ECHO COVID 19 CONVERSATIONS SERIES

Advance Care Planning and COVID-19 in Nursing Homes

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Financial Disclosures

Dr. Unroe is the CEO of Probari (www.probarisystems.com) a healthcare start-up founded to improve care in nursing homes through implementing the evidence-based OPTIMISTIC clinical care model.

Learning Objectives

- Describe current evidence regarding COVID-19 and end-of-life care
- Discuss special considerations related to advance care planning and COVID-19
- Identify tools to support person-centered care during COVID-19

Preparation – Advance Care Planning

- Conversations about values, goals, and treatment preferences
- Talking about goals of care and treatment preferences is not always easy. It can be uncomfortable and stressful.
- Residents and families may need help identifying their goals.
  - They may be afraid because of what they see on the news, or not being able to see one another.
  - They may have loved ones with COVID-19.

COVID-19 and Advance Care Planning

- COVID-19 complications require urgent decision-making.
- Advance care planning conversations can prepare residents and families for these decisions.
- Proactively identifying and documenting resident/family preferences to avoid invasive life-prolonging treatment will help ensure treatments are provided only when aligned with resident wishes.

A framework for thinking about Goals of Care

Understanding which goal is most important to a resident and/or the family will help them make treatment decisions that reflect these goals.

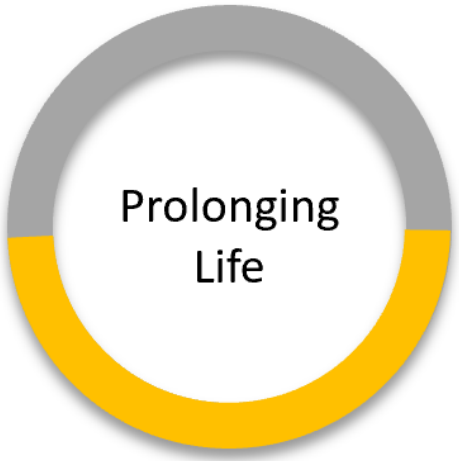
Cardiopulmonary Resuscitation (CPR)

- Involves firm chest compressions administered when a person's heart and breathing stop
- Goal is to restart cardiopulmonary functioning.
- Medical orders written to reflect CPR preferences include Full Code (attempt resuscitation) and DNR (do not resuscitate).

CPR – Key Information

- CPR survival rates are low in the nursing home, just 3 out of 100 residents (3%) will survive
- CPR survival rates are believed to be lower for residents with COVID-19
- Requires intubation and ventilator support
- Risks of CPR include:
  - brain damage
  - broken ribs
  - organ damage

Cardiopulmonary Resuscitation and Goals of Care



If the main goal is to prolong life, CPR can be attempted if a person's heart and breathing stops.

OR

If the main goal is to improve comfort or maintain function, resuscitation should not be attempted.

Resuscitation & COVID-19 Considerations

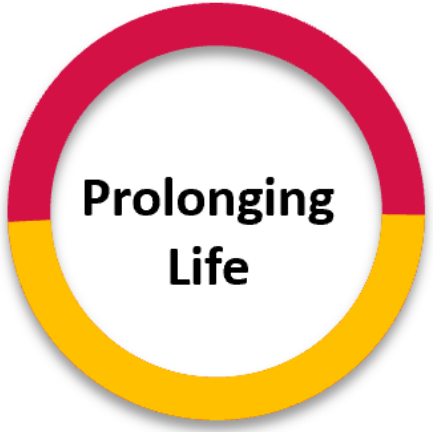
Attempt Resuscitation

- We should assure residents and families we will do all we can to honor their preferences.
- There may be other factors outside our control such as hospital capacity or ventilator supply that may limit options in some circumstances.

Hospitalization

Hospital care for evaluation, stabilization of medical conditions, or treatment intended to prolong life.

Hospitalizations & Goals of Care



If the goal is to prolong life, the hospital may be the right place to get the treatments that are only offered in that setting.

If the goals are focused on maintaining function, hospitalization may be appropriate for selective treatments.

If the goals are focused on comfort care, hospitalization should be avoided unless intensive comfort interventions are needed that cannot be provided with available resources in place.

Hospitalizations and COVID-19 Considerations

Goal = Comfort Care

- For residents who prefer comfort care, transfer should be avoided if at all possible.
- Residents with possible or confirmed COVID-19 may be moved in order to isolate them from other residents.
- Reassure residents and families that there is a plan to treat residents in place for symptoms including cough, shortness of breath, and fever.

Hospitalizations and COVID-19 Considerations

Goal = Maintaining Function

- Residents who transfer to the hospital for any reason may not be able to return quickly due to the risk of exposing other residents to the virus.

Goal = Prolonging Life

- We should assure residents and families we will do all we can to honor their preferences.
- There may be other factors outside our control such as hospital capacity or ventilator supply that may limit options in some circumstances.

