Nursing Home ECHO

COVID-19 Action Network

Virginia Nursing Homes * VCU Department of Gerontology
VCU Division of Geriatric Medicine * Virginia Center on Aging

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Agency for Healthcare Research and Quality

Institute for Healthcare Improvement

Session 10

Infection Prevention and Management:

Advance Care Planning in the Time of COVID-19

Quality Assurance-Performance Improvement:

Practical Solutions for Advance Care Planning

CE/CME Disclosures and Statements

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The following planners, moderators or speakers have the following financial relationship(s) with commercial interests to disclose:
Christian Bergman, MD – none; Dan Bluestein, MD – none; Joanne Coleman, FNP-none; Laura Finch, GNP - none; Tara Rouse, MA, CPHQ, CPXP, BCPA – none; Sharon Sheets-none;

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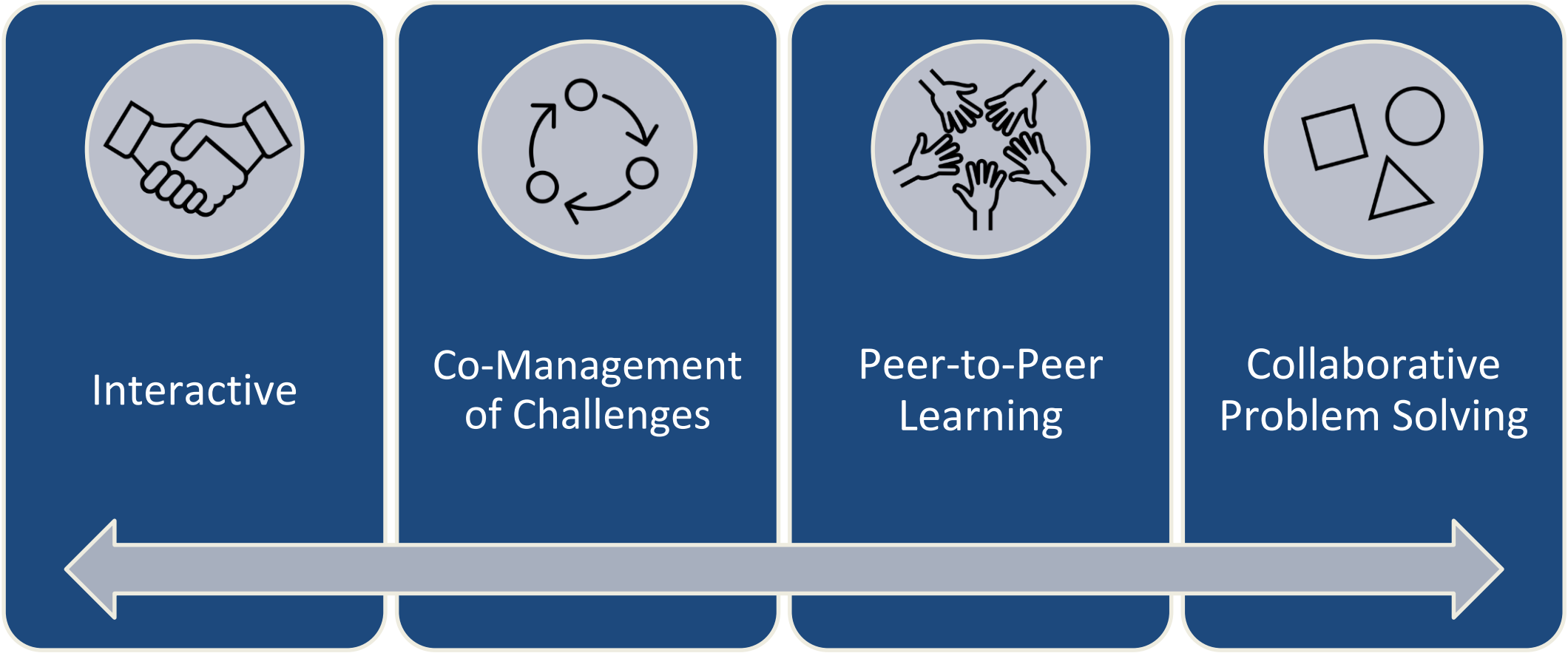

