COVID Conversations:
Advance Care Planning and POLST

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Objectives

• Explain why Advance Care Planning conversations are even more vital now in light of the COVID-19 pandemic

• Summarize specific areas where medical treatment decisions may be different for COVID-19 versus other types of serious medical conditions, based on prognosis, location of care, and other factors

• Explore and identify strategies for having ACP and POLST conversations with patients and families, specific to COVID-19 in addition to general strategies
Disclosures

• Dr. Steinberg has no relevant financial disclosures or potential conflicts of interest
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• Medical Director, Hospice by the Sea
• Medical Director, Life Care Center of Vista
• Medical Director, Carlsbad by the Sea Care Center
• Vice President, National POLST
• President-Elect, AMDA – The Society for Post-Acute and Long-Term Care Medicine
COVID CONVERSATIONS | TOOLBOX

The 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.

https://coalitionccc.org/covid-conversations-toolbox/
Advance Care Planning (ACP) is...

A series of 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
Does COVID change this?

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
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
Selected ACP documents

(not meant to be exhaustive)
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*
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.
Making an advance directive legal in light of COVID/social distancing

How does witnessing happen?
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
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
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
## Advance directive vs. POLST

<table>
<thead>
<tr>
<th>Advance directive</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>General instructions for FUTURE CARE</td>
<td>Specific orders for CURRENT CARE</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>
Section A of California POLST

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)*

EMSA - EMERGENCY MEDICAL SERVICES AUTHORITY - CALIFORNIA - ALASKA

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)
<table>
<thead>
<tr>
<th>MEDICAL INTERVENTIONS:</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>In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.</td>
</tr>
<tr>
<td>☐ Trial Period of Full Treatment.</td>
<td></td>
</tr>
<tr>
<td>☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.</td>
<td>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.</td>
</tr>
<tr>
<td>☐ Request transfer to hospital only if comfort needs cannot be met in current location.</td>
<td></td>
</tr>
<tr>
<td>☐ Comfort-Focused Treatment – primary goal of maximizing comfort.</td>
<td>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.</td>
</tr>
<tr>
<td>Additional Orders:</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>MEDICAL INTERVENTIONS:</th>
<th>If person has pulse and/or is breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Comfort Measures Only Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location.</td>
<td></td>
</tr>
<tr>
<td>☐ Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital only if comfort needs cannot be met in current location.</td>
<td></td>
</tr>
<tr>
<td>☐ Full Treatment In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.</td>
<td></td>
</tr>
<tr>
<td>Additional Orders:</td>
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</tbody>
</table>
Section B—Full Treatment

• Full Treatment
  • Full use of all hospital has to offer
    • Including ICU & intubation/ventilation, dialysis, etc.
  • Invasive, intense, aggressive
• CPR = most invasive/aggressive intervention
  • Those choosing CPR in Section A must choose Full Treatment in Section B (common error)
• Can be for trial period, either a specific time or just left blank and defer to decisionmaker
  • This is what most people who desire full treatment want (trial period, not forever—“pull the plug” eventually)
  • With COVID-19, average time on ventilator is much longer (weeks) than for other common reasons for respiratory failure (e.g., sepsis)
“All this does not mean we shouldn’t use ventilators to try to save people. It just means 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/3bS9h6I](https://nyti.ms/3bS9h6I)
Section B—Selective Treatment

• Selective Treatment (formerly “Limited”)
  • Most complex category
  • Not ready for comfort as primary goal, but want less invasive treatment—weighs burdens vs. benefits
    • No intubation/ventilation (CPAP/BiPAP OK)
    • Think twice before surgery or ICU (but could consider)
    • Treat treatable conditions if not too burdensome
    • What many people would consider “No Heroics”

• “Do Not Transfer” option
  • Acknowledges residents who want these treatments in nursing home or assisted living, but not hospital—but still must transfer if comfort needs can’t be met in current setting
  • Very useful for nursing homes—treat-in-place
  • May be especially useful in the time of COVID-19, depending on local hospital conditions
  • But nurses have to be aware of this and remind the doc when there is a change of condition!
Section B—Comfort-Focused Treatment

• Comfort-Focused Treatment
  • Everyone gets comfort care
    • Whether box is checked or not
  • Choice is mostly for patients close to the end of life—interventions designed to prolong life generally not wanted, typically chosen by hospice patients
  • Don’t send to hospital unless comfort can’t be managed in current location (some settings may not have a choice, e.g., Assisted Living)
  • Change in condition—Evaluate
    • For example, broken hip may need surgery to address pain, which promotes comfort
    • Needs special consideration during the COVID pandemic
Section B—Free-Text Options

• Anything may be written in the free-text section, although it may not always have the force of a physician’s order
  • e.g., “No transfusions”; “No mechanical ventilation > 14 days”; “No antibiotics”;
  • Can consider writing in something specific to COVID pandemic and the treatment options in the event patient develops COVID.

