Institute for Healthcare Improvement

conversation ready

Having the Conversation at Three Life Stages: A Guide for Providers

	No Serious Illness	Serious Illness	Advanced Serious Illness
Sample Case Progression	Ms. Smith is a 68-year-old woman with hypertension, hyperlipidemia, and history of smoking. She was recently diagnosed with emphysema/COPD. She's coming in for a routine follow-up for her hypertension with her daughter.	At age 71, Ms. Smith developed a COPD exacerbation, which turned into a pneumonia with significant shortness of breath. She was admitted to the hospital. She was sick enough to require BIPAP and was in the ICU. Eventually, she recovered and was discharged home. She is now in your office for routine follow-up.	Now 75 years old, Ms. Smith has had a couple admissions for less severe COPD exacerbations. She was eventually placed on home oxygen, and then about 2 months ago her illness seemed to progress. You talk more, and it becomes clear that she doesn't want to have to go back to the hospital if it isn't necessary. She really prefers to stay at home.
Conversation Goals	• Build trusting and respectful relationships • Learn about the patient as a person • Establish a surrogate decision maker • Promote patient-surrogate-family conversations	• Continue to build trusting, respectful relationships • Continue to learn more about the patient as a person • Ensure a good understanding of diagnosis, prognosis, and treatment options • Anticipate emergencies and make a plan when appropriate • Promote patient-surrogate-family conversations	• Rely on the trusting, respectful relationships that were built • Keep the focus on the patient as a person • Ensure a good understanding of diagnosis, prognosis, and treatment options before introducing hospice • Continue to hope for the best, but prepare for when things don't go well
Examples of What to Say	• Normalize the conversation • Try starting it after family history *"Have you ever thought who would speak for you if you couldn't speak for yourself? Is it ok if we talk about that?"* • If they already have an advance directive (AD): *"May I see it? What does it say?"* • If they do not have an AD: *"Can I offer you some tools to start thinking about it?"*	• Talk about "what matters most" *"Can you tell me your understanding of what happened in the hospital?"* *"What was that like for you?"* *"How are you doing now?"* *"If surrogate decision making was needed, how was that?"* • Identify the values that guided decision making, i.e., "what mattered most"	*"You have been in and out of the hospital quite a bit. How has that been?"* *"How do you feel about your quality of life?"* *"Given everything that has happened, what are you hoping for?"* *"Unfortunately, we don't have any more treatments to help your lungs get better."* *"It seems to me what matters most to you is to [stay out of the hospital, control your symptoms at home, and make the most of each day OR stay out of the hospital but continue to receive treatment] and I think [hospice OR home care] is the best way of doing that."*

Billing Details	New Codes from CMS • Use 99497 if you meet or exceed 16 minutes	• Use 99497 + 99498 if you meet or exceed 46 minutes
	Documentation Requirements • Total time in minutes • Patient/surrogate/family "given opportunity to decline" • Details of content • Attending MDs and DOs, as well as NPs and PAs (i.e., those who are authorized to independently bill Medicare for CPT services), are the only providers who can use these codes.	• If medical management billing is based on medical decision making, then you can bill as you normally would in that scenario. On top of that, you should also bill based on time spent for ACP. • If instead you are billing for the medical management based on time, you should be sure you do not double count the time spent on the advance care planning conversation.

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