VCU

ECHO COVID 19 CONVERSATIONS SERIES

Advance Care Planning and COVID-19 in Nursing Homes

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Also thank you to Kathleen Unroe, MD Indiana University for slide content

Financial Disclosures

Dr. Wright has no financial disclosures

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.
- The best time to discuss goals of care is either before or immediately following a diagnosis of COVID-19

COVID-19 and Nursing Homes

- Mortality rate in hospitalized elders sent from LTC = 32% (JAMDA, November 2020).
- Mortality rate in LTC = 20% (CMS data, January 2021)
- Older LTC patients have higher mortality rates

COVID-19 and Goals of Care Discussion

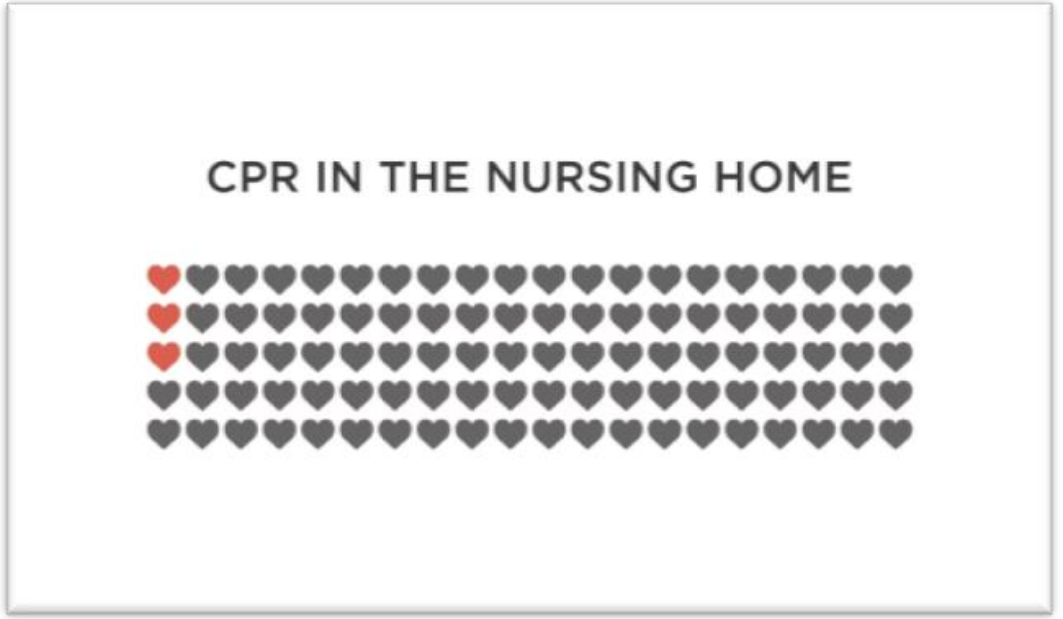
- Simplify Discussion: this is not a POST discussion!
- Decision tree is two-fold: hospitalize or comfort care
- Patients who are DNR can choose either hospitalization or comfort care
  - But those who choose comfort care must be “DNR”
  - “Full code” = hospitalization

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



Hospitalization

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

What can the Hospital offer those with COVID?

- Hi flow oxygen with Bi-PAP
- Intubation (84% mortality rate for elders >80, Am J Respir Crit Care Med. 2021 Jan 1)
- Remdesivir: can reduce recovery time in some patients, but benefit unclear in elderly
- IV steroids (unclear benefit)
- Antibiotics if needed
- Mortality rate is still high in elders transferred to hospital (32%)
  - In my experience, mortality rate is much higher (greater than 90%)

Comfort Care

Care that focuses on comfort/symptom management rather than curative care

What can LTC offer those with COVID?

