Difficult Conversations:
How to Address Heart Failure Throughout the Continuum

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DISCLOSURE

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Disclosures

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Objectives

1. Identify why difficult conversations are needed in heart failure
2. Review common conversations needed in the continuum of HF
3. Share a framework and tools for these conversations
4. Briefly review billing for advance care planning
The Heart Failure Journey

1. ~ 6.5 million Americans have HF
   ~ 960,000 new HF cases per year

2. ~2200 heart transplants U.S. has remained static

3. Durable VAD implantations continue to increase

4. Stage D HF is 90% at 1 year mortality

5. Annual number of cardiovascular deaths in US remains higher than all common cancers combined
Why are Difficult Conversations Important in Stage Heart Failure?

Simply having prognostic information available is not sufficient

Discussions require initiative and experience

Use of guided discussions can inform medical decision making

Failure of advance care planning often leads to a hospitalized end of life course
Why have difficult conversations when facing advanced heart failure?

Life with advanced heart failure:
- highly morbid
- significant symptoms
- significant functional limitation

Veterans study of symptomatic HF reveals:
- 63% had low energy
- 58% experienced SOB
- 55% had pain

AHF is highly lethal

Stage D life expectancy is often less than 1 year

AHF demonstrates increased intensity of care and frequency of hospitalizations at EOL

Increased intensity of care and frequency of hospitalizations are negatively correlated with patient satisfaction

Patient survey at academic HF clinics revealed significant discordance between patient predicted life expectancy vs actual (overestimate longevity by 40%)

Significant gaps exist in patient prognostic understanding

LeMond et al 2011
Continuous IV inotropic therapy:
- Palliative intervention – helps symptoms
- Possibly increase risk of sudden cardiac death

Patient narrative component:
Recent study revealed 2 preference groups
- Group A: preferred a significantly shortened life with fewer symptoms
- Group B: preferred longevity regardless of symptoms

Common Discussions Needed in AHF
- Surrogate decision maker
- Surrogate decision making
- ICD placement/deactivation
- Code status
- Prognosis
- Intensity of EOL care
- Symptom assessment
- Inotrope use/risks

LeMond et al 2011
How and when do you decide to start or re-visit advance care planning conversations?
How and when do you decide to start or re-visit advance care planning conversations?

NOTE: ACP conversations should recur as health or life circumstances change.
Advance Care Planning Framework

Initiate the conversation

Explain advance care planning

Identify a health care agent

Elicit and Document preferences
Initiate the conversation

“We want to make sure you get the best care possible. An important part of your routine medical care is having a plan for future unexpected events. Would it be ok if we discuss this today?”
Explain advance care planning

“Advance care planning helps you make healthcare choices if you have a sudden illness or injury. It includes identifying someone you trust to make medical decisions if you cannot speak for yourself and giving this person information about what is most important to you in your healthcare.”
Identify a health care agent

“A great place to start is to identify a health care agent. This is someone you trust to make medical decisions for you if you are too sick to make decisions for yourself. Is there someone you would want to be your agent?”
Elicit and Document preferences

“An advance directive is a legal document that provides written instructions to your health care agent about your wishes for medical care if you cannot make your own decisions. Could we review one today?”
Conversation Resources
Learn skills that matter.

VitalTalk’s free resources are organized into topics (or “tools”) that all clinicians need. Within each tool below are a series of related videos and access to “Quick Guides” to provide real-time support and reminders. For more comprehensive training, please consider our online and in-person courses.

First Steps Towards Conversation
An introduction to the VitalTalk ethos, tools, and methodology.
VITALtalk

Experience the transformative outcomes of effective communication.

Core techniques and tools:

- **Disclose Serious News**: 5 Videos
  - When giving difficult news, less is more.

- **Address Goals of Care**: 10 Videos
  - Smoothing discussions about prognosis and treatment.

- **Conduct a Family Conference**: 2 Videos
  - How to build relationships with family and promote patient-centered care.

More communication tools:

- **Establish Rapport**: 4 Videos
  - How you start a conversation makes a difference.

- **Track & Respond to Emotion**: 6 Videos
  - Things to remember when your patient is emotional.

- **Offer Prognostic Information**: 2 Videos
  - How to balance hope and realism.

- **Defuse Conflicts**: 2 Videos
  - Conflicts are inevitable. Here’s how to handle them.

