

as a few probable solutions to help prevent social isolation and its related complications in older people.

Therefore, we consider interaction with the youth as an excellent way to keep older adults happy and connected through telephone and videoconferencing while also informing them about the need to stay home during the COVID-19 crisis. The youth can teach older adults about using digital platforms (e.g., a smart phone or a computer), which can be a helpful way to keep them engaged.

This process would not only reinforce intergenerational solidarity, but would also promote lifelong learning for older adults, which is an sustainable development goal 4 goal; it would prevent social isolation in the older adults and the youth would be enriched through social connection and knowledge sharing with older friends.

This model of a virtual relationship could be extended to face-to-face teaching for youth once the COVID-19 crisis is over. The authors have already tried this through the Non Governmental Organization Healthy Aging India, which is implementing an intergenerational learning model in multiple states of India. Retired older adults are teaching underprivileged schoolchildren in government schools in their area, and they are showing substantial improvements in mood and cognitive ability. Additionally, the schoolchildren are showing improvements in academic and life skill performance; these findings are supported by many studies globally.<sup>8,9</sup>

Therefore, the authors suggest that, while confined at home, people of both generations should pick up their telephones and connect with each other, regardless of whether they are across the country or across the globe.

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## REFERENCES

- Cheung JT, Yu R, Wu Z, Wong SY, Woo J. Geriatric syndromes, multimorbidity, and disability overlap and increase healthcare use among older Chinese. *BMC Geriatr*. 2018;18(1):147.
- Zhou F, Yu T, Du R, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *Lancet*. 2020;395:1054-1062.
- Huang Y, Zhao N. Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 epidemic in China: a web-based cross-sectional survey. *medRxiv*. 2020;288:112954.
- Armitage R, Nellums LB. COVID-19 and the consequences of isolating the elderly. *Lancet Public Health*. 2020;5(5):e256.
- Jones S. Spanish Minister Says Older People Found "Dead and Abandoned." <https://www.theguardian.com/world/2020/mar/23/spain-distributes-650000-testing-kits-as-coronavirus-deaths-rise-steeply>. Published March 23, 2020. Accessed April 28, 2020.
- Shoukat S. Cell phone addiction and psychological and physiological health in adolescents. *EXCLI J*. 2019;18:47.
- Gualano MR, Voglino G, Bert F, Thomas R, Camussi E, Siliquini R. The impact of intergenerational programs on children and older adults: a review. *Int Psychogeriatr*. 2018;30(4):451-468.
- Newman S, Hatton-Yeo A. Intergenerational learning and the contributions of older people. *Ageing Horiz*. 2008;8(10):31-39.
- Ghosal A. Intergenerational Learning Centre: An AIIMS Idea Brings Young, Old Together in Capital's Classrooms. <https://indianexpress.com/article/cities/delhi/intergenerational-learning-centre-an-aiims-idea-brings-young-old-together-in-capitals-classrooms-5157825/>. Published May 1, 2018. Accessed April 28, 2020.

## During COVID-19, Outpatient Advance Care Planning Is Imperative: We Need All Hands on Deck

*To the Editor:* A woman with a history of obesity, diabetes, cardiovascular disease, and end-stage renal disease was admitted to an overburdened New York hospital with respiratory distress due to coronavirus disease 2019 (COVID-19). At the time of admission, she was unable to speak for herself, and given restrictions on visitation, it took much effort to find her daughter who did not know the patient's medical wishes. Before COVID-19, the daughter had accompanied her wheelchair-bound mother to all of her appointments including visits with an endocrinologist, cardiologist, primary care doctor, and physical therapist in the preceding 3 months, as well as dialysis appointments three times a week. However, advance care planning (ACP) had never been discussed.

The COVID-19 pandemic has clinicians, health systems, and governments working on multiple fronts to keep people from getting sick and care for those who fall ill. Accordingly, much attention has been given to increasing hospital capacity, ramping up testing, and developing therapeutics or a vaccine. Alongside these efforts, we see an urgent need to prepare older adults and other at-risk populations for the possibility of severe illness through a massive upscaling of ACP in the outpatient and nursing home setting. To do this will require a concerted effort by all clinicians and allied health professionals.