- Hi flow oxygen with non-rebreather mask
- Monoclonal antibody infusion: can reduce recovery time in some patients, but benefit still unclear in elderly
- SQ or PO steroids if indicated
- Anti-coagulation if needed
- Some testing, including CXR, bloodwork
- Antibiotics if needed for secondary pneumonia
- Expert symptom management
- Coordination with hospice if needed
- A controlled, quiet atmosphere where residents are cared for by CNAs and nurses who know them

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.**

The most important documentation is the discussion you had with the resident or POA. This MUST be documented in the chart. Do it immediately, before you forget!

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.
- **The most important directives will come from family/POA, however!**

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."

Time-sensitive COVID-specific ACP

- Any effective ACP discussion must be built on trust.
  - Enter any ACP discussion knowing that this is your primary goal
  - Gain trust through honesty and openness
  - Avoid defensiveness
  - Avoid conjecture
  - Listen openly
  - Sympathize and empathize
- Start with individual information – how is the resident doing?
  - The family member/POA could have very little information
  - Will want to know condition and prognosis
  - May need to vent, may be angry
    - How did they get it?
    - Who gave it to them?

Time-sensitive COVID-specific ACP

- Introduce the topic
  - "Your mom is doing okay at this point, but it's still early in the disease process. I wanted to talk to you today to get your guidance on what you would want us to do if things got worse."
    - You're asking them for help
    - You're letting them know that they make the final decision on disposition
    - You're letting them know that you may be the expert in medicine/treatment, but they are the experts in goals of care
  - Don't stop there – they still need information to make an informed decision!

Time-sensitive COVID-specific ACP

- General Information
  - Prognosis
    - "Although most people survive COVID, it can be deadly, especially in older people."
    - "We have seen that the first 5-7 days are the most critical, but people can have a sudden decline up to 10 days or more after infection."
- Goals of Care
  - "If your mom gets worse, we would want to know what you think she would want. You know her much better than we do, so when the time comes, we'll want to know what you think she would want for herself"
    - Notice that you're reminding the POA that the decision is to be made on her behalf. What she would want, not what they would want
  - There are a lot of things we'll do for your mom if she gets worse. We can use oxygen, steroids, breathing treatments and antibiotics. We can even use IV fluids (and monoclonal antibody infusion – if you are using this).
    - Notice that you're depicting the nursing home as a place where professional, competent care is given.

Time-sensitive COVID-specific ACP

- The decision tree has two main branches: **hospitalize or comfort care**

- "But if your Mom gets worse despite the things we're doing for her, we'd like you to think about what you would want us to do. We would ask for your decision between two options: either **hospitalize** (and I'll talk about that) or **comfort care** (and I'll talk about that too)."

Time-sensitive COVID-specific ACP

- Hospitalization:
  - “In the hospital, there are many things they can do. They can give more oxygen, they can use a medication to try to kill the virus called remdesivir, and they can put your mom on a mechanical ventilator. It’s important for you to know that most elders do not survive once they’re on a ventilator, and that about 30% of nursing home patients die when they go to the hospital”
- Comfort Care
  - “The other choice is what we call comfort care. With comfort care, you would decide to keep your mom here, even if she passes away from her illness. We would use medications to keep your mom comfortable, but we would not be able to cure her if she’s passing away from COVID.”

Time-sensitive COVID-specific ACP

- Time to pause
  - "That's a lot of information and I know this is really hard to think about. What questions do you have?"
    - Allow time for further questions
    - What treatments would you use in comfort care?
      - Talk about morphine for SOB, lorazepam for anxiety
      - Again, reassure, that you could, if appropriate continue antibiotics and other measures meant to prolong life
    - Would hospice be involved?
      - Yes, although in many cases, the interval between worsening and death can be less than a day
      - You must be prepared to administer comfort care without hospice
    - What's the difference between DNR and DNH? What about the Advance Directive?
- Gauge readiness to make a decision
  - "You may want to think about this and talk with family, but which of the two choices are you leaning towards right now?"
    - It's important to at least start walking with the POA towards a decision. Things change fast with COVID.

