WELCOME

All Names in Chat	Please type the name(s) of everyone at your facility in the attendance in the chat. • This helps us know and track your facilities attendance for payment
Mute	Please remember to mute your audio when you're not speaking.
Cameras	As part of participation in this ECHO session, we ask that you have your cameras turned on in order to build a more engaging community of practice.

1

ECHO COVID ACTION NETWORK Session 10

ADVANCE CARE PLANNING AND COVID-19 IN NURSING HOMES

2

Poll

3

Learning Objectives

- Describe end-of-life care in face of COVID-19
- Discuss special circumstances related to advance care planning
- Identify tools for advance care planning
- Know how to determine decisional making capacity

4

Side bar: how long does previous COVID infection protect you from re – infection ?

- Study of 20,000 health care workers, 84 % women
- Average time between 1st and 2nd infection was 160 days
- Note: only 34% of 2nd infections were symptomatic
- Conclude: 86% protection from re-infection for up to 6 months.

BMJ 2021: 372:n124

5

Preparation for Advance Care Planning

- Recognize that advance care planning can be uncomfortable and stressful for the nursing home resident, family and health care professionals
- Often, residents and families either over-estimate remaining life expectancy or they are unaware of how long a NH resident is likely to live.

6

COVID and ADVANCE CARE PLANNING

- COVID-19 complications can be sudden or progressive
- Of those who die, 33% have a sudden course
- Need to pro-actively assess remaining life expectancy (e.g., use University of California at San Francisco www.eprognosis.org)
- Up to 20 % mortality of 80 + year olds with COVID-19

7

Importance of aligning treatment options with patient preferences

- Preferences often change
  - Hopkins study found 90% of conscious older adults in the emergency room changed their advance care directives
- Know when comfort care is the only realistic option

8

A framework for thinking about Care Goals

9

Odds of surviving CPR decrease with age

AGE	SURVIVAL AFTER CPR IN HOSPITALS
70 – 79 years old	19 percent
80 – 89 years old	15 percent
90 + years old	12 percent

bit.ly/1fUyOhD Age and Ageing

10

Odds of surviving critical care with COVID infections

Age	Discharged alive (%)	Deceased (%)
16 – 49	76.4	23.6
50 – 69	54.2	45.8
70 +	32.9	68.1

