Proactive Care Planning for COVID-19

What matters most to you matters to us

Note to User: This guide is for use by clinicians to proactively help healthcare agents or dedicated decision maker (DDM) of individuals at risk for complications associated with COVID-19 express their desires for care, in the event the individual develops the infection. This information will allow clinicians to create plans for care that will honor each individual’s preferences and decisions.

This conversation can be delivered through telecommunication, video conference, in-person, etc. If a previous introduction conversation has occurred, start at #3 below.

1. The invitation (virtual or in person)

“It is important that the healthcare team understands what matters most to [name of individual] in the event that [name of individual] becomes seriously ill as a result of COVID-19. We are eager to make sure we understand what they would want.”

“As the healthcare agent/DDM for [name of individual], your role is to help the healthcare team:

− Follow [name of individual’s] previous decisions and
− Make decisions in difficult moments (e.g., stressful times, differing opinions, crisis situations) that are in line with [name of individual’s] goals, values, and preferences.

“I know this is a lot to take in all at once. I want to support you any way I can. These can be tough decisions to make and talk about especially in these uncertain times. Think of these conversations as a gift of love to [name of individual], making sure their goals and values are honored by the decisions you make.”

“We are here to help you get started today. What questions do you have?”

2. Provide the context for having further conversation

“There’s no way to tell if a sudden illness, such as COVID-19, could leave [name of individual] seriously ill and you, as their healthcare agent/DDM, may need to make decisions about treatment options. By giving direction ahead of time, the doctors will know what matters most to [name of individual] and can recommend treatments that match [name of individual’s] goals and values.”

“Has [name of individual] completed a POLST form?”

- If yes: “It is important to review this document with the care team now to understand what matters most in the event [name of individual] becomes seriously ill.”
- If no: “We are here to help you have a conversation with the care team.”
3. Explore goals, values, and preferences about what the person would want if they became very ill
(Ask exploratory questions using communication skills; clinicians work to top of license; if unable to
answer a question/support making a decision, create list of questions for physician, advanced
practitioner.)

“What do you understand about COVID-19?”

“What do you understand about the complications of COVID-19 in the context of [name of
individual’s] current medical condition(s)?” Provide education per your organization’s guidance
(e.g., CDC guidelines).

“What is most important for [name of individual] to well? For example, if they were having a
good day, what would happen on that day?”

“What personal, cultural, or spiritual beliefs does [name of individual] have, if any, that would
impact their care?”

“What worries you most about the situation? What fears do you have?”

4. Summarize the conversation so far

“Thank you for helping me better understand what matters most to [name of individual]. You have
said [describe themes from the conversation, e.g., goals, values, beliefs]. Does this summary capture
our conversation accurately, so far?” If no, amend. If yes, continue.

5. Priorities for Medical Care and Treatment Options
(Start with the priority that best matches what matters most to the individual.)

“If a sudden illness, such as COVID-19, left [name of individual] seriously ill, there may be a need to
make decisions about treatment options and where [name of individual] might receive care, such as
at home, hospital, or care facility. By giving direction ahead of time, the doctors will know what
matters most to [name of individual], and the treatments that will best match their goals and
values.”

“Let’s begin by defining [name of individual’s] priorities for medical care.”

<table>
<thead>
<tr>
<th>PRIORITIES FOR MEDICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVING LONGER</td>
</tr>
<tr>
<td>• Live as long as possible, even if I do not know who I am or who I am with</td>
</tr>
<tr>
<td>• Be in the hospital and receive all care my doctors think will help me, even if it means relying on machines to keep me alive</td>
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</table>
6. Make a decision about serious illness treatment options

“Based on what you have told me about what is important to [name of individual] and what we have discussed about COVID-19, let’s explore treatment options if [name of individual] becomes seriously ill and discuss the ones that best meet their goals.”

“The priorities for medical care seem to fit with a [Full, Selective, Comfort-Focused] treatment. Like we did for [name of individual’s] priorities, let’s go through the treatment options to see which one meets their goals. Whatever the choice, [name of individual] will be treated with respect, dignity, and be kept comfortable.”

Note to User: Use Help with Breathing and/or CPR Decision Aid for individuals with underlying serious illness, if available.

### TREATMENT OPTIONS FOR SERIOUS ILLNESS

<table>
<thead>
<tr>
<th>FULL TREATMENT</th>
<th>SELECTIVE TREATMENT</th>
<th>COMFORT-FOCUSED TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustaining life by all medically effective means</td>
<td>Maintaining health while avoiding burdensome treatments</td>
<td>Maximizing comfort through symptom management</td>
</tr>
<tr>
<td>Includes:</td>
<td>Includes:</td>
<td>Includes:</td>
</tr>
<tr>
<td>- Medication and treatment to keep you comfortable</td>
<td>- Medication and treatment to keep you comfortable</td>
<td>- Medication and treatment to keep you comfortable</td>
</tr>
<tr>
<td>- Emotional and spiritual care</td>
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<td>- Emotional and spiritual care</td>
</tr>
<tr>
<td>May include:</td>
<td>May include:</td>
<td>May include:</td>
</tr>
<tr>
<td>- Being in the hospital and Intensive Care Unit (ICU)</td>
<td>- Being in the hospital but AVOIDING the ICU</td>
<td>- Being in the hospital ONLY if comfort needs not met</td>
</tr>
<tr>
<td>- A trial of full treatment, if desired, e.g., ventilator</td>
<td>- Non-invasive positive airway pressure</td>
<td>- Oxygen, suction, and manual treatment of airway for comfort</td>
</tr>
<tr>
<td>- IV medications and IV fluids</td>
<td>- A trial of select treatment, if desired, e.g., non-invasive positive airway pressure</td>
<td>- Medications by mouth</td>
</tr>
<tr>
<td>- Long-term tube feedings</td>
<td>- IV medications and IV fluids</td>
<td>- Food and fluids by mouth, if able</td>
</tr>
<tr>
<td>- CPR, intubation, and/or ventilator</td>
<td>- Short-term tube feedings</td>
<td></td>
</tr>
<tr>
<td>Does NOT include:</td>
<td>Does NOT include:</td>
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</tr>
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</table>

7. Summarize and validate their decision

“Just so I understand you correctly, if [name of individual] becomes ill with COVID-19 and a treatment decision needs to be made, you would prefer [Full treatment, Selective Treatment, Comfort-Focused Care].”

“What else would you want us to know about what is important to you and [name of individual] at this time?”

“What questions do you have?”

Reaffirm: “I appreciate having this conversation with you today. It is a lot to take in all at once. I want to support you any way I can. These can be tough decisions to make and talk about especially in these uncertain times. Think of these conversations as a gift of love to [name of individual] making sure their goals and values are honored by the decisions you make.”
If relevant, i.e., when treatment options are full or selective treatment AND crisis standards of care are a real possibility, add, “In the current crisis, we can’t promise that resources will always be available to provide any and all interventions. However, we will always do our best to provide interventions that give reliable benefits, and we will always care for all individuals with compassion and dignity.”

8. Create a care plan that will honor the individual’s preferences and decisions
   a. For those who prefer not to be hospitalized, you must ensure medical plans of care are available and in place to provide aggressive symptom management in desired care location. Make arrangements/referrals as appropriate to ensure those resources are available in the desired care location.
   b. Modify physician orders and update/create POLST form, as appropriate.
   c. Document conversation and decisions in medical record.