Time-sensitive COVID-specific ACP

- Record decision if POA is ready
  - If hospitalize: “I’ll make sure that is recorded as your preference. We will, or course, call you with any changes that we think might need hospitalization.”
  - If comfort care: “I’ll make sure that’s recorded as your preference. We’ll of course let you know if we’re worried that she’s declining.”
    - “You’ll also be able to visit if we feel she’s at risk of passing away. Understand that you will be at risk of COVID exposure, but we will give you all the necessary PPE to help protect you.”
- Give time for any more questions, reassure that they will be informed about any significant changes.
  - Don’t over-promise about communication. Personal daily progress checks may not be realistic in a widespread COVID outbreak.
- Document immediately in the record. Use a spreadsheet if helpful.

Name	Positive date	PCR confirmed date	Most recent negative	Room of orgin	Current room	Hospitilzation	Bamlanivimab infusion	COVID Deaths	ACP Discussion date/decision
	12/17/2020	12/17/2020	11/25/2020	[redacted]					12/19 - Full code, hospital if necessary
	12/17/2020	12/17/2020	11/25/2020				12/26/20, 1/2 dose		12/19 - DNR, hospital if necessary
	12/17/2020	12/17/2020	12/7/2020					1/2/2021	12/19 - Full code, hospital if necessary
	12/17/2020	12/17/2020	11/25/2020					12/28/2020	12/19 - DNR, prob would want comfort care
	12/21/2020	12/21/2020	12/18/2020						12/22 - DNR, leaning towards comfort care, talking with brother
	12/21/2020	12/21/2020	12/18/2020						12/22 - DNR/comfort care
	12/21/2020	12/21/2020	12/18/2020					12/25/2020	12/24 - DNR/comfort care, no hospitalization
	12/21/2020	12/21/2020	12/18/2020						12/24 - DNR/hospice
	12/21/2020	12/21/2020	12/18/2020						12/24 - Change to DNR/Do not hospitalize/comfort care
	12/21/2020		12/18/2020						12/22 - DNR/leaning towards comfort care, will speak with son
	12/22/2020		12/21/2020						12/24 - DNR/comfort care
	12/22/2020		12/21/2020					1/4/2021	12/24 - DNR/comfort care
	12/22/2020		12/21/2020						12/24 - DNR/comfort care
	12/22/2020		12/21/2020						12/22 - unsure about GOC, talking to family
	12/22/2020		12/21/2020						12/24 - DNR/comfort care
	12/24/2020		12/21/2020					1/15/2021	12/24 - DNR/ comfort care
	24-Dec		12/21/2020						12/24 - DNR/comfort care/do not hospitalize
	12/24/2020		12/21/2020						12/24 - DNR/leaning towards comfot care - speaking with family
	12/24/2020		12/21/2020				12/27/2020, full dose		12/24 - DNR/comfort care/do not hospitalize
	12/24/2020		12/21/2020						12/24 - DNR, hospitalize if needed
	12/24/2020		12/21/2020			[redacted]		1/3/2021	[redacted]
	12/24/2020		12/21/2020				12/26/20, full dose		12/24 DNR/comfort care
	12/24/2020		12/21/2020				12/28/2020, full dose		12/24 - spoke with POA, unsure about disposition, will discuss with family
	12/27/2020						12/31/2020, full dose		12/28 - DNR/comfort care, no hospitalizations
	12/27/2020		12/23/2020				12/28/2020, full dose		12/27 - DNR/DNH
	12/27/2020								12/28 - DNR/family discussing
	12/27/2020						12/30/2020, fulldose		12/28 - DNR/hospitalize if necessary
	12/29/2020								12/30 - DNR/comfort care
	12/29/2020								12/30 - DNR/comfort care
	12/29/2020							1/15/2021	1/11 - DNR/comfort care
	12/29/2020								12/31 -DNR/patient notes she is leaning towards comfort care, will want to discuss further if disease progresses
	12/29/2020						12/31/2020,full dose		12/30 - DNR/leaning towards comfort care, but talking with family
	12/30/2020		12/29/2020						12/31 -DNR/comfort care
	12/30/2020		12/29/2020						12/31 - DNR/comfort care
	1/2/2021		1/1/2020						1/4 - Sister: DNR, comfort care
	1/5/2021						1/8/2021, full dose		1/5 - spoke with daughter- DNR/ comfort care
	1/17/2021						1/18/2021, full dose		1/17 - hospitalize if needed
	1/18/2021							1/21/2021	1/18 - comfort care
	1/18/2021								1/20 - full code, hospitalize if needed
	1/9/2021					[redacted]			1/27 - full code, hospitalize if needed

