**Introducing and Scheduling Proactive Care Planning for COVID-19**

*What matters most to you matters to us*

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**Note to User:** This guide is for use by team member to invite and schedule the healthcare agents or dedicated decision makers of individuals at greatest risk for complications from COVID-19, to have a proactive conversation about their preferences for care.

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.
   
   − 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.”

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 and where [name of individual] might receive care, such as staying at home, hospital, or care facility. By giving direction ahead of time, the doctors will know what matters most to [name of individual], and 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.” Proceed to #3: Make recommendations to continue the conversation.

   - **If no:** “We are here to help you have a conversation with the care team, so they know your answers to questions such as:

     − What is most important for [name of individual] to live 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 would [name of individual] want if they became very ill? For example, would they want their medical care to focus on living longer, maintaining current health, or comfort care?

     − Anything else you would want us to know about what is important to [name of individual] at this time?”
3. Make recommendations to continue the conversation

“Thank you for taking the time to talk with me today. Let’s talk about next steps. Can I schedule a time for you to talk with a clinician and continue the conversation, to make sure the care team is sure to know and honor [name of individual's] preferences for care?”

“What questions do you have? Thank you again for talking with me today.”

**Note to User:** Make an appointment (telephonic, telemedicine, video conference, or in-person, as appropriate) to talk with a clinician (e.g., Facilitator, nurse, social worker, chaplain, physician, advanced practitioner) to continue the conversation.