Office of Patient Experience

COVID-19 ADVANCE CARE PLANNING TOOLKIT

Advance Care Planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their values, goals and preferences regarding future medical care. The goal of ACP is to help ensure that people receive medical care that is consistent with their preferences during serious and chronic illness.

ACP includes Advance Directives (AD) for all adults and “goals of care” discussions for seriously ill patients. During the COVID-19 pandemic, many patients are under quarantine or droplet precaution isolation. This toolkit offers options to conduct ACP while decreasing risk of exposure for Cleveland Clinic caregivers.

Advanced Directives

a) AD Instruction guides: Power of Attorney & Living Will
b) Completion guide for patients admitted to Ohio hospitals
c) Completion guide for patients admitted to Florida hospitals
d) Cleveland Clinic and Epic have released a home monitoring program to help patients track COVID-19 symptoms while sheltering in place. COVID-19 Home Monitoring: MyChart Care Companion patients are enrolled in a 14-day interactive care plan through Epic’s MyChart Care Companion, where they enter symptoms, temperature and oxygen once a day. On Day 2, patients are provided resources about Advance Directives (click HERE to view options provided to the patient).

Advance Care Planning Communication

a) An online ACP communication course is available at R.E.D.E. to Communicate: Advance Care Planning
b) A worst case/best case scenario Prognosis Discussion video is available for surgical patients. This technique can be applied to share a prognosis about any type of treatments offered.
c) COVID-19 ACP Card: This card offers two conversation guides:
   i) CALMER: This applies to Advance Care Planning before the surge.
   ii) SHARE: This applies to time-sensitive conversations about rationing and is intended for use during a crisis or a surge state.
d) Code Status Brochure (PWO 17712)
   i) DNR Policy course: Available in MyLearning.
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<th>ACP Documentation</th>
<th>Advance Care Planning Documentation in Epic</th>
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| ACP Virtual Visits | a) Inpatient eConsult Playbook: [https://ccf.jiveon.com/docs/DOC-18086](https://ccf.jiveon.com/docs/DOC-18086)  
b) Outpatient eConsult Playbook: [https://ccf.jiveon.com/docs/DOC-16876](https://ccf.jiveon.com/docs/DOC-16876)  
c) [Top 10 Tips for Communication during Virtual Visits](https://ccf.jiveon.com/docs/DOC-16876)  
d) [Empathy in Virtual Visits](https://ccf.jiveon.com/docs/DOC-16876) |
| ACP Facilitators | a) Spiritual Care caregivers has been trained to help providers conduct the exploration of wishes, values and worries virtually. To request an ACP facilitator consult contact, call 216.444.2518 or pager # 22956. |
| Advance Care Planning Billing | a) For details about ACP face-to-face billing, click [HERE](https://ccf.jiveon.com/docs/DOC-18086).  
b) During the COVID-19 pandemic, ACP is also billed for virtual or telephone encounters. Click [HERE](https://ccf.jiveon.com/docs/DOC-18086) for more information.  
i) Virtual visits require audio and video and they are billed with the same billing codes for face-to-face ACP encounters.  
ii) If the encounter is only using audio, it is billed as a telephone encounter.  
iii) For more information about COVID-19 ACP billing, click [HERE](https://ccf.jiveon.com/docs/DOC-18086). |

If you are interested in implementing an ACP workflow or for more information, contact: **End of Life Center.**