Time-sensitive COVID-specific ACP

1. Gain trust with honesty, openness and information
2. Remind them that you are in need of their guidance (they are the experts in goals of care)
3. Remind them that they have the final say in goals of care
4. They need to make an informed decision – give them information
5. Narrow decision tree to 2 branches – hospitalize or comfort care
6. Make sure comfort care does not equate to “giving up” – there's a lot of good professional work that goes into providing comfort
7. Try to elicit as much information re. goals as possible in this first conversation. COVID moves fast.
8. DOCUMENT ASAP!

Thank you!
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Processes to Support Effective and Meaningful Advance Care Planning

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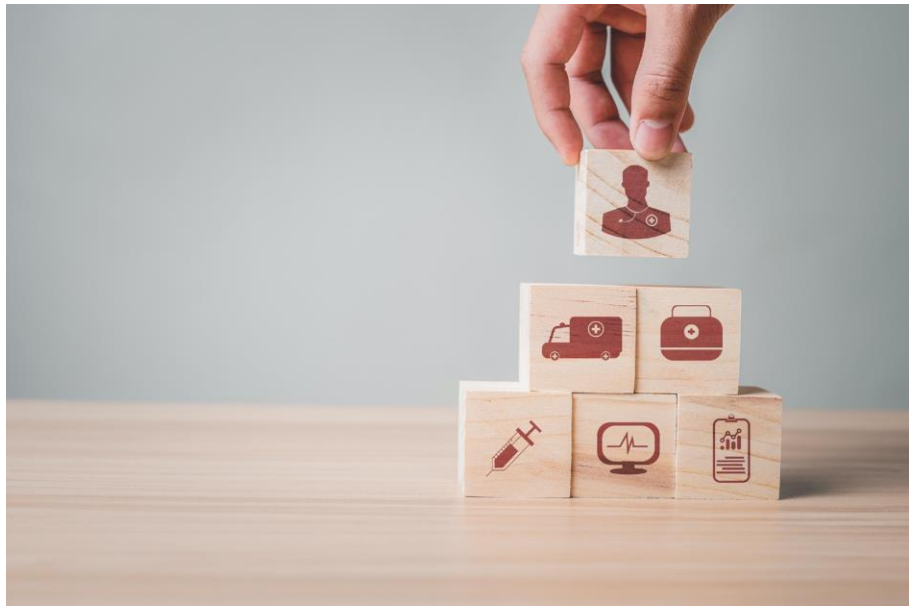
Small Group Discussions

- **Group 1:** Has your facility established a process to review goals of care when considering hospitalization?
- **Group 2:** Does your facility have a process to ensure transfer of advanced care planning documentation when residents are transferred to another facility?
- **Group 3:** How has your facility engaged caregivers in these conversations, what has been different in these conversations amid the pandemic?
- **Group 4:** What are the ideas that interest you from this presentation? What processes would you need to adopt or adapt?

