It was the best of times, it was the worst of times....
By: Sandy Severson, Vice President of Care Improvement

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair ..., we had nothing before us, we were all going direct to Heaven, we were all going direct the other way ...”
Charles Dickens

Charles Dickens wrote about a time of chaos, conflicts, and despair, as well as happiness. It in fact tells us about the time of extreme opposites without any in-betweens. While many of us cannot see any good in the COVID-19 pandemic, I’m an eternal optimist and can. I see good in the overwhelming sacrifice healthcare workers are making to help others. In the face of great adversity, suffering and despair. I see overwhelming acts of kindness, growth, and innovation. Despite the psychological trauma and moral distress, I see people stretching their minds, digging deep, and creating new models and resources that are desperately needed. In the chaos of financial demise, I am witnessing giants lose their self-righteousness, be humbled and begin to work together to find solutions to impossible situations.

No matter how positive I am, the reality of COVID-19 pandemic is harsh and is placing unprecedented demands on our entire healthcare system. Many feel ill prepared for the difficult conversations they must have. As a result of the pandemic a plethora of new resources have been developed to support healthcare providers in communicating effectively with their patients/residents. This newsletter is devoted to supporting you in having meaningful conversations with people who are at risk or have COVID-19 to ensure care aligns with their personal values.

Communication Resources When Caring for COVID-19 or Seriously Ill Patients.
These are new resources developed specifically for COVID conversations. All are free and easily accessible/downloadable:

- COVID Ready Communication Playbook: Tools developed by VITAL Talk to provide practical advice with examples on how to talk to people you may suspect have COVID, those who have COVID, and their loved ones.
- Serious Illness Care Program COVID-19 Response Toolkit: Conversation guides developed for outpatient and inpatient, as well as short video examples, and telehealth communication tips.
- CAPC COVID-19 Response Resources: Includes communication scripts and conversation videos, symptom management protocols, patient, and family support resources and more.
- National POLST COVID-19 Resources: Guide for completing POLST forms in crisis

- National Hospice and Palliative Care Organization COVID-19 Shared Decision-Making Tool
- Respecting Choices COVID-19 Resources: Resources to help you have conversations about treatment preferences before a crisis, tools to support specific treatment decisions in high risk individuals, and resources for high risk individuals and their loved ones.
- The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19): This JAMA article provides a framework for informed assent in situations of medical futility.

**Advance Care Planning Resources**

The following advance care planning documents have all been revised to be person and family centered.

- Arizona Living Will and Healthcare Power of Attorney short forms: A short one-page living will followed by a one-page Healthcare Power of Attorney with Mental Health Authority option. This is a document that is understandable for all and still meets the legal requirements.
- Arizona Prepare for Your Care Healthcare Directives: Large print, 4th grade reading level advance care planning documents. Includes the Prehospital Medical Care Directive and POLST directions.
- Arizona Attorney General Healthcare Directives: Newly revised documents including POLST.
- Arizona POLST Form: Arizona POLST is aligned with National POLST using their standardized form.

**Arizona POLST In Action**

Arizona POLST is part of the National POLST Program that helps patients get the medical treatments they want, and avoid medical treatments they do not want, when they are seriously ill or frail. It’s about helping people live the way they want until they die. POLST is only for the seriously ill and frail and is different than an advance directive because it is a portable medical order completed by a healthcare provider after a goals of care conversation and shared decision making about current treatment preferences. POLST exists because other advance care planning documents (advance directives and DNR forms) do not meet the needs of all seriously ill and frail individuals. Visit the AzPOLST website to learn more about POLST and review educational modules available.

**National Healthcare Decision Day**

National Healthcare Decision Day (NHDD), April 16th, is a day set aside every year, to *inspire, educate and empower the public and healthcare providers about the importance of advance care planning.*

In a 2018 statewide survey 60% of Arizonans shared they have not completed their healthcare directives. Reasons for not completing them was because they have not gotten around to it (41%), haven’t thought about it (22%) and lastly, because they are still healthy (20%). This may be the perfect time to reach out to loved ones who are socially isolated and begin these important conversations.

Now is the time for healthcare providers to step up their efforts to engage patients in thoughtful conversations about planning for the future. As our health systems prepare for (or are now dealing with) waves of COVID-19 patients, clinicians at all levels of care can do their part by adding these
items to their check list:

- Engage seniors and medically frail patients and their loved ones in conversations about medical treatments if they are or become seriously ill.
- Encourage patients or their surrogates to express their wishes and complete appropriate documents. Those who are relatively healthy should complete a living will and healthcare power of attorney. Those with chronic or serious illness may consider working with their healthcare provider to discuss and complete a POLST.
- If advance care planning documents are already in place, conduct a review to be sure that the information is still valid and up to date.

In the News
The Coalition to Transform Advanced Care (C-TAC) has shared new policy recommendations with Congressional leadership as they continue to craft legislation in response to the COVID-19 pandemic. The suggested policy changes cover a variety of areas affecting those on the front lines of this crisis, including advance care planning and expanding the workforce caring for those with serious illness during this difficult time. Recommendations included the following:

- Waive patient cost-sharing and deductibles for Medicare Advance Care Planning services
- Include clinical social workers and registered nurses in the definition of eligible practitioners who can bill for Medicare Advance Care Planning services
- Ensure that advance care planning documents executed validly in one state are honored in other states
- Include palliative care as an eligible primary care service under the National Health Service Corps program, which would officially recognize palliative care as a subspecialty of public health services

Have questions, want to know how we can help? Contact us today!