COVID Conversations:
Medical Decision Making in the Face of Serious Illness
Today's Presenters

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Objectives

• Explain the importance of conversations in advance care planning and POLST
• Describe purpose and content of an advance health care directive and POLST form
• Explain the difference between a POLST form and a health care directive
• Discuss how the COVID-19 crisis is impacting advance care planning and POLST.
Californians can live well in the face of serious illness* including COVID-19
COVID Conversations and patient-centered care
COVID-19 pandemic makes the threat of becoming seriously ill frighteningly real — and greatly emphasizes the need to know each patient’s values and wishes regarding treatment options. Conversations around serious illness and medical treatment options can be very empowering. Patients are often relieved to be asked about their values and wishes, family members avoid the anguish of guessing what the patient would want, and medical providers can move confidently in providing patient-centered care.

The Coalition for Compassionate Care of California is the respected voice for advance care planning and palliative care in California, with nearly 20 years of experience in creating a range of resources and educational materials to support healthcare providers and consumers. We’ve gathered together some of our best resources, as well as those of other respected leaders, in this COVID Communications Toolbox to provide easy access and support for healthcare providers and consumers as they navigate decision-making during these challenging times. We will be regularly updating this resource as additional materials are developed or identified.

**Conversation Tools**

- Decision aids, COVID-specific scripts, conversation tips, and other tools to help facilitate conversations about care during serious illness and COVID-19.

**Advance Directives**

- Downloadable advance directive forms, tools and resources to support creating advance directives.

**POLST**

- Physician Orders for Life-Sustaining Treatment (POLST) form, FAQs, best practices, and other POLST resources.
Advance Care Planning (ACP)

Conversations about:

What is important to the individual:
Hopes, goals, and concerns about the future

The realities facing the individual:
Diagnoses, abilities, limitations, resources, treatment preferences
Benefits of ACP

From the person’s perspective:

• Increases likelihood that wishes will be respected at end of life
• Achieves a sense of control
• Strengthens relationships
• Relieves burdens on loved ones
• Eases sharing of medical information (HIPAA)
• Provides opportunities to address life closure
Benefits of ACP

From the healthcare perspective:

- Person-centered care
- Avoid unwanted or unnecessary care
- Improved family and caregiver relations
- Helps to reduce moral distress among healthcare providers
Care Planning is for Everyone
Everyone

- Wishes Explored
- Wishes Expressed
- Wishes Honored
Across the continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness (at any age)

Complete a POLST Form

Treatment Wishes Honored
COVID-19

How is COVID-19 impacting conversations about ACP and POLST?
What healthcare professionals need to hear from patients

Surrogate
• Who is to speak for the patient if incapacitated**

Treatment wishes
• Such as resuscitation (CPR), intubation/ventilation

Values, Goals, Preferences
• What makes life worth living
• What can/can’t be sacrificed or compromised
• What needs to be completed before death
• What is unacceptable to the patient
  “I’d rather die in comfort than _____.”
• Special faith-based or cultural preferences
What patients need to hear from healthcare professionals

• Diagnoses
• Threats to wellbeing and function
• Natural progression of underlying disease process – including COVID-19, based on their specific health conditions
• Treatment options and likely outcomes
  ✓ Benefits
  ✓ Risks and Burdens
  ✓ Short and long-term results/outcomes
  ✓ Alternative interventions/treatments
  ✓ Course of disease with no intervention
  ✓ Comfort-focused interventions
What is an Advance Health Care Directive?

Tool to make healthcare wishes known when a patient is unable to communicate

Allows a person to do either or both of the following:
1. Appoint a surrogate decision-maker, healthcare agent
2. Give instructions for future healthcare decisions
Choosing a surrogate

- Willing and able
- Available
- Can make difficult decisions
- Knows values and preferences
- Will speak for you despite their interests, beliefs

*May or may not be the “closest family member”*
Who cannot be a surrogate

- Patient’s supervising healthcare provider(s)  
  Unless related to patient

- Any employee of the healthcare institution where the patient receives care  
  Unless related to patient

- Any operator or employee of facility where the patient lives  
  Unless related to patient
Verbally Appointed Surrogate

- The duration of appointment is for the period of health facility stay or 60 days, whichever is shorter.

