COVID Conversations:

Team Approach to Assisting Patients with Advance Care Planning
Objectives

• Describe why ACP is important especially in the context of the COVID-19 outbreak
• Identify the opportunities to talk about ACP with patients
• Describe different contributions each healthcare team member can bring and how to work together as a team to support patients with ACP
Many thanks to CCCC’s Sustaining Supporters who make it possible for us to continue to do this important work.
COVID Conversations
and patient-centered care
COVID-19 Conversations Toolbox
coalitionccc.org/covid-conversations-toolbox/

COVID CONVERSATIONS | TOOLBOX

The COVID-19 pandemic makes the threat of becoming seriously ill frighteningly real — and greatly emphasizes the need to know your 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.
Today's Presenter

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COVID conversations:
Team approach to assisting patients with ACP

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Objectives

• Describe why ACP is especially important during the COVID-19 pandemic
• Identify opportunities to talk about ACP with patients
• Describe how you and your team members can work together to assist patients with ACP
Why is ACP important in the COVID-19 pandemic?

• To ensure patients receive the care they want that align with their goals and values
• To avoid unwanted high-intensity care when resources and health care capacity are limited
• To minimize risk of transmission of COVID-19, moral distress, and grief
Naming surrogate decision maker

1. Choose a medical decision maker
   - This person will speak for you if you cannot speak for yourself
     - They can make sure your doctors know about the care you want
     - Keep their phone number on hand
     - If able, choose a back-up medical decision maker
   - A good medical decision maker is someone who:
     - Can talk to the doctors for you in person or by phone
     - You trust to follow your wishes and what is best for you
   - Let your medical decision maker know they were chosen
     - This website can show you how: prepareforyourcare.org
Complete an Advance Directive/Living Will

WHO: All patients you encounter

Useful language:

“Because you may become very sick quickly with COVID-19, it is important to talk with your family, friends, and healthcare providers about what is most important for your life and medical care. It is also helpful to have your wishes written in a form. Advance directive is a form that allows you to name and write down the decision maker and what you want for medical care. Have you ever completed an advance directive?”
Complete an Advance Directive/Living Will

Have you ever completed an advance directive?” ”

• If YES – “That’s great. Do you remember what you wrote? Do you still feel the same way? Do you know where this form is? It is important to share the information in this form with your family and friends, and bring a copy with you if you need to go to the hospital.”

• If NO – “This is OK. A good place to start is [Example, use local preference].”

• Share resources, e.g., PREPAREforYourCare.org.
Goals of Care Conversation

WHO: Patient with serious illness, COVID high risk

Useful tool for clinicians: Serious Illness COVID Conversation Guide

Outpatient

Useful flow and language:

• Set up
• Assess (understanding about their health)
• Share your understanding (Use “wish, worry”)
• Explore (most important, worried, important ability, medical treatment, loved ones)
• Close and recommend
SICG: Set up and Assess

This is a difficult and scary time with the coronavirus. I’m hoping we can talk about what is important to you, so that we can provide you with the best care possible. Is that okay?

What do you understand about how the coronavirus could affect your health?
What are you currently doing to protect yourself from getting the virus?
May I share with you my understanding of how the coronavirus could affect your health?
Most people who get the coronavirus get better on their own. However, people who are older or have other health problems like yours can get very sick and may not survive. The treatments that we use to try to help people live, like breathing machines, may not work. If they do work, recovery from the illness is uncertain. [Pause, respond to emotion].

We really hope that you don’t get the virus, but it is important to prepare in case you do.

Given your [medical condition]/age, I’d like to think together about what would be important to you if you became very sick and couldn’t speak for yourself.
SICG: Explore

What would be **most important** for your healthcare providers or loved ones to know if you became very sick and couldn’t speak for yourself?

With all that’s going on, what are you most **worried** about?

What **abilities** are so important to you that you can’t imagine living without them?

If we think they may not help or may cause suffering, some people make decisions to avoid treatments like breathing machines or CPR if they get very sick. If that happened to you, have you thought about **medical treatments** that you may or may not want?

How much do your **loved ones** know about your priorities and wishes?
This can be hard to talk about. At the same time, this conversation can help us ensure that **what matters most to you** guides your care if you get sick.

I’ve heard you say ____. I think it’s important to **share this information with your loved ones** so they can speak for you if you can’t. I recommend that we complete a healthcare proxy so we know who you trust to make decisions if you can’t.

[If additional recommendations] I also recommend ____.

This is an uncertain time for all of us. **We will do everything we can** to help you and your family through this.
Offering POLST

WHO: COVID high risk patients (w serious illness, 80+ w frailty, 70+ w respiratory disease, CVD, DM)

Useful tool: [https://polst.org/](https://polst.org/)

- A **POLST (Portable Medical Orders for Life Sustaining Treatment)** translates patient wishes for life-sustaining treatment into medical orders.
- The medical order can be followed by emergency personnel outside of the hospital.
What’s the difference?