Documentation

Documentation is important to help ensure the care team can access information about the resident's goals of care and treatment preferences.

If a resident transfers out and EMS or emergency department providers cannot find the resident's advance care planning documents, **the resident's preferences may not be honored.**

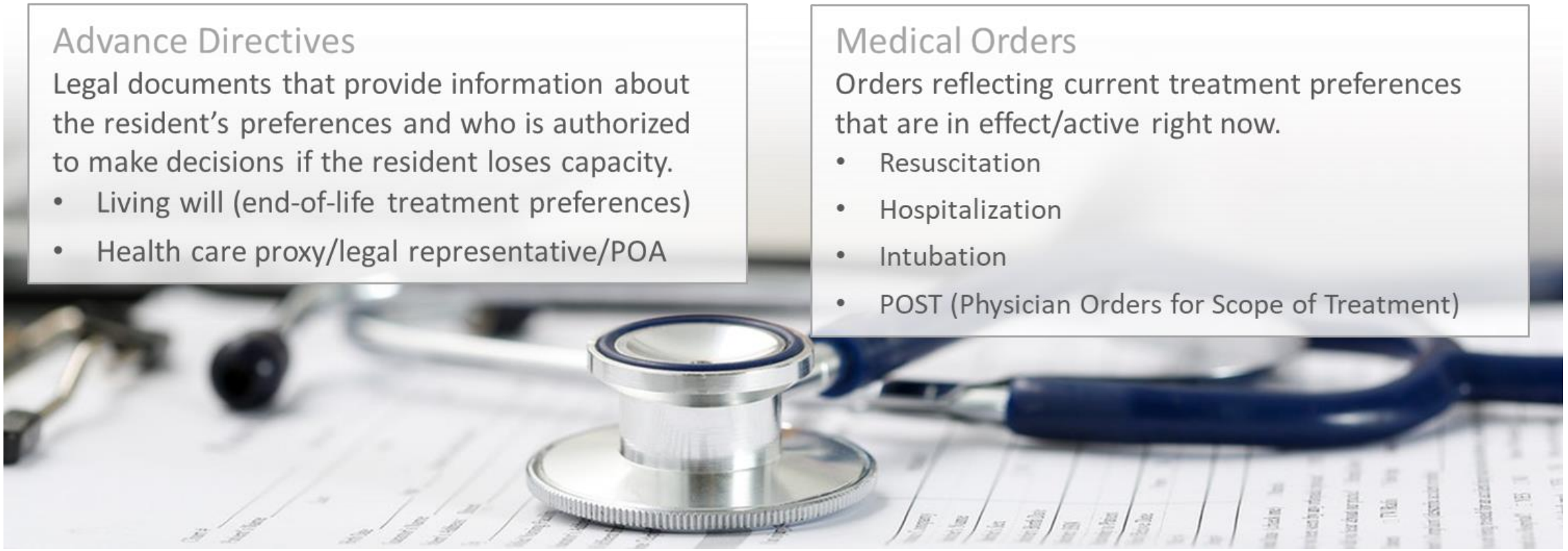
COVID-19 and Advance Care Planning Documents

It is important to send advance care planning documents **with** residents when transferring to another facility or the hospital

- Risk that resident preferences may not be known by other health care providers
- Important to document and communicate if a resident has a preference to avoid treatment (e.g. intubation, ventilation, or ICU care).
- Include the name and phone number of the resident's health care proxy/representative and family members.