- A verbally appointed surrogate has priority over a healthcare agent named in a document for the specified duration.
NOTE: The above are shown as examples of advance health care directive forms available for use in California
Requirements for making an advance directive legal in California

• Individual/owner’s signature
• Date of execution
• Witnesses or Notary

You do not need an attorney for this.
Who cannot be a witness?

Neither witness can be:

• Patient’s healthcare provider or employees of patient’s healthcare provider
• Operator or employee of community care facility or assisted living facility
• The agent named in the advance directive

One of the witnesses cannot be:

• Related to patient by blood, marriage, adoption
• Entitled to a portion of the patient’s estate
For California skilled nursing facility residents:

When executing a new advance directive, one witness must be the long-term care ombudsman.
Making an advance directive legal in light of COVID/social distancing

How does witnessing happen?
POLST
Physician Orders for Life-Sustaining Treatment

• Portable medical order
• Provides instructions regarding specific medical treatment
• Legally binding across healthcare sites in California
• Valid only if appropriately signed
• NOT FOR EVERYONE—including not for every nursing home or assisted living resident
# Advance directive vs. POLST

<table>
<thead>
<tr>
<th>Advance directive</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>General instructions for <strong>FUTURE CARE</strong></td>
<td>Specific orders for <strong>CURRENT CARE</strong></td>
</tr>
<tr>
<td>Needs to be retrieved</td>
<td>Stays with the patient</td>
</tr>
<tr>
<td>Many different forms</td>
<td>Single, standardized form</td>
</tr>
<tr>
<td>Signed by patient &amp; witnesses or notary</td>
<td>Signed by patient (or HC Agent) and physician</td>
</tr>
</tbody>
</table>
Indications for POLST form

- Serious illness
- Medically frail
- Chronic progressive condition
- “Surprise” question
Indications for POLST during COVID crisis

• What are the indications?
• Are they different from usual?
• Have the conversation!!
• COVID-specific POLST?
• Probably expand the population who could be offered POLST
• Specific chronic conditions
• Ventilator issues
Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

A
CARDIOPULMONARY RESUSCITATION (CPR):
- If patient has no pulse and is not breathing.
- If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.
- Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B
MEDICAL INTERVENTIONS:
- If patient is found with a pulse and/or is breathing.
  - Full Treatment – primary goal of prolonging life by all medically effective means.
    - In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
      - Trial Period of Full Treatment.
  - Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
    - In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
      - Request transfer to hospital only if comfort needs cannot be met in current location.
  - Comfort-Focused Treatment – primary goal of maximizing comfort.
    - Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders: __________________________

C
ARTIFICIALLY ADMINISTERED NUTRITION:
- Offer food by mouth if feasible and desired.
  - Long-term artificial nutrition, including feeding tubes. Additional Orders: __________________________
  - Trial period of artificial nutrition, including feeding tubes. __________________________
  - No artificial means of nutrition, including feeding tubes. __________________________

D
INFORMATION AND SIGNATURES:
- Discuss with: Patient (Patient Has Capacity) □ Legally Recognized Decisionmaker □
  - Advance Directive dated ________, available and reviewed → Health Care Agent if named in Advance Directive:
    - Name: __________________________
    - Phone: __________________________
  - Advance Directive not available □
  - No Advance Directive □

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s medical condition and preferences.

Print Physician/NP/PA Name: __________________________
Physician/NP/PA Phone #: __________________________
Physician/PA License #: __________________________
NP Cert. #: __________________________

Physician/NP/PA Signature: __________________________ Date: __________________________

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name: __________________________
Signature: __________________________ Date: __________________________
Relationship: __________________________

Mailing Address (street/city/state/zip): __________________________
Phone Number: __________________________

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*From versions with effective dates of 6/2/2009, 4/15/2011, 10/12/2014 or 01/01/2016 are also valid.
Section A

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

<table>
<thead>
<tr>
<th>Patient Last Name:</th>
<th>Date Form Prepared:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient First Name:</td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Patient Middle Name:</td>
<td>Medical Record #: (optional)</td>
</tr>
</tbody>
</table>

EMSA #111 B
(Effective 1/1/2016)*

CARDIOPULMONARY RESUSCITATION (CPR):
If patient has no pulse and is not breathing.
If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/DNR  (Allow Natural Death)
## Section B