**Advance Directive**
- For anyone 18+
- Provides patient preference for treatment in the event s/he cannot speak for self
- Does not guide Emergency Medical Personnel
- Appoints a Healthcare Representative
- No need for health care provider’s signature

**POLST**
- For those with serious illness or frailty – at any age
- Provides medical orders for life sustaining treatment
- Provides medical order to Emergency Medical Personnel
- Needs health care provider’s signature
- SDM information is optional
Decision Making: Life Sustaining Treatment

WHO: Inpatient/ICU COVID(+) patients

Useful tool:
- Serious Illness COVID Conversation Guide Inpatient
- VitalTalk COVID ready communication playbook
This can be hard to talk about. I really appreciate your sharing this information with me.

I heard you say that ___ is really important to you. Given what you told me, and what we know about your current health, I would recommend that we... [CHOOSE A or B]

A. use intensive care if necessary, including CPR or breathing machines. If something changes to make us worry that these treatments are not likely to work, we will tell you or your [trusted decision maker]. Is that okay?

B. provide only treatments that we think will be helpful. This means that we would not do CPR or breathing machines but will provide all other available treatments to help you recover and be comfortable. Is that okay?

We can revisit this at any time. We will do everything we can to help you and your family through this.
Decision Making: Life Sustaining Treatment

<table>
<thead>
<tr>
<th>Deciding</th>
<th>When things aren’t going well, goals of care, code status</th>
</tr>
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<tbody>
<tr>
<td>What they say</td>
<td>What you say</td>
</tr>
<tr>
<td>I want everything possible. I want to live.</td>
<td>We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? <em>What do I need to know about you to do a better job taking care of you?</em></td>
</tr>
<tr>
<td>I don’t think my spouse would have wanted this.</td>
<td>Well, let’s pause and talk about what they would have wanted. Can you tell me what they considered most important in their life? <em>What meant the most to them, gave their life meaning?</em></td>
</tr>
</tbody>
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VitalTalk COVID ready communication playbook
Proactive ACP in COVID time: Healthy persons

Even healthy persons could face serious illness with COVID

1. Reach out to all of your patients
2. Share facts about COVID-19 and counsel on protective measure
3. Engage patients and their family to have a plan
   • Name surrogate decision maker
   • Share what matter and priority
   • Complete/review an advance directive

WHO on your team is in best position to do this?
Proactive ACP in COVID time: With serious illness

Patients with underlying conditions have higher risk to develop **serious complications** with COVID

1. Reach out to all of your patients
2. Share facts about COVID-19 and high risk and counsel on protective measure
3. Engage patients and their family to have a plan
   - Name surrogate decision maker
   - Share what matter and priority
   - Offer POLST if patients know what they want

WHO on your team is in best position to do this?
Team approach

• Everyone can pitch in.
• Everyone can help patients to have an ACP
  • Who is well positioned to do this?
  • Build a system to do it consistently
• Whoever has conversation with patients documents it where others can see.
• Earlier conversations help later decision making
• Create a process for communicating with external health care professionals about the patient’s ACP.

WE ARE ALL IN THIS TOGETHER
Unique COVID issues: Social distancing and isolation

• When you SHARE facts about COVID-19, you may want to explain that it is possible that visitors will not be allowed in hospitals.

• No visitors could be an important factor determining whether the patients want to be hospitalized or not.

With coronavirus victims dying alone, doctors and families share a common grief
The Washington Post April 13, 2020
Unique COVID issues: Social distancing and isolation

In LTCF, visitors may not be allowed. If patients choose to stay/go home, plan and implement specific actions to follow:

• Follow-up tele/home visit
• Comfort measure (e.g., medication, O2) at home
• Instruct and support caregivers (ADLs, protection)
• Arrange hospice service if appropriate
Unique COVID issues: Social distancing and isolation

• Obtaining signatures on advance directives and POLST may be difficult
• States have different regulations
• In the pandemic, innovative work arounds and exemptions (e.g., verbal order for POLST, e-signature)
• Most healthcare organizations respect the patient’s expressed wishes
Unique COVID issues: Tips for telehealth

Figure out technology first – then let technology disappear:
• Start the visit by confirming pt/fml can see and hear you.
• Let pt/fml know that it is ok to interrupt if they need to pause or make adjustment.
• Confirm that you will call them in the event that the connection is lost during the visit.
• Speak slowly and clearly and check every so often to ensure that you are being heard.
• Remember to look at the camera. Match your “head size” to theirs.
Unique COVID issues: Tips for telehealth

- **Acknowledge** the strangeness of the moment we are in.
  
  “This is really an uncertain time for everyone lately, how are you and your families doing with this uncertainty?”

- **Transition in** to set up ACP.

- End the visit by **summarizing** what you heard, what the plan is, and reaffirming your commitment to the patient
Unique COVID issues: Tips for telehealth

- **Documentation:** Document and bill as you would in face-to-face. Document patient consent for telehealth service (verbal is allowed).

- **Billing:** Telehealth can be used for advance care planning (CPT codes 99497 and 99498).

- **Virtual visit algorithm:**

- **List of telehealth services:** https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Useful sites and tools

Ariadne Labs Serious Illness COVID-19 Conversation Guide (outpatient and inpatient)
• https://www.ariadnelabs.org/coronavirus/clinical-resources/covid-conversations/

Center to Advance Palliative Care
• https://www.capc.org/toolkits/covid-19-response-resources/

PREPARE for your care COVID-19 & You
• https://prepareforyourcare.org/covid-19

VitalTalk
• https://www.vitaltalk.org/guides/covid-19-communication-skills/
Thank you

Questions?

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