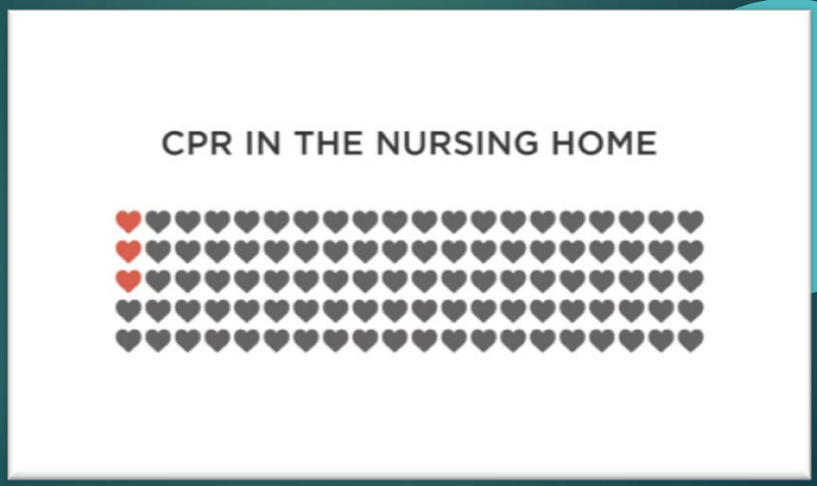
11

Medical orders reflect CPR preferences

- Full Code = attempt resuscitation
- DNR = do not resuscitate

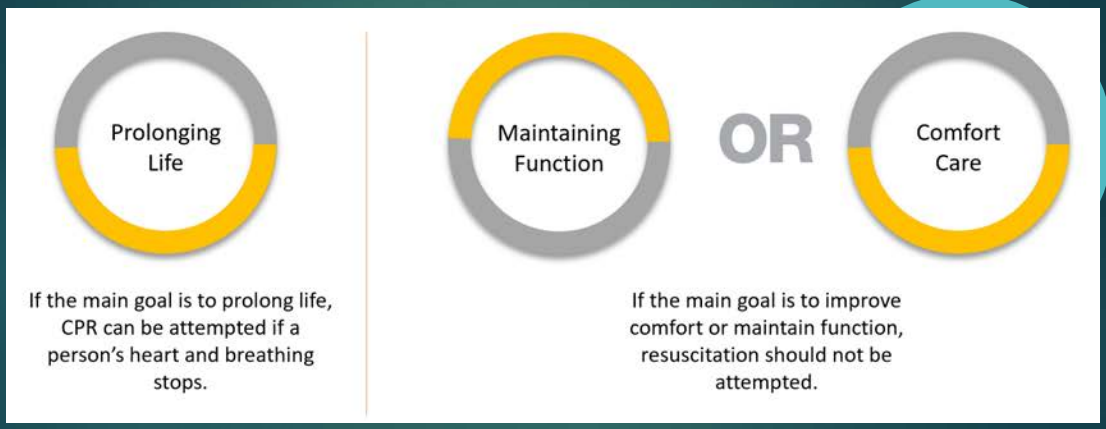
12

CPR in nursing homes has 3% survival



13

Cardiopulmonary Resuscitation and Goals of Care

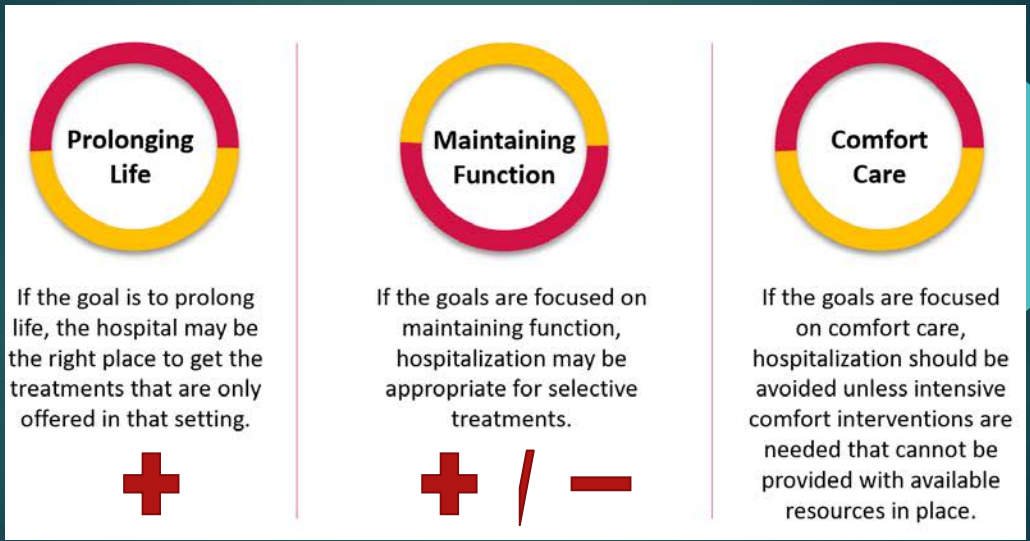


14

What about Do Not Hospitalize requests ?