### MEDICAL INTERVENTIONS:

<table>
<thead>
<tr>
<th>Check One</th>
<th>If patient is found with a pulse and/or is breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Full Treatment – primary goal of prolonging life by all medically effective means.</td>
<td></td>
</tr>
<tr>
<td>☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.</td>
<td></td>
</tr>
<tr>
<td>☐ Comfort-Focused Treatment – primary goal of maximizing comfort.</td>
<td></td>
</tr>
</tbody>
</table>

- In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
- **Trial Period of Full Treatment.**
- **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: ____________________________
We have to ask ourselves some serious questions:

- What do I value about my life?
- If I will die if I am not put in a medical coma and placed on a ventilator, do I want that life support?
- If I do choose to be placed on a ventilator, how far do I want to go? Do I want to continue on the machine if my kidneys shut down? Do I want tubes feeding me so I can stay on the ventilator for weeks?”

Source: Dr. Kathryn Dreger, NYT [https://nyti.ms/3bS9h6l](https://nyti.ms/3bS9h6l)
Section C

<table>
<thead>
<tr>
<th>Check One</th>
<th>Artifially Administered Nutrition:</th>
<th>Offer food by mouth if feasible and desired.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Long-term artificial nutrition, including feeding tubes.</td>
<td>Additional Orders: ________________________</td>
</tr>
<tr>
<td>□</td>
<td>Trial period of artificial nutrition, including feeding tubes.</td>
<td>________________________</td>
</tr>
<tr>
<td>□</td>
<td>No artificial means of nutrition, including feeding tubes.</td>
<td>________________________</td>
</tr>
</tbody>
</table>
POLST Best Practices

• POLST is *always voluntary* for patients
• POLST is not indicated for all patients*
• POLST should be re-visited when there is unexpected or significant change of condition
• POLST can be voided by patient *at any time*
• Surrogate decision-makers can void or change a POLST *when circumstances change* *(Provider should be involved in discussions)*
POLST is not just a check box form!

It represents and memorializes a **conversation**

- Prognosis and realistic outcomes
- Choices based on patient’s values
- Goals and focus of care
Pre-hospital DNR

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM
An Advance Request to Limit the Scope of Emergency Medical Care

I ___________________________ request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart
breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital
emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any “DNR” notations.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or
other health personnel as necessary to implement this directive.

Thereby agree to the “Do Not Resuscitate” (DNR) order.

Patient's Legally Recognized Health Care Delegation Signature

Physician Signature

Date

Physical Exam

Primary Provider

Telephone

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Key Elements in Conversations

- Openness to talk, listen & trust
- Preferences for information & family disclosure
- Understanding of their illness
- Life goals, including upcoming milestones
- Fears and anxieties
- Unacceptable states of health or function or tradeoffs
COVID Conversations

• Is it OK if we talk about what’s important to you and how the new coronavirus might affect you, so we can be sure we can give you the kind of care you’d want if you got the virus?

• This conversation can help your family and help us, your health care team, if that ever happened.
COVID Conversations

• What do you know about the coronavirus?

• What can you tell me about your other medical conditions and how they affect you?

• Have you thought about what might happen if you were to get this virus? Do you have any specific fears about it?
“It can be difficult to predict what would happen if you got the virus, already being at risk from your [medical conditions]. Many patients get mild cases, and I hope you would be one of them, but I’m worried that you could get very sick quickly, and I think it’s important for us to prepare for that possibility.”
Transfer/Treatment Decisions

- Risks of going to hospital are greater than they usually are because of the virus

- Even without COVID, preferable to treat patients in “lowest” safe care location (home, SNF, AL)

- Issues around access to family visits, may influence choice of location to receive care

VitalTalk, Ariadne Labs, CAPC & others
Managing documents

- Give copy to the healthcare agent
- Make copies for other loved ones
- Discuss with provider/doctor/hospital and place in medical record
- Keep a copy
- Bring for hospital admission

Remember: Photocopies/faxes/scans are just as valid as the original.
What if the patient changes his/her mind?

• Anyone can revoke their healthcare directive or appoint a new healthcare agent at any time

• POLST can be modified by a patient with capacity, and by legally recognized decisionmaker when appropriate

• Best practice is to execute a new document
Process recap

• Select a spokesperson/healthcare agent
• Discuss wishes with agent, loved ones, providers
• Complete advance directive document, give copies to agent, loved ones, doctor
• After COVID - review and make changes