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

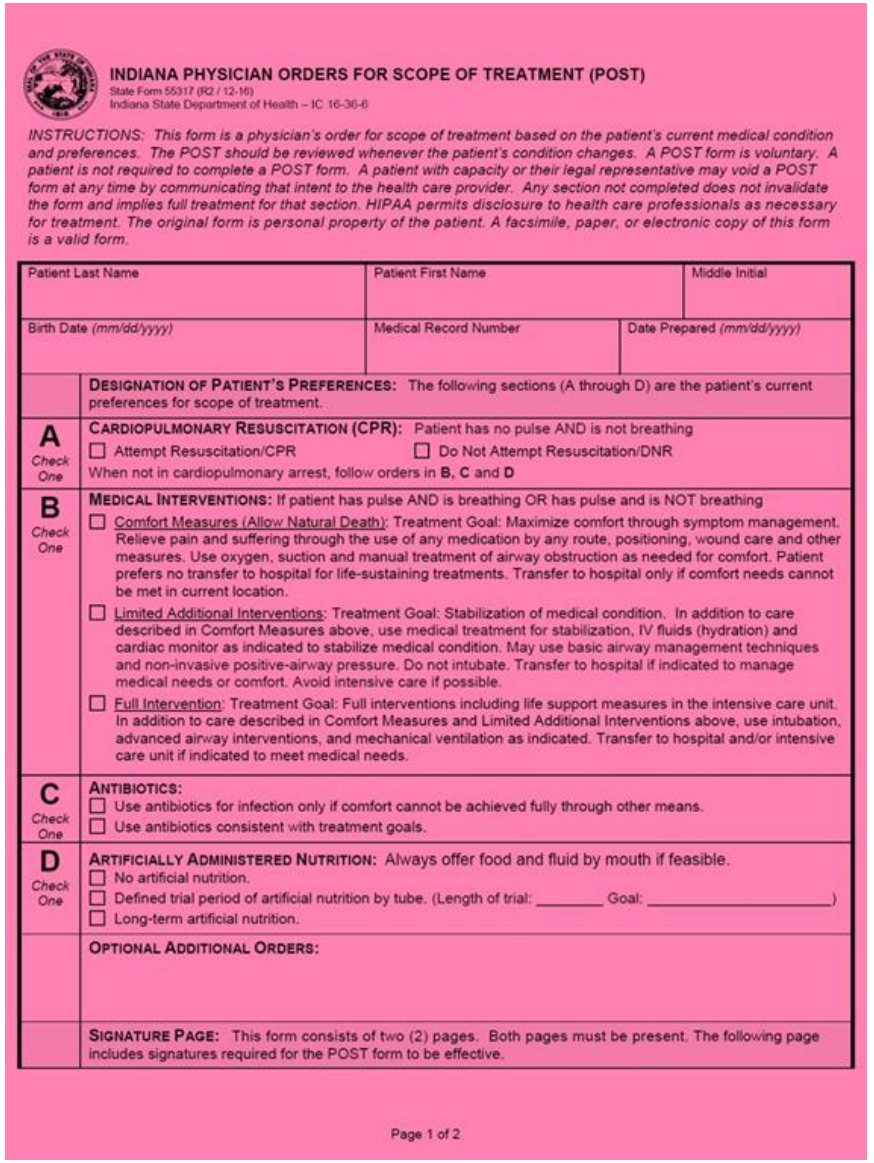
Orders reflecting current treatment preferences that are in effect/active right now.

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

The POST Program

POST is used to document treatment preferences as medical orders. Key features include:

- Records treatment preferences as actionable medical orders that EMS can follow
- Permits documentation of preferences to have or decline treatments
- Transfers across treatment settings with resident



INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)
State Form 55317 (R2 / 12-16)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial

Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*
CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing
☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR
When not in cardiopulmonary arrest, follow orders in **B, C** and **D**

B *Check One*
MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing
☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.
☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.
☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*
ANTIBIOTICS:
☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.
☐ Use antibiotics consistent with treatment goals.

D *Check One*
ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.
☐ No artificial nutrition.
☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)
☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Page 1 of 2

POST & COVID-19

- Educate staff to engage in ACP conversations and document
- Be proactive – approach POLST eligible residents at risk
- Maintain master list of patients who have POLST during COVID-19 to review once pandemic subsides
- If preferences change due to COVID-19, document on the form under "Optional additional orders"

Source: National POLST at www.polst.org

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."

CALMER Conversation Guide (adapted)

VITAL talk

Check in	Take a deep breath (yourself!). "How are you doing with all this?" (Take their emotional temperature.)
Ask about COVID	"What have you been thinking about COVID and your situation?" (e.g., living in a nursing home, your Mom living in a nursing home)(Just listen)
Lay out issues	"Here is something I want us to be prepared for." "You mentioned COVID. I agree." "Is there anything you want us to know if you/your loved one got COVID OR if your/your loved one's COVID gets really bad?"
Motivate them to choose a proxy and talk about goals of care	"If things took a turn for the worse, what you say now can help your family / loved ones" "Who is your backup person–who helps us make decisions if you can't speak? Who else? (having 2 backup people is best) "We're in an extraordinary situation. Given that, what matters to you? (About any part of your life? About your health care?) "What is your treatment goal? (explain goals of care: comfort care, maintaining function, prolonging life)
Expect emotion	Watch for this – acknowledge at any point "This can be hard to think about."
Record the discussion in the medical record.	Use POLST if available and appropriate. Any documentation – even brief — will help other health care providers and your resident. "I'll write what you said in the chart. It's really helpful, thank you."

Acknowledgements

Dr. Susan Hickman
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Resources

- Respecting Choices
  - www.respectingchoices.org
- Prepare for your Care
  - www.Prepareforyourcare.org
- Indiana POST
  - www.indianapost.org
- National POLST
  - www.POLST.org
- Center to Advance Palliative Care
  - https://www.capc.org/covid-19/

Additional COVID-19-Specific Resources

Advance Care Planning During a Crisis for Nursing Homes Presentation

Advance Care Planning and COVID-19

CALMER Goals of Care Discussion Guide

Symptom Management in the Nursing Home During COVID-19

The educational handout is below.

Symptom Management in the Nursing Home During COVID-19

Care Guidance for Residents and Staff

Care Guidance for Residents

Self Care Guidance for Staff

https://www.optimistic-care.org/probari/covid-19-resources

Thank you!

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