The process of ACP, which involves selecting a surrogate decision maker, documenting wishes, and having conversations about what is important in one's life,<sup>1</sup> —is our best mechanism for aligning treatment with patients' goals. Although planning before possible decisional incapacity is always important, the strict visitor restrictions implemented to reduce in-hospital spread of COVID-19 compound the urgency for ACP. With nobody at the bedside to speak on their behalf, incapacitated

COVID-19 patients risk receiving goal-discordant care as overstretched clinicians are forced to act quickly.<sup>2</sup>

Our recent research shows that most older adults at risk for morbidity and mortality due to COVID-19 have not planned adequately before admission to an intensive care unit (ICU).<sup>3</sup> For patients, the legal language used in most advance directives (ADs) and state-to-state variation in legal requirements, such as the need for witnesses or a notary, are all barriers to ACP, particularly in marginalized populations.<sup>4</sup> Current physical distancing recommendations have only made the ramifications of these legal requirements more challenging. For healthcare professionals, many remain uncomfortable discussing ACP or feel that ACP is someone else's job.<sup>5</sup>

These barriers must be addressed to permit national upscaling of ACP immediately. The surge of COVID-19 is upon us, with hospitalized older adults bearing the brunt of the morbidity and mortality and growing severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission in nursing homes. Clinicians working in acute care settings are desperate for information about how to best care for the patients in front of them. For example, one of us recently admitted a nearly 100-year-old patient with dementia to the ICU with presumed COVID-19 and had to resort to a midnight call via a telephone interpreter to discuss intubation with a family that was ill prepared to participate in decision making. This should be a never event. We must identify such at-risk persons and help them and their families plan ahead. Doing so will help mitigate the cumulative moral distress to families and to our workforce that comes with inadequate ACP.

With nonessential outpatient visits and procedures canceled, many clinicians and allied health professionals have been wondering how to help those on the frontlines. Engaging outpatients in ACP is one important way. We detail here how to conduct an efficient high-yield ACP conversation and suggest mechanisms for clinics, health systems, and governments to foster ACP.

**Proposal 1:** We need *all* clinicians (eg, nurses, physicians, pharmacists, etc) and allied health professionals (eg, dietitians, physical and occupational therapists, etc), regardless of specialty and discipline, to help outpatients engage in ACP. This includes those working in nonacute settings (eg, clinics, nursing homes, and dialysis centers). These conversations can take place during any scheduled visit, whether in person, by phone, or by video. Targeting initial ACP efforts toward older adults and other persons at highest risk for severe COVID-19 is a reasonable approach. However, we believe all persons should be asked at least to identify a surrogate decision maker because the risk for morbidity and mortality from COVID-19 is universal.

**Proposal 2:** Clinicians can use a simple three-step approach to begin ACP (Table 1). This includes (1) asking patients to select a surrogate decision maker, (2) encouraging them to talk to their surrogate about what matters most and record their wishes in an AD, and (3) documenting patient's wishes in the medical record. Documentation is crucial given

that current physical distancing efforts may impede access to and completion of ADs. Importantly, clinicians must follow local documentation practices to ensure the ACP information is readily retrievable by others, not buried in progress notes.

Some people will have very clear wishes about specific medical treatments, such as whether or not they would want cardiopulmonary resuscitation. Most, however, will not. The point of beginning ACP conversations in the outpatient setting is not to force premature decisions about possible therapies but rather for patients to identify a surrogate and articulate their values that others can later apply to in-the-moment decisions.<sup>6</sup> Patients may have additional questions about COVID-19, their prognosis, or health system capacity. Health professionals engaging in these upstream ACP conversations can refer patients to their primary care physician or respond to questions using COVID-19 communication resources (Table 2).

**Proposal 3:** Health systems should leverage messaging capabilities, such as patient portals, automated calls, or text messages to disseminate ACP materials and prime patients for ongoing ACP discussions. Health navigators may help reach older adults and other vulnerable populations with less access to digital communication. Messaging campaigns should point patients toward freely available ACP tools for facilitating conversations about goals and completing state-specific AD.<sup>7</sup> Electronic health record triggers may also help lower the activation energy for initiating ACP by prompting clinicians to discuss ACP with appropriate patients. If able, health systems should allow patients to upload completed AD to the electronic health record.

**Proposal 4:** Hospitals and states should consider temporarily pausing legal requirements for AD completion that run counter to physical distancing. This may include waiving the need for witnesses and/or a notary, or allowing oral directives to be documented in the outpatient setting. Furthermore, in cases where patients have clear wishes, we should permit clinicians to complete a physician's order for life-sustaining treatment (POLST) during a phone or video visit.