15

Hospitalization & Goals of Care

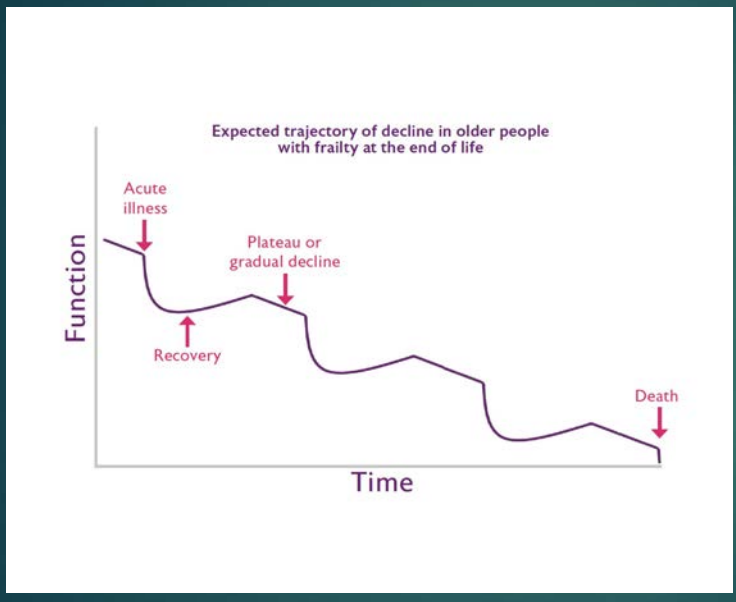


16

If the goal is comfort care, then hospitalization should be avoided

- Treat resident in a COVID unit at the facility, including monoclonal antibody cocktail intravenously
- Share treatment plan with resident and family

17



If the goal of hospitalization is to prolong life then know

1. the chances of accomplishing this goal and
2. how many months or years of active life expectancy are to be gained.

18

Documentation

- Easy access of staff to resident's goals of care and treatment preferences
- It may seem obvious, but if transferring out of facility, the Advance Care Planning documents need to accompany the resident

19

Important

- Include name and phone number of resident's proxy or health care representative

20

Advance Care Planning Documentation Tools

There are two kinds of advance care planning documentation tools:

Advance Directives

Legal documents that provide information about the resident's preferences and who is authorized to make decisions if the resident loses capacity.

- Living will (end-of-life treatment preferences)
- Health care proxy/legal representative/POA

Medical Orders

Orders reflecting current treatment preferences that are in effect/active right now.

- Resuscitation
- Hospitalization
- Intubation
- POST (Physician Orders for Scope of Treatment)

21

What Matters

- Establish clear priorities
- Reduce care burden
- Better integrate care

Health Outcome Goals
(What patient wants)

Health Care Preferences
(What patients can do)

22

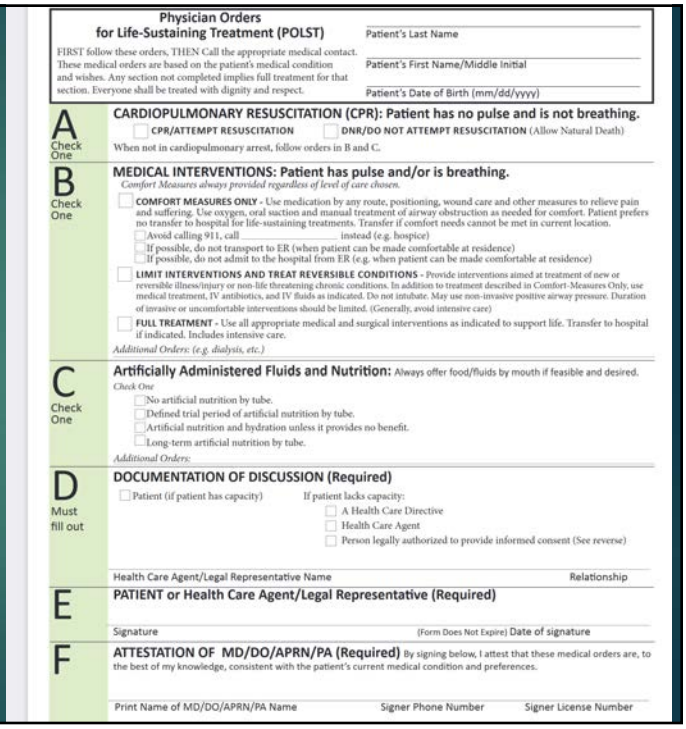
Differences Between **POLST and Advance Directive**

Characteristics	POLST	Advance Directive
Population	Seriously Ill	All Adults
Timeframe	Current and Future Care	Future Care
Form Can Completed By:	Physician / Healthcare Professionals	Patients
Healthcare Agent / Surrogate	Authorized to discuss options if patient lacks capacity.	Cannot complete form.
Transfer/Portability	Provider responsibility	Patient/Family Responsibility
Periodic Review	Provider responsibility	Patient/Family Responsibility

23

POLST

1. Maintain a registry of residents with and without POLST
2. PIP suggestion: train staff in ACP conversations and determine if change in POLST or Percent of documented POLST



Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth (mm/dd/yyyy)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.**

☐ CPR/ATTEMPT RESUSCITATION ☐ DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B Check One — **MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.**

Comfort Measures always provided regardless of level of care chosen.

