.bmc.com>lewin-three-stage-model-change

Sandoval, M. B., King, J. G., Hart, V., & Repp, A. B. (2019). Increasing advance care planning in primary care practices: Multi-site quality improvement initiative. *Journal of General Internal Medicine*, *34*(6), 809–811. https://doi.org/10.1007/s11606-018-4800-4

Schichtel, M., Wee, B., Perera, R., & Onakpoya, I. (2020). The effect of advance care planning on heart failure. *Journal of General Internal Medicine, 5*(3),874–884. https://doi.org/10.1007/s11606-01905482-w

Sedini, C., Biotto, M., Bel'skij, L., Grandini, R. E., & Cessari, M. (2021). Advance care planning and advance directives: An overview of the main critical issues. *Aging Clinical and Experimental Research*, *34*(2), 325–330. https://doi.org/10.1007/s40520-021-02001-y

Seecof, O. M., Allannoff, M., & Parks, S. (2021). Lessons learned from a pilot project on telemedicine advance care planning in an urban geriatric primary care office. *American Journal of Hospice and Palliative Medicine*, *39*(6), 701-704. https://doi.org/10.1177/10499091211036978

Seiter, C. R. (2021). Benefits, barriers and self-efficacy messages in advance care planning education materials. *Health Communication, 36*(11), 1397-1404. https://doi.org/10.1080/104102362020.1754601

Sherry, D., Dodge, L. E., & Buss, M. (2022). Is primary care physician involvement associated with earlier advance care planning?: A study of patients in an academic primary care setting. *Journal of Palliative Medicine*, *25*(1),75-80. https://doi.org/10.1089/jpm.2021.0069

Valenti, K. G., Janssen, L. M., & Medeiros, K. (2021). "By the time she got sick, it was just kind of too late": A qualitative study on advance care planning among bereaved lesbian, gay, and bisexual older women. *Pallative Medicine, 36*(2). https://doi.org/10.1177/02692163211065279

Vynca, Cone Health, and Triad Healthcare Network partner to Improve Advance Care Planning in North Carolina. (2019). Retrieved from https://www.prnewswire.com/news-releases/vynca-cone-health-and-triad-healthcare-network-partner-to-improve-advance-care-planning-in-north-carolina-300911179.html

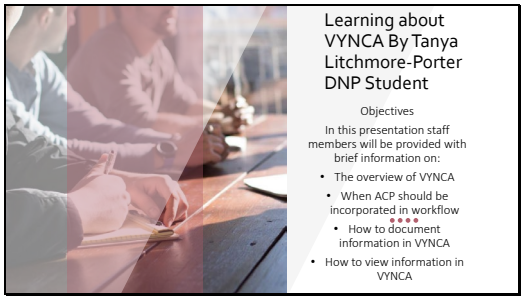
Weathers, E., O'Caoimh, R., Cornally, N., Fitzgerald, C., Kearns, T., Coffey, A., Daly, E., O'Sullivan, R., McGlade, C., & Molloy, D. W. (2016). Advance care planning: A systematic review of randomized controlled trials conducted with older adults. *An*

international Journal of Midlife Health and Beyond, 91, 101–109. https://doi.org/10.1016/j.matuuritas.2016.06.016

Zhu, Y., & Enguidanos, S. (2022). Advance directives completion and hospital out-of-pocket expenditures. *Journal of Hospital Medicine, 17*(6), 437-444. https://doi.org/10.1002/jhm.12839

Zwakman, M., Jabbarian, L. J., Delden, J. V., Van Der Heide, A., Korfage, I. J., Rietjens, J., Seymour, J., & Kars, M. C. (2018). Advance care planning: A systematic review about experiences of patients with a life-threatening or life-limiting illness. *Palliative Medicine Journal*, *32*(8), 1305–1321. https://doi.org/10.1177/0269216318784474

Appendix A

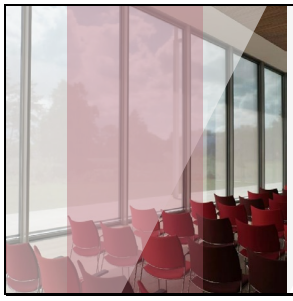


Learning about VYNCA By Tanya Litchmore-Porter DNP Student

Objectives

In this presentation staff members will be provided with brief information on:

- The overview of VYNCA
- When ACP should be incorporated in workflow
- How to document information in VYNCA
- How to view information in VYNCA



Overview of VYNCA

What is VYNCA

- A standardized workflow system where patients' end-of-life wishes are documented and can be viewed and amended at any point in time.
- Vynca which is based in Palo Alto, California, provides comprehensive advance care planning technology solutions that enable healthcare organizations to deliver high-quality end-of-life care consistent with an individual's preferences (Vynca, cone health, and triad healthcare network partner to improve advance care planning in North Carolina, 2019).

When ACP should be incorporated in workflow

- At each visit, CMA opens the advance directives tab and reviews documents in Vynca
- CMA completes health care directives flowsheet or Goals of care form
- Note templates pull the information into provider note
- If no advance directives are on file, CMA provides a copy of the NC Advance Directive form to the provider with the KPN at the time of the appointment. KPN is a vendor that provides tools that give providers an overview of what gaps a patient has in their healthcare.
- Provider then initiates a brief discussion about the importance of these documents.
- Sometimes, patient opts to discuss more, sometimes a follow-up appointment is made to review.
- keep the code status portion updated and working on completing more MOST forms with patients after their AWVs.