COVID-19 has upended life worldwide, throwing health systems into crisis and overburdening the healthcare workforce. Soberingly, the worst may be yet to come, and even in cities where the curve has flattened, COVID-19 will be a menace for many months if not years. Governments and health systems have moved mountains to increase capacity, streamline systems of care, and promote physical distancing. Further efforts must include a broad nationwide push to engage outpatients in ACP now, before a medical crisis, particularly for older adults and others at high risk of a poor outcome of COVID-19. The work of scaling ACP will not be easy, but it is of utmost importance. We need all hands on deck.

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**Table 1. Approaches to Simple, Efficient Advance Care Planning for All Health Professions**

Step	Action to take	Sample phrasings
1	Ask about a surrogate decision maker	<p>“I wanted to take a moment to talk to you about advance care planning. This involves choosing an emergency contact and describing what is most important in your life.”</p> <p>“Is there someone you would trust to help make medical decisions for you if there ever came a time you could not speak for yourself?”</p> <p><i>If yes:</i> “That’s great. Now is a good time to tell or remind them that you chose them for this role and what is important to you. That way they can be the best advocate for you if needed.”</p> <p><i>If no:</i> “It is OK if you cannot think of someone right now. If someone comes to mind in the future, please let your medical providers know.”</p>
2	Ask about an advance directive	<p>“Have you ever completed an advance directive? This is a legal form that lets you name your medical decision maker and describe your wishes for medical care.” Did your doctor ever fill out a POLST form, a physician’s orders about your wishes?”</p> <p><i>If yes:</i> “That’s great. Do you remember what you wrote down? Do you still feel the same way? Do you know where this form is?”</p> <p>“The most important part is to now share the information in this form with your family and friends. Remember to bring the form with you if you need medical care.”</p> <p><i>If no:</i> “This is OK. One place you can start is the website <a href="http://PREPAREforYourCare.org">PREPAREforYourCare.org</a> [<i>one example, use local preference</i>] that has simple information and advance directive forms for free. You can fill the form out on your computer, phone, or tablet, or download and print.”</p> <p><i>[Optional due to physical distancing]:</i></p> <p>“The forms sometimes need extra witnessing or a notary to be legal. For now, it is OK to review it and sign and date it. The most important part is that you discuss it with your family and friends and medical providers.”</p>
3	Document patient’s wishes	Learn and use your hospital’s standard documenting practices so that advance care planning information can be quickly found by frontline providers when needed.

**Table 2. Additional Resources for Exploring Patients’ Goals and Values in the Setting of COVID-19**

- <https://www.capc.org/toolkits/covid-19-response-resources>
- <https://www.vitaltalk.org/guides/covid-19-communication-skills>
- <https://respectingchoices.org/covid-19-resources>
- <https://www.ariadnelabs.org/coronavirus>

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**REFERENCES**

- Sudore RL, Lum HD, You JJ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary Delphi panel. *J Pain Symptom Manage.* 2017;53(5):821-832.e1.
- Curtis JR, Kross EK, Stapleton RD. The importance of addressing advance care planning and decisions about do-not-resuscitate orders during novel coronavirus 2019 (COVID-19). *JAMA.* 2020;323(18):1771-1772. <https://doi.org/10.1001/jama.2020.4894>
- Block BL, Jeon SY, Sudore RL, Matthay MA, Boscardin WJ, Smith AK. Patterns and trends in advance care planning among older adults who received intensive care at the end of life. *JAMA Intern Med.* 2020;180(5):786-789. <https://doi.org/10.1001/jamainternmed.2019.7535>
- Castillo LS, Williams BA, Hooper SM, Sabatino CP, Weithorn LA, Sudore RL. Lost in translation: the unintended consequences of advance directive law on clinical care. *Ann Intern Med.* 2011;154(2):121-128.
- O’Hare AM, Szarka J, McFarland LV, et al. Provider perspectives on advance care planning for patients with kidney disease: whose job is it anyway? *Clin J Am Soc Nephrol.* 2016;11(5):855-866.
- Sudore RL, Fried TR. Redefining the “planning” in advance care planning: preparing for end-of-life decision making. *Ann Intern Med.* 2010;153(4):256-261.
- Sudore RL, Schillinger D, Katen MT, et al. Engaging diverse English- and Spanish-speaking older adults in advance care planning: the PREPARE randomized clinical trial. *JAMA Intern Med.* 2018;178(12):1616-1625.