Advance Directive Section

• Important to track down if person has an existing AHCD
• If not, they can orally designate a decisionmaker, should be specified on form and ideally execute AHCD shortly thereafter (must have decisional capacity)
Section C – Artificial Nutrition

- Remember: Tube feeding is not medically indicated in patients with advanced dementia
- This section was taken off Oregon’s POLST form
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
Key Elements in Conversations

• Patient willingness to talk
• Patient preferences for information
• Patient understanding of their illness
• Patient preferences for family disclosure and/or decision-making
• Personal life goals, including upcoming milestones
Key Elements in Conversations

- Fears and anxieties
- Unacceptable states of health/function (vs.)
  - Tradeoffs they are willing to accept
- Recognizing that people can change their minds
- Exploring emotional and spiritual factors
- Mutual trust and a willingness to listen

VitalTalk, Ariadne Labs & others
Coronavirus Conversations

• Prepare by determining if there is an AHCD, POLST or other documentation of treatment preferences in chart/EHR
• If so, familiarize yourself with the contents—and if there is an agent/proxy designated, offer to include them in the conversation when broaching subject
• “Take your own pulse.”
Coronavirus 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

• Have you chosen a person to make decisions for you if you were unable to speak for yourself? Who is it? Are you confident they can do it?

VitalTalk, Ariadne Labs, CAPC & others
Coronavirus Conversations

• What do you know about the coronavirus? Is there anything you’d like me to tell you about it?
• 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? (e.g., hospital, vent)
Coronavirus Conversations

• “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.”
Coronavirus Conversations

• Goal clarification:
  • What are your
    • …most important goals if you get ill?
    • …biggest fears about the future?
    • …abilities that you can do now that you can’t imagine living without in the future?
  • Does your family know about these values?
    • It’s a hard subject, but best to talk about them

VitalTalk, Ariadne Labs, CAPC & others

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Coronavirus Conversations

Summarize

• Acknowledge emotion, allow for silence
• Thank you for having this hard conversation
• What I’m hearing you say is that what’s most important to you is .........., and that if you weren’t able to ...... you would not want to live that way. Is that right?
• Based on that, and based on your condition and what I know about the virus, I would recommend .... because.....
Coronavirus Conversations

Summarize

- I hope things don’t get worse, but I am glad we talked about this, in case they do.
- We will do everything we can to make sure we give you the care you want to receive, and I will make sure orders are written that reflect that.
- Is there someone else you’d like me to talk to about our conversation?
- *I care about you. We will walk this path together.*
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
• No-visitor rules can be waived in some locations for actively dying patients
Transfer/Treatment Decisions

• During surge→crisis, triage decisions may change usual access to care (CPR, ventilation).
• Reassure patient/family that rules are applied fairly and not capriciously or based on individual physician judgment, age, etc.
• Is it ethical to ask people in advance to forgo treatment they would otherwise have wanted?
• Ability to provide adequate comfort/palliative interventions in non-hospital locations
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/surgery

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 or state new treatment preferences 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

- Gather and share information on goals, values
- Select a spokesperson/healthcare agent
- Discuss wishes with agent, loved ones, providers
- Complete advance directive document, DPOA-HC
- Give copies to agent, loved ones, doctor
- Periodically review and make changes
- **POLST** form when appropriate, if desired
Summary

• COVID-19 adds another layer of complexity to ACP treatment decisions
• Specifically, decisions to hospitalize, and to intubate/ventilate may be nuanced
• Remember DN(A)R doesn’t mean “let me die”
• Dying of dehydration is not a bad way to go, but the public does not know that
• Lack of physical closeness with family is a very difficult part of the COVID picture in health care institutions
• Remote/virtual visits can help facilitate ACP discussions