3

How do I initiate ACP discussions

- Explain that it is important for any adult who may experience a sudden, unexpected event (like MVA)
- Needed if unable to communicate and make own health care decisions
- Ideally conversation should be held BEFORE completing the advance directive forms (living will/HCPOA legal documents, DNR and/or MOST physician orders)
- Includes conversations between pt and health care agent (difficult if it does not happen)
- NOT once and done—readdress as health and preferences change
- Identify barriers that affect the patients when completing the documents
- Explore the patient's perspective on completing them

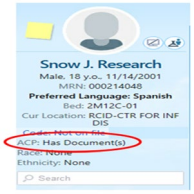
4

How do I initiate ACP discussions Cont'd

- Affirm the purpose of ACP
- Provide educational info
  - Health care agent qualities
  - Local resources
  - NC advance directive form, copy of DNR, MOST to review
- Create a follow-up plan

5

Where to find patients' wishes



- Cone Health and Triad Healthcare Network purchased a 3rd party product called **Vynca** to help assist in the capture, upload, and view a patient's wishes
- Patient wishes, including DNRs, MOSTs, Healthcare Power of Attorney, Living Wills, Goals of Care and other forms of Advance Directives can be found on the **patient's storyboard**

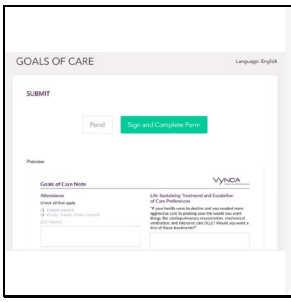
How to document information in VYNCA

- **Click the Advance Care Planning tab found in the patient storyboard. It will display has ACP documents or none if not present.**
- **Under Directives, click ACP; click Vynca.** Click on the thumbnail under All Documents to see the full availability of documents.
- **Goals of Care form can be completed here and viewed throughout the health system—this is the preferred location to document ACP discussions for this reason**
- **MOST (Medical Orders for Scope of Treatment) forms can be completed through the Vynca portal with patients in clinic or virtually with health care assists**

Advance Care Planning Documentation Requirements

- **Document a brief summary of the voluntary conversation**
  - Detail should reflect and justify length/complexity of the conversation
  - Document who was present, including the patient
  - Document total time in minutes and start and end times
  - Examples include statements such as:
    - "Time in" and "time out"
    - "Face time start" and "face time stop"
- **Form completion may or may not occur**
  - If forms are completed, document which forms were completed and maintain a copy in the record

7

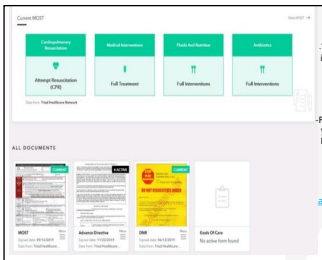


Everyone can Capture a Patient's Wishes

-While MOST and DNR forms need to be completed by a physician, a **Goals of Care** form can be **created by any clinical staff**

-This document, while not a medical or legal document, shares the patients' current beliefs and feelings about the type of care they would like to receive

-Because this document is created in **Vynca** the document is accessible to all Cone Health inpatient and outpatient practices/facilities



How to view information in VYNCA

-To access Vynca, click on the ACP link found in the patient storyboard. It will display Has Document(s) when ACP documents are present or None if not. This will load the Advance Care Planning Dashboard.

-From the Advance Care Planning Dashboard, you will see two panes. One for the Current MOST, and one for All Documents. Click on the thumbnail under All Documents to see the full availability of documents.

Email advancecareplanning@conehealth.com for future information

Reference

Vynca, Cone Health, and Triad Healthcare Network partner to Improve Advance Care Planning in North Carolina. (2019). Pr Newswire. https://www.prnewswire.com

Appendix B

How to Bill Advance Care Planning Discussions

You can offer ACP services during Medicare Wellness Visits (MWVs)

(which covers both the Annual Wellness Visit [AWV] and the Initial Preventive Physical)

Medicare pays for ACP as either:

- An optional element of a patient's MWV
- A separate Medicare Part B medically necessary service

If you bill this service more than once, document the patient's health status change or wishes about their end-of-life care. There's no limit on how often you can report ACP for a patient.

When a patient gets ACP services outside the MWVs, we encourage you to tell the patient that Part B cost

sharing applies as it does for other physicians' services.

CODING

Hospitals and Providers may bill ACP services if the practice scope and the Medicare benefit category include the services described below…

CPT Codes	Billing Code Descriptors
99497	***Advanced care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 16-30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	***Advanced care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such documents, when performed) by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

NOTE: There are no limits on the number of times you can report ACP for a given patient in a given time.

BILLING

***Medicare waives the ACP coinsurance and the Part B deductible when the ACP is: delivered on the same day as a covered MWV (HCPCS codes G0438 or G0439) ● Offered by the same provider as a covered MWV ● Billed with modifier –33 (Preventive Services)

If Medicare denies the MWV for exceeding the once-per-year limit, Medicare can still make the ACP payment as a separate Medicare Part B medically necessary service. In that case, Medicare applies the deductible and coinsurance to the ACP