☐ **COMFORT MEASURES ONLY** - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

☐ Avoid calling 911, call _____ instead (e.g. hospice)

☐ If possible, do not transport to ER (when patient can be made comfortable at residence)

☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS** - Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care)

☐ **FULL TREATMENT** - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C Check One — **Artificially Administered Fluids and Nutrition:** Always offer food/fluids by mouth if feasible and desired.

Check One

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Artificial nutrition and hydration unless it provides no benefit.

☐ Long-term artificial nutrition by tube.

Additional Orders:

D Must fill out — **DOCUMENTATION OF DISCUSSION (Required)**

☐ Patient (if patient has capacity)

If patient lacks capacity:

☐ A Health Care Directive

☐ Health Care Agent

☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name — Relationship

E — **PATIENT or Health Care Agent/Legal Representative (Required)**

Signature — (Form Does Not Expire) Date of signature

F — **ATTESTATION OF MD/DO/APRN/PA (Required)** By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Name of MD/DO/APRN/PA Name — Signer Phone Number — Signer License Number

24

What can we say to residents and families?

"You know this virus is going around. Have you thought about what it means for you?"

"What goal of care is most important to you now?"

"Not many older people who are sick enough to need a ventilator to breathe will survive. If you get a bad case, would you want to go to the hospital and potentially be treated in an ICU on a ventilator?"

"We will do our best to honor your preferences."

25

Does the resident have decisional capacity ?

26

High rates of capacity impairment found in long term care

- 44 – 69 % of residents

27

What influences medical treatment decisions ?

Table 2.7 Valued Activities and Abilities

Item	N	Influence A lot (%)	Influence A little (%)	Influence Not at all (%)
My level of physical pain at the moment	95	45.3	27.4	27.4
The level of physical pain involved in the treatment	94	37.2	40.4	22.3
My quality of life at the time	96	62.5	22.9	14.6
Ability to enjoy simply pleasures (read, tv, radio) at the time	97	52.6	22.7	24.7
A desire to live as long as possible	95	47.4	22.1	30.5
The extent to which I would depend on others for personal care	96	58.3	26.0	15.6
Who (family members or professionals) provides personal care	95	58.9	28.4	12.6
The financial impact on my family	94	59.6	16.0	24.5
The emotional impact on my family	91	70.3	19.8	9.9
My feelings and beliefs (e.g., fears) about dying	95	35.8	23.2	41.1
My religious beliefs about the situation	95	34.7	17.9	47.4
Ability to still communicate with others	96	77.1	12.5	10.4
Ability to still make decisions for myself	97	80.4	11.3	8.2

28


Decision Making Abilities
Understanding
Appreciation
Reasoning
Communicating a Choice

29


Summary

30

SUMMARY

- Advance Care Planning is an on – going process
- Training staff in ACP can facilitate 100 % compliance
- Define WHAT MATTERS to the resident
- Educate resident and family about remaining life expectancy

31

Summary

- Use observation and tools to determine Decisional Capacity
- Define health care goals in terms of life prolonging, maintenance of function or comfort care
- Create PIPs around What Matters to achieve Resident – Centered Care

32

RESOURCES

33

Tools for Decisional Capacity

- Assessment of Capacity to Consent to Treatment (ACCT)
- MacArthur Competence Assessment Tool (MAC CAT)

- These tests are lengthy and best left to social worker or psychologist.

34

Advance Care Planning During a Crisis for Nursing Homes Presentation

Advance Care Planning and COVID-19

CALMER Goals of Care Discussion Guide

35

Resources

- https://www.geripal.org/p/covid.html
- Respecting Choices COVID-19 Resources
- National POLST: Long-Term Care Facility Guidance for POLST and COVID-19•
- “What Matters” to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults•
- The Conversation Project and "Conversation Ready"•
- Go to the Hospital or Stay Here? A Nursing Home Guide: http://decisionguide.org

36