A Structured Tool for Communication and Care Planning in the Era of the COVID-19 Pandemic



https://www.jamda.com/article/S1525

Pragmatic Innovations in Post-Acute and Long-Term Care Medicine
Feasible new, practical products or approaches intended to improve outcomes or processes in post-acute or long-term care

A Structured Tool for Communication and Care Planning in the Era of the COVID-19 Pandemic

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ABSTRACT

Residents in long-term care settings are particularly vulnerable to COVID-19 infections and, compared to younger adults, are at higher risk of poor outcomes and death. Given the poor prognosis of resuscitation outcomes for COVID-19 in general, the specter of COVID-19 in long-term care residents should prompt revisiting goals of care. Visitor restriction policies enacted to reduce the risk of transmission of COVID-19 to long-term care residents requires advance care planning discussions to be conducted remotely. A structured approach can help guide discussions regarding the diagnosis, expected course, and care of individuals with COVID-19 in long-term care settings. Information should be shared in a transparent and comprehensive manner to allay the increased anxiety that families may feel during this time. To achieve this, we propose an evidence-based COVID-19 Communication and Care Planning Tool that allows for an informed consent process and shared decision making between the clinician, resident, and their family.

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Keywords: Advance care planning, COVID-19, skilled nursing facility, long-term care

Problem

The coronavirus disease 2019 (COVID-19) pandemic has a strong influence on the prognosis of individuals living in long-term care (LTC) settings. Recent media reports indicate that at least one-third of COVID-19 deaths are among LTC residents.[1,2] In the majority of states reporting, at least 50% of deaths are among nursing home and assisted living residents.[3,4] Frail health combined with communal living conditions, insufficient personal protective equipment, and chronic understaffing are all likely contributing factors to COVID-19 related deaths among LTC residents.

On March 13, the Centers for Medicare and Medicaid Services (CMS) issued guidance to restrict visitors, including family members, from entering LTC facilities as a means to help reduce the spread of COVID-19 to vulnerable LTC residents.[5] Although necessary, this restriction has caused distress. Some families must face the psychological burden of not being able to see and hold their loved ones at the end of life. Further, depriving frail older people of important emotional support and social interactions may contribute to their decline. Further complicating matters is the necessity to use telephones or telemedicine to conduct many advance care planning discussions, rather than through face-to-face interactions. Considering these unique circumstances, we developed a structured approach to support meaningful advance care planning conversations among clinicians, residents, and their families facing COVID-19 infections.

Innovation

We developed the COVID-19 Communication and Care Planning Tool to provide a structured approach to advance care planning conversations with LTC residents and their families regarding COVID-19 infection and expected outcomes (Figure 1). The communication tool is intended to guide staff through conversations specifically around concerns related to COVID-19 infections, a crisis situation considered an important opportunity for advance care planning discussions.[6] Although there is no evidence to support any 1 clinical tool for advance care planning,[7] the COVID-19 Communication and Care Planning Tool incorporates best practices about discussing serious illness care goals; sharing prognostic information, understanding fears and goals, wishes for family involvement, exploring views on trade-offs and impaired function, and eliciting decision-making preferences.[8]

Using the mnemonic COVID, the communication tool begins by addressing the expected course and outcomes for nursing home

Conflict of Interest: R.L.P.J. discloses research funding from Pfizer and Merck; she has served on advisory boards for Pfizer and Roche. G.D. discloses serving on an advisory board for Roche. The remaining authors declare no conflicts of interest.

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Communication Care Planning Tool

C COURSE OF ILLNESS

Briefly describe COVID-19

- COVID-19 causes a viral respiratory illness that can spread from person to person.
- Residents of nursing homes are particularly at risk for this infection.
- They are also at risk of getting more serious COVID-19 infections and death.

Describe the range of symptoms that people with COVID-19 infection may experience

- The course of illness varies among different people and we cannot predict how it will affect your loved one.
- Some people have the virus and have almost no symptoms.
- Some can experience a flu-like illness,body aches and worsening of confusion and recover.
- Some may have sudden shortness of breath and quick deterioration and death, all within a few hours.
- Some patients may have fevers, a cough and shortness of breath over many weeks. Somewill eventually recover. Others will continue to decline and develop severe shortness of breath, and may die.

O OUTCOMES IN OLDER ADULTS

Describe the poor outcomes associated with COVID-19 infection among nursing home residents.

- Onein three nursing home patients with COVID-19 infection will die.

