

310-HH - END OF LIFE CARE AND ADVANCE CARE PLANNING

EFFECTIVE DATES: 10/01/17, 10/01/18, 03/01/19

APPROVAL DATES: 05/18/17, 07/11/18, 02/19/19

I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), ALTCS E P/D, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs as delineated within this Policy including: Tribal ALTCS, the American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES) unless otherwise delineated within this Policy. (For FES, see AMPM Chapter 1100). This Policy establishes requirements for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

II. DEFINITIONS

ADVANCE DIRECTIVE A document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

ADVANCE CARE PLANNING A part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

1. Educate the member/guardian/designated representative(s) about the member's illness and the health care options that are available to them,
2. Develop a written plan of care that identifies the member's choices for treatment, and
3. Share the member's wishes with family, friends, and his or her physicians.

CURATIVE CARE Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.

END-OF-LIFE (EOL) CARE A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

HOSPICE SERVICES A program of care and support for terminally ill members who meet the specified medical criteria/requirements.

PRACTICAL SUPPORT

Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to: housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

III. POLICY**A. END OF LIFE CARE CONCEPT**

EOL care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and Practical Supports. The goals of EOL care focuses on providing treatment, comfort, and quality of life for the duration of the member's life.

The EOL concept of care strives to ensure members achieve quality of life through the provision of services such as:

1. Physical and/or behavioral health medical treatment to:
 - a. Treat the underlying illness and other comorbidities,
 - b. Relieve pain, and
 - c. Relieve stress.
2. Referrals to community resources for services including, but not limited to:
 - a. Pastoral/counseling services, and
 - b. Legal services.
3. Practical Supports are non-billable services provided by a family member, friend or volunteer to assist or perform functions including, but not limited to:
 - a. Housekeeping,
 - b. Personal Care,
 - c. Food preparation,
 - d. Shopping,
 - e. Pet care, and
 - f. Non-medical comfort measures.

Members aged 21 years and older who receive EOL care may continue to receive Curative Care until they choose to receive hospice care.

Members under the age of 21 may receive Curative Care concurrently with EOL care and hospice care.

B. ADVANCE CARE PLANNING

Advance Care Planning is initiated by the member's qualified health care professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. For the purposes of Advance Care Planning, a qualified health care professional is a Medical Doctor (MD), Doctor of

Osteopath (DO), Physician Assistant (PA), or Nurse Practitioner (NP). Advance Care Planning is meant to be an ongoing process for the duration of the member's life. Advance Care Planning often results in the creation of an Advance Directive for the member. Refer to AMPM Policy 640 for provider requirements pertaining to Advance Directives.

1. Contractors shall ensure providers perform the following as part of the EOL concept of care when treating qualifying members:
 - a. Conduct a face-to-face discussion with the member/guardian/designated representative to develop Advance Care Planning,
 - b. Teach the member/guardian/designated representative about the member's illness and the health care options that are available to the member to enable them to make educated decisions,
 - c. Identify the member's healthcare, social, psychological and spiritual needs,
 - d. Develop a written member centered plan of care that identifies the member's choices for care and treatment, as well as life goals,
 - e. Share the member's wishes with family, friends, and his or her physicians,
 - f. Complete Advance Directives,
 - g. Refer to community resources based on member's needs, and
 - h. Assist the member/guardian/designated representative in identifying Practical Supports to meet the member's needs.

2. Contractors shall provide care/case management to qualifying members and coordinate with and support the member's provider in meeting the member's needs. In addition, the care/case manager will assist the member/guardian/designated representative in ensuring Practical Supports and community referrals are maintained or revised to meet the member's current needs.

Advance Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The provider may bill for providing Advance Care Planning separately during a well or sick visit.

C. HOSPICE SERVICES

Refer to AMPM Policy 310-J.

D. TRAINING

Contractors shall ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

E. NETWORK ADEQUACY

Contractors shall ensure an adequate network of providers who are trained to conduct Advance Care Planning. Refer to ACOM Policy 415.