Advance Care Planning Recommendations During COVID-19

Patricia Bomba, MD, MACP, FRCP
MOLST & eMOLST Program Director
Member, MSSNY Bioethics Committee and Task Force on End-of-life Care

Everyone 18 years of age and older should have an up-to-date health care proxy (HCP).
Encourage a family discussion for all patients considering COVID-19. Lead by example. Start with your own family conversation. Be sure your HCP is up-to-date.

Identify these patient groups:

- All patients who have a HCP. Be sure the HCP is up to date, properly completed & contact information for the health care agent (HCA) and alternate HCA is available.
- All patients who do not have a HCP. Encourage them to choose the right HCA & alternate HCA, have a conversation and complete a HCP. Ask the patient to share a copy with the physician for the medical record.
- All individuals with I/DD who do not have a health care proxy but retain the capacity to choose a HCA. Completion of a HCP must include capacity determination. This is especially important for those who lack capacity to make end-of-life decisions.

"Social distancing" has brought some nuclear families together and separated others. Through the power of technology, these important advance care planning conversations can occur through phone and videoconferencing during this crisis. Two witnesses to the signature are required. The HIPAA security rules have been waived during this time. If video conferencing is unavailable, have two witnesses to verbal consent and document in your medical record, as you would for someone unable to sign but is able to provide an oral advance directive. In this case, the oral advance directive is the appointment of a health care agent. Case law allows for "clear and convincing evidence" of an oral advance directive. Learn more on documenting witnesses for health care proxies during social distancing on Special Considerations: COVID-19 on CompassionAndSupport.org.

Provide the tools to help your patients. CompassionAndSupport.org aims to engage, educate and empower all individuals 18 & older on the value of ACP discussions & completion of a health care proxy. Follow the Five Easy Steps outlined in the Community Conversations on Compassionate Care. There are multiple Advance Care Planning pages, for example Choose the Right Health Care Agent, including several special considerations, such as a page on Special Considerations in the I/DD population with FAQs and Can't Find a Health Care Agent, as well as videos for your patients to watch.

Focus on patients who are appropriate for MOLST.
For individuals who reside in nursing homes, assisted living and others appropriate for MOLST in the community who have existing an DOH MOLST/eMOLST forms, it is time to review and renew the medical orders considering COVID-19. For those who do not have a DOH MOLST/eMOLST, screen and identify patients who are appropriate for MOLST and offer MOLST. These include:

1. Patients whose physician, NP, or PA* would not be surprised if they die in the next year or two
2. Patients who live in a nursing home or receive long-term care services at home or assisted living
3. Patients who want to avoid or receive any or all life-sustaining treatment **today**
4. Patients who have one or more advanced chronic conditions or a new diagnosis with a poor prognosis

5. Patients who have had two or more unplanned hospital admissions in the last 12 months coupled with increasing frailty, decreasing functionality, progressive weight loss or lack of social support

Preparing for a well-informed shared decision-making process for MOLST.

The physician, NP or PA* should have a thoughtful MOLST discussion with the appropriate decision maker (patient, health care agent or surrogate), using the 8-Step MOLST Protocol, bearing in mind the patient's current health status, prognosis, goals for care and COVID-19. A care plan that includes palliation and supportive care is necessary for those patients who choose to remain and be treated in place.

To prepare for the MOLST discussion, the physician, NP or PA* and the identified medical decision-maker should review the MOLST Form and the specific web pages that identify the medical orders included on the MOLST. Special attention should be paid to resuscitation preferences, respiratory support and future hospitalization/transfer. For patients with chronic renal insufficiency, discussion should also focus on dialysis. Similarly, for those with dementia, neurodegenerative disorders, etc., discussion should include feeding tubes. The PEG Tube Guidelines were reviewed and updated by a workgroup and approved by the *Monroe County Medical Society Quality Collaborative* in March 2020. Several tools are available, including the Benefits and Burdens, Legal and Ethical Issues.

If an individual lacks capacity, does not have a properly completed HCP, and lacks capacity to choose a HCA, MOLST cannot be signed until the §SCPA 1750-b process is completed, as outlined on the OPWDD Checklist. Only a physician, not an NP or PA, can sign a MOLST under 1750-b.

Barriers to MOLST discussions are removed during the crisis.

In working with physicians over the past several weeks, it has helped to discuss process and solutions to potential barriers:

- ACP CPT codes 99497 (first 30 mins) and 99498 (each additional 30 mins) can be billed in all settings, including inpatient. The codes can also be billed in conjunction with E&M, TCM & CCM codes, among others. All Medicare & Medicaid carriers must cover them. Check with private carriers for additional coverage details.
- HIPAA-mandated security requirements for telemedicine have been lifted. CMS guidance on Telehealth, March 20, 2020.
- Many carriers are improving reimbursement for phone calls and telemedicine visits.

Physicians are requesting and gaining urgent access to eMOLST.

With the growing use of telemedicine, interest in eMOLST has exploded. Learn more about the value, added benefits and how to get urgent access to eMOLST at eMOLST: Urgent Access. Physicians have found eMOLST is the easiest way to review and renew MOLST.

The NYSeMOLSTregistry.com is an electronic database centrally housing eMOLST forms & documentation of the discussion to allow 24/7 access in an emergency. eMOLST allows for accurate electronic completion of the current DOH-5003 MOLST form. By moving the MOLST form to a readily accessible electronic format and creating the NY eMOLST Registry, health care providers have access to eMOLST forms at all sites of care including hospitals, nursing homes and in the community.

eMOLST is strongly encouraged and available for all patients, including individuals with I/DD. eMOLST follows a standardized process and integrates the DOH Checklists and OPWDD Checklist. When the physician, NP or PA (as of June 17, 2020) signs eMOLST, it is immediately part of the eMOLST Registry.

Resources

MOLST.org is focused on patients who are appropriate for MOLST - patients with advanced illness and/or advanced frailty.

- Additional COVID-19 Guidance is provided on how to complete a MOLST, including effective communication skills considering COVID-19.
- Special requirements exist for completion of MOLST for individuals with I/DD who lack capacity. How to completer MOLST and meet the requirements during the crisis is outlined on OPWDD: Individuals with I/DD in the COVID-19 section. The OPWDD Checklist is available here as a fillable PDF.
- Ethics & The Law (includes links to 2015 DOH/NYS Task Ventilator Guidelines)
- MOLST Process: Thoughtful MOLST Discussion Ethical & Legal Requirements I/DD
- MOLST Form: Resuscitation, Respiratory Support, Hospitalization, Feeding Tube Guidelines, Dialysis
- Federal & State Guidance
- Additional information on Palliative Care & Hospice, Pain Management, Pain Guidelines, Death & Dying

*The authority and accountability for a physician assistant to complete a MOLST is effective June 17, 2020, unless an Executive Order modifies the date.