Describe the prognosis for those with severe COVID-19 infection

- In one study, 2 of 3 patients who were sick enough to be in the intensive care unit (ICU) died. Most of the people who died were older and had chronic illnesses.
- Among COVID-19 patients who had a cardiac arrest inside the hospital, only 4 out of 132 survived. Of those, 3 did not regain their usual state of health as it was before the COVID-19 infection. For the majority of these patients, the cardiac arrest happened in front of someone and resuscitation (or CPR) was started within a minute. Most of the time cardiac arrests do not happen while someone is watching, and patients have an even lower chance of survival.

V PROVISIONS WE HAVE MADE

Describethe general care provided for the residents in the COVID-19 area

- We have moved your loved one to a specialized COVID-19 unit.
- Our staff will continue to provide routine care like helping with turning, feeding (if needed) and mouth care.
- We arefrequentlychecking their oxygen levels with pulse oximetryand for symptoms like fever, pain, cough, diarrhea, and shortness of breath.

Describethe care plans specific for people with COVID-19infections

- As we anticipate the needs of your loved one, we have medicines and equipment at the ready to provide care though this disease course.
- We have acetaminophento help lower fevers and to relieve muscle aches and pains.
- If your loved one becomes short of breath, we can start supplemental oxygen. We have oxygen concentrators and oxygen tanks available.
- People with infections can become dehydrated. We will encourage your loved one to drink more fluids and give intravenous fluids if needed.
- Sometimes people who are dying from respiratory disease–like a COVID-19 infection–will develop what we call "air hunger." We have medication to help relieve the anxiety and suffering that go along with this.
- Our staff will be with your loved one at the end of his/her life if that happens.

Offer empathy and solutions about visiting restrictions.

- We understand it must be so hard on you to not be able to see and visit with your loved one. It's especially hard now that your loved one has a COVID-19 infection.
- It has been tough for our staff that you cannot visit. They understand how important it is for our residents to see families. We have missed seeing you.

I INFORMED CONSENT

Address if a "Do Not Hospitalize" order should be considered

- Let's talk about what your loved one's wishes are for their healthcare.
- We have to think about your loved one's health before they became infected and now the high chance of death due to a COVID-19 infection.
- If your loved one becomes very sick, we can consider transferring them to the hospital or caring for them here where our staff knows them.
  - Knowing what we know about outcomes of COVID-19 would your loved one have wanted to be transferred to the hospital?

Discuss "Do Not Resuscitate" orders

- When people have a cardiac arrest and get CPR, the chest compressions cause a great deal of pain and injury.
- Even in the best of circumstances, few people with your loved one's health conditions would survive CPR.
- If your loved one has a cardiac arrest–that is, their heart stops– how would you like us to care for your loved one?
  - Would you want us to perform chest compressions on your loved one?

D DOCUMENTATION

Summarize and document intervention(s) that are requested by the family or resident

- Hospital Transfer or Do Not Hospitalize.
- Attempt chest compressions or Do Not Resuscitate

Review communication plan

- Plan for staff to family communication and vice versa.
- Plan for communication between residents and loved ones using devices

Fill out documents and write orders that need to be created and formally signed off (*e.g.*, AMDA COVID-19 ACP document, POLST, *etc.*)

Leave in Action

- Consider opportunities for improvement in your facility re: Advance Care Planning
- Write an AIM Statement that describes what you would like to work on first to

Honoring the Work

Examples From the Field

AHRQ ECHO National Nursing Home COVID-19 Action Network

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MFA Norfolk Health and Rehab

Break slide

NEXT UP – WRAP UP & NEXT STEPS

Announcements

Next Week

Promoting Safe Care Transitions During COVID-19 — Admission, Discharges and Transfers

CE Activity Code

Within 7 days, text the attendance code to (804)625-4041

Questions? email ceinfo@vcuhealth.org

Attendance

Because attendance rewards and CE credit are dependent upon your ECHO attendance, contact us at nursinghome-echo@vcu.edu if you have a conflict.

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