Advance Care Planning in the Outpatient Geriatric Medicine Setting

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KEYWORDS

• Advance care planning • Geriatric medicine clinic • Advance directive • POLST

KEY POINTS

- Advance care planning contributes to patient-centered care in the outpatient geriatric medicine clinic.
- Advance care planning can include advance directives, Physician Orders for Life Sustaining Treatment (POLST), and do-not-resuscitate orders.
- Leading advance care planning conversations requires skill, which can be developed over time.
- Medicare allows for advance care planning conversations to be reimbursed if documented correctly.

Patient-centered care is the new mantra for health care. The concept is simple, defined as "care that is respectful of and responsive to individual patient preferences, needs, and values and [ensures] that patient values guide all clinical decisions."[1] This type of care is the cornerstone of geriatric medicine. Geriatric patients have complex medical needs and often must make complex decisions regarding specific treatments and the impact of treatments on their future health. Advance care planning provides the method to ensure that patient values guide clinical decision making. Advance care planning involves discussing future medical decisions that a patient might need to make, letting others know about their preferences, and documenting those preferences in an advance directive.[2] This article discusses how advance care planning can be done effectively and efficiently in the outpatient geriatric medicine setting.

Geriatric patients live with chronic illness that can have significant impacts on their health. Approximately 60% of older adults live with 2 or more chronic illnesses, such

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Prim Care Clin Office Pract 44 (2017) 511–518
http://dx.doi.org/10.1016/j.pop.2017.04.008
0095-4543/17/Published by Elsevier Inc.

as heart disease, chronic obstructive pulmonary disease, stroke, diabetes, cancer, and dementia.[3] These illnesses are common causes of death in the adult population. As a result, advance care planning is very important to geriatric patients. However, 70% of adults 65 years of age or older have completed some type of advance care planning,[4] although this completion rate varies among patient demographics and clinical settings. The 1990 Patient Self Determination Act requires hospitals and skilled nursing facilities to ask each patient on admission whether they have an advance directive and, if present, to record it in the patient's medical record.[5] The law does not require a patient to complete an advance directive for treatment. The law requires individual states to determine how the advance directive is written and implemented, resulting in variation from state to state. The basic components of an advance directive include (1) identification of a health care proxy, (2) how future care should be done when faced with a terminal or end-stage illness, and (3) ability to document a do-not-resuscitate order if desired. These basic components of the advance directive should be honored when a patient crosses state lines. A state advance directive should be honored if a patient seeks care in a federal facility such as a Veterans' Affairs (VA) medical center. However, if the advance directive discusses components that are noncompliant with local state laws (such as states with death-with-dignity laws or assisted-death laws), these components would not be honored. The geriatric clinic must have a firm knowledge of the state laws regarding advance directives and advance care planning.

Geriatric assessment offers many assessment tools that focus on function, cognition, and polypharmacy. Advance care planning should be included in this discussion. Somewhere between social history and activities of daily living, the clinician should ask whether the patient has an advance directive. If the patient has, a directive, the clinician should ask for the advance directive to be brought to the office so that it may be added to the electronic medical record. Geriatric patients may have opportunities to complete an advance directive outside of a clinic or hospital. These sites may include churches, senior centers, or an attorney's office. Patients completing advance directives at these sites may not have discussed the document with health care personnel and may need to review the document for clarity in the clinic. A patient's formal estate planning or trust may include advance care planning. If a patient has only completed a will, advance care planning would not be included. Other excellent opportunities to discuss advance directives and advance care planning include after hospitalization for exacerbation of chronic illness, after a new diagnosis of serious illness, or when moving to a new place because activities of daily living or instrumental activities of daily living have become impaired.

Advance care planning conversations have shown great benefit in decreasing hospitalizations, decreasing intensive treatments at end of life, increasing hospice use, and ensuring that patients die in the environment of their choice.[4] These benefits lead to cost-effective and high-quality treatment at end of life.[6] As a result, Medicare recognizes the importance of these conversations and developed Centers for Medicare & Medicaid Services codes for reimbursement after these conversations have been held.[7]

- CPT (Current Procedural Terminology) code 99497: advance 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 30 minutes, face to face with the patient, family members, and/or surrogate
- CPT code 99498: each additional 30 minutes (list separately in addition to code for primary procedure)

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