- **Bear Witness to the End**: 3 Videos
  - Helping patients find acceptance.

- **Stay Strong**: 2 Videos
  - Empowering clinicians with communication skills that stick.

- **Cultivating Your Skills**: 1 Video
  - Tools to become a better communicator.

https://www.vitaltalk.org/resources/
Addressing Goals of Care: “What’s most important?”
Advance Care Planning – Billing 101*

*Disclaimer, please confer with your local billing and compliance to understand unique circumstances for your site of practice
Activities and Requirements for ACP Billing

<table>
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<tr>
<th>Common Activities for ACP Encounters</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>Designating a proxy</td>
<td>Face to Face with patient, family member(s) and/OR surrogate</td>
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<tr>
<td>Deciding among options for treatment</td>
<td>Document discussion</td>
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<tr>
<td>Reviewing and refining goals of care</td>
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<tr>
<td>Discussing healthcare options for EOL care</td>
<td>CMS did not impose a limit on the number of times code may be billed</td>
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<tr>
<td>Discussion and/or completion of forms such as advance directives, POLST forms</td>
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ACP Billing Codes, Reimbursement, & Documentation

Two Codes:
➔ CPT code 99497 - first 30 minutes
  (minimum of 16 minutes)
  ~ 2.4 wRVU’s

➔ CPT code 99498 - each additional 30 minutes
  (minimum of 16 minutes past the first 30 minutes documented)
  ~2.1 wRVU’s

NOTES
- No limits on number of times in a year, no limit on time, no limit on location of discussion
- Cannot be billed in addition to Critical Care Codes

Documentation:
- No specific format required
- Acknowledge receptiveness to service
- Document time spent (minutes)
- Document location
- Document person(s) involved in discussion
- Summarize discussion
ACP-- FAQ

1) Does the patient need to be given a choice/notified that you will be discussing ACP?
   → Yes, as it can lead to cost sharing common with Medicare part B

2) Does the patient need to be present?
   → No, can be with surrogate or family

3) Can you provide telephonically?
   → No, requires face-to-face visit

4) Can more than one provider bill?
   → Yes
5) Is there a limit to the physician specialty?
   → No

6) Is there a limit to the number of codes billed?
   → No

7) Can Advance Care Planning codes be billed together with routine hospital visit E/M charges?
   → Yes, but not on same day as critical care codes
CMS Resources for more details on ACP Billing Codes

CMS Overview

CMS FAQ
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
Easier to read resources

10 tips for Compliant use of ACP codes –
Jones et al.:

AAFP guidance:

Table 2. Ten Tips for Compliant Use of ACP Codes for Medicare Patients

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<tr>
<td>1.</td>
<td>Medicare has adopted CPT® codes 99497 and 99498 to reimburse for ACP and will utilize CPTs broad definition of ACP.</td>
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<tr>
<td>3.</td>
<td>ACP is reimbursable when performed by a physician or qualified health professional, defined as a nonphysician provider, including nurse practitioners, physician assistants, and clinical nurse specialists.</td>
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<td>4.</td>
<td>ACP discussions held by other members of the healthcare team are reimbursable if performed “incident to” the services of a billing practitioner, including a minimum of direct supervision.</td>
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<td>5.</td>
<td>ACP codes may be billed on the same day/during the same visit as an Evaluation and Management code, with the exception of critical care codes, or they may be billed as stand-alone codes.</td>
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<td>6.</td>
<td>ACP codes may be used in the inpatient, outpatient, skilled nursing facility, and home settings but not during telehealth or phone-based visits.</td>
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<td>7.</td>
<td>Patients should be informed that Part B cost sharing under Medicare is in effect and be given the opportunity to refuse ACP services.</td>
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<td>8.</td>
<td>While CMS has authorized payment for ACP using ACP codes 99497 and 99498, the ultimate decision to pay providers will be made at the Medicare Administrative Contractor level.</td>
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<td>9.</td>
<td>ACP codes may be billed as often as every day and may be billed for patients who have elected the Medicare Hospice Benefit.</td>
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<td>10.</td>
<td>ACP codes can be used in addition to transitional care management and chronic care management codes and within global surgical periods.</td>
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CMS, Centers for Medicare and Medicaid Services.
Thank you
References

AHA Heart and Stroke Statistical Update 2018.
https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000558

Center to Advance Palliative Care - https://www.capc.org/about/palliative-care/


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