Advance Care Planning via Telemedicine in the time of COVID-19

Purpose – We should provide medical care that is concordant with patient's wishes.
To protect people's rights, we need to document:
a) Health Care Proxy information and
b) Advance Care Planning for Life Sustaining Treatment.

This is critically important during this pandemic as: 1) Patients are much more likely than ever before to present without a health care proxy due to social distancing; 2) Many of our patients do not have documented wishes; 3) Many people are not familiar with how poor the health care outcomes are for at risk populations with COVID-19 associated respiratory failure; and, 4) People's wishes vary significantly, but we do not know what people want unless we talk with them about this. It is best to engage patients before they are in extremis. National data shows that over 90% of patients have limits to what medical care they would want. With informed decision-making about advance care planning we can do our best to advocate for our patients.

- This document contains an **example template** approach for Advance Care Planning discussions in the ambulatory setting.
- This document also provides the steps needed to **legally document and bill** for such conversations with dot phrases that have been approved.
- A separate EPIC Tip Sheet will exhibit the workflow. By following the EPIC work flow you will be able to 1) provide appropriate documentation of the conversation, 2) assign the health care proxy, and 3) enter orders relating to life sustaining treatments. These orders will appear at the top of the patient's EPIC screen for all providers to see.
- Additional steps will be needed to send documentation to the patient. This would be needed, for example, to protect a person who does not want to be intubated from being intubated by Emergency Medical Services or at other hospitals if they present for care at other facilities. For patients who lack decisional capacity, advance care planning conversations will need to happen with the patient's health care proxy.

Many patients are scared right now. Talking about death and dying can be difficult but, when appropriately presented it can also be extremely relieving. The topic is on people's minds. It will likely not be a surprise that this is something to address at this time. If you approach this topic with a calm perspective, you will likely be able to reassure patients and put them at ease.

Current overall estimates are that 20% of people intubated with COVID-19 will survive. However, outcomes for patients who are older or have comorbidities are markedly worse.

By follow the EPIC Advanced Care Planning workflow (separate document) you have a path for the information you need, and you will be able to enter the relevant information. If you enter data such as a DNR status, this will appear in the patient's EPIC header so providers can be easily informed. Patients have the right to change their wishes, so it is perfectly reasonable to check in with people about their advanced directives over time.

Patients and providers can have emotional reactions to talking about death and dying. Yet, it can also be quite relieving and professionally gratifying to have these conversations. Afterall, if you know patients goals and wishes you can advocate for them and protect their rights.

Example Template

The template below provides conversational prompts that may also be useful.

A. Health Care Proxy

It is best that all patients identify a health care proxy. Also, this is a relatively easy topic to start with.

INTRODUCTION:

Hello, I am calling to talk about how things are going with COVID-19…

You have probably heard that most people who get this virus actually do fairly well, but that some people get extremely sick and even die from COVID-19…

HEALTH CARE PROXY:

So, I need to ask you, if you got very sick – so sick that you could not communicate with the doctors, who should speak to us for you?

➔ Please document the name and phone number in the ACP EPIC form.

Some patients have not determined who might be their health care proxy. These people should be encouraged to do so now.

DOES NOT HAVE HEALTH CARE PROXY:

I see. Well, who to you think might be able to do this?

Just because a person may have a health care proxy does not mean that there has been clear communication about goals of care or specific medical treatments. Inviting participation of the health care proxy is an excellent opportunity to promote such communication.

REQUESTING HEALTH CARE PROXY PARTICIPATION:

Is [name of health care proxy – or potential proxy] there with you? It would be great if he/she/they might be able to join our conversation.

The health care proxy might be physically present or might need to be merged onto the call. Including the proxy is an excellent way to improve communication and to protect patients wishes. Discordance between patients and their proxies about goals of care can lead to anxiety and patients getting medical interventions that they do not want.

B. Goals of Care

Identify the patient's overall values and preferences.

Global assessment:

If you became very sick, it would be great for me to know more about your wishes. This way I can work to protect your wishes. If you became very sick, would you want to live as long as possible no matter what, or are there any situations where you would not want to get life support?

Some people will be able to answer this question right away. Other people might need clarification.

This global assessment of goals allows you to get a sense of how the patient approaches the topic of advance care planning and will give you the opportunity to tailor the conversation according to their wishes. In this way you can differentiate between people who want a life-prolonging approach to medical care versus people who accept limitations, i.e., limited medical care.

C. Preferences

CPR Preferences (expressed life-prolonging orientation):
Ok, so, I need to be more specific to understand how we should take care of you if you get extremely sick. For example, if your breathing became so weak that you would need a breathing machine to survive, would you want the breathing machine even if we thought the chance of ever getting off the breathing machine was very small?

CPR Preferences (expressed limited medical care orientation):
Ok, so, I need to be more specific to understand how we should take care of you if you get extremely sick. For example, if your breathing became so weak that you would need a breathing machine to survive, given what you told me you would not want a breathing machine if we thought the chance of ever getting off the breathing machine were very small? Is that correct?

This can be tailored according to what was learned about goals.

The same approach can be used to ascertain preferences if the patient experiences cardiac arrest. It would be reasonable to start with the issue of respiratory distress as this is very much on people's minds at this time. The EPIC template includes options to specify the patient's preferences regarding the different elements of life-prolonging treatments.

D. Confirmation and Communication Regarding Preferences

Explain what you will do and what you want them to do
You have told me that [what you have learned about their goals] is very important to you. You have also told me that you [what you have learned about their preferences regarding treatments]. I will write this in the medical record. I will also send you a letter about our conversation. Please talk with your health care proxy about this to make sure they understand your wishes.

Legal Documentation
There are two dot phrases to use in your note and in the letter to the patient. The letter to the patient is in lieu of the official MOLST form. They can be instructed to use this letter to communicate with emergency medical services or with providers at other hospitals if they present to other facilities.

.COVIDACP

Due to the COVID-19 crisis, [name] was not able to complete a Medical Order for Life Sustaining Treatment (MOLST) FORM, and instead, the patient and I discussed the patient's advance care

planning wishes. Specifically, this note documents the fact that [NAME] wishes that medical professionals [should attempt resuscitation /should not attempt resuscitation (Do Not Resuscitate – DNR)][should intubate and ventilate / should not intubate and ventilate (Do Not Intubate – DNI)][should transfer to the hospital / should not transfer to the hospital unless needed for comfort (Do Not Hospitalize – DNH)]. This note reflects this patient's own free will and reflects his/her wishes and goals of care as expressed to me.

.COVIDACPbyproxy

In view of this patient's incapacity to communicate I have spoken today with his/her/their Health Care Agent [NAME OF AGENT]. Due to the COVID-19 crisis, the Health Care Agent was not able to complete a Medical Order for Life Sustaining Treatment (MOLST) FORM, and instead, we discussed the patient's advance care planning wishes. Specifically, this note documents the fact that medical professionals [should attempt resuscitation /should not attempt resuscitation (Do Not Resuscitate – DNR)][should intubate and ventilate / should not intubate and ventilate (Do Not Intubate – DNI)][should transfer to the hospital / should not transfer to the hospital unless needed for comfort (Do Not Hospitalize – DNH)]. The patient's representative (indicated above) confirms that this note reflects his/her/their assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her/their assessment of the patient's best interests.

Billing

Coding for Advance Care Planning typically requires a face-to-face encounter. This requirement has been waived. Please include one of the dot phrases listed above.

CPT 99497: First 30 minutes or less

CPT 99498: For >30 minutes

Please note – these codes work as stand-alone activities OR they can be **added** to primary billing codes if Advance Care Panning is done as part of a separate billable activity.