Advance Care Planning in the time of COVID 19

Cohort 8 Session 7

January 15, 2021

11:00 am

Please note, Project ECHO collects registration, participation, questions/answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives.

AHRQ ECHO National Nursing Home COVID-19 Action Network

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Today's Agenda

Follow-up from Session 6 – Vaccine Management & Managing Social Isolation during COVID 19

Advance Care Planning in the Time of COVID 19

Discussion

Quality Improvement Discussion

Wrap-up and Poll

Questions & Answers

Session 6 Follow Up: Vaccine Management & Managing Social Isolation During COVID 19

Add custom questions or just open for discussion

Please unmute and share.

What would make today a good day for you?

ECHO COVID 19 CONVERSATIONS SERIES

Advance Care Planning and COVID-19 in Nursing Homes

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Learning Objectives

- Review components of advance care planning
- Discuss special considerations related to advance care planning and COVID-19
- Identify tools to support person-centered care during COVID-19

Massachusetts Covid-19 Experience

- Over 60% of the almost 13,000 MA deaths in have been nursing home patients/residents
- Many futile hospitalizations/intubations
- Concerns about hospital supply: ICU beds, vents, 02, nursing and other staff
- Many deaths without loved ones nearby
- Hospice unable to be on-site
- Great stress for loved ones
- Complicated grief risk for survivors
- Ongoing fear, loneliness and isolation
- Health care worker exhaustion
- New emerging treatment options

What is Advance Care Planning?

- A process of conversations that allow patients to identify their goals, values and treatment preferences
- Documents these preferences for loved ones and clinicians
- Identifies a surrogate decision maker in the event of incapacity

Mr. and Mrs. Z

- Mr. Z is a 90 y/o man who has been a long-term nursing home resident with mild dementia and a prior stroke. He gets along well with all staff, especially the day shift CNA, Marie
- At baseline he can articulate his needs clearly
- He is wheelchair level, needs assist of 1 for transfers.
- Baseline activities are being in day room participating in recreational activities
- His wife, 84, used to visit 3x/week but no visits have been allowed for the past 6 weeks. It is often asks staff the same questions repetitively.
- On May 10, 2020 he develops covid-19, with cough, low grade temp and is quite confused.
- The charge nurse checks the legal documents section of the chart and is relieved to see he has an advance directive that names his wife as his health care proxy.

Health Care Proxy Role

- Understand the medical situation of the resident/patient
- Understands their care goals, values and wishes and will make decision that are aligned with them

Cohort 8 Case Study

- What should happen next?
- Do you have any concerns?

Cohort 8 Case Study (cont.)

- The social worker speaks with the primary nurse and Marie who both express concern that Mrs. Z, who has called 4 times in the past hour, appears overwhelmed with the change in her husband.
- The physician is updated and sees Mr. Z that day and writes a progress note and an order stating he does not have decision making capacity
- The social worker reviews the health are proxy document and notes the son, Bill is named the alternate proxy
- The social worker then contacts Bill agrees this it is too much for his mom to make decisions.
- A zoom call is arranged with the doctor, social worker, Bill, and Mrs. Z

COVID-19 and Advance Care Planning

- COVID-19 can cause rapid deterioration over days, even hours requiring urgent treatments decisions
- Advance care planning is challenging to do in a crisis where many patients/residents are impacted
- Advance care planning conversations can prepare residents and families for these decisions.
- Proactively identifying and documenting preferences may avoid invasive life-prolonging treatment and help ensure treatments are provided that are aligned with resident wishes.

Preparation – Advance Care Planning

- Residents and families may need help understanding, expressing and identifying care goals exacerbated by:
  - Concerns about isolation
  - Their own experience with COVID-19.
- For health care providers, conversations about values, goals, and treatment preferences
  - Are not always easy
  - Can be uncomfortable and stressful
  - Require preparation
  - Can be learned with training and practice

Case Study

- What kinds of decisions need to be made regarding Mr. Z's care?
- Who leads those discussions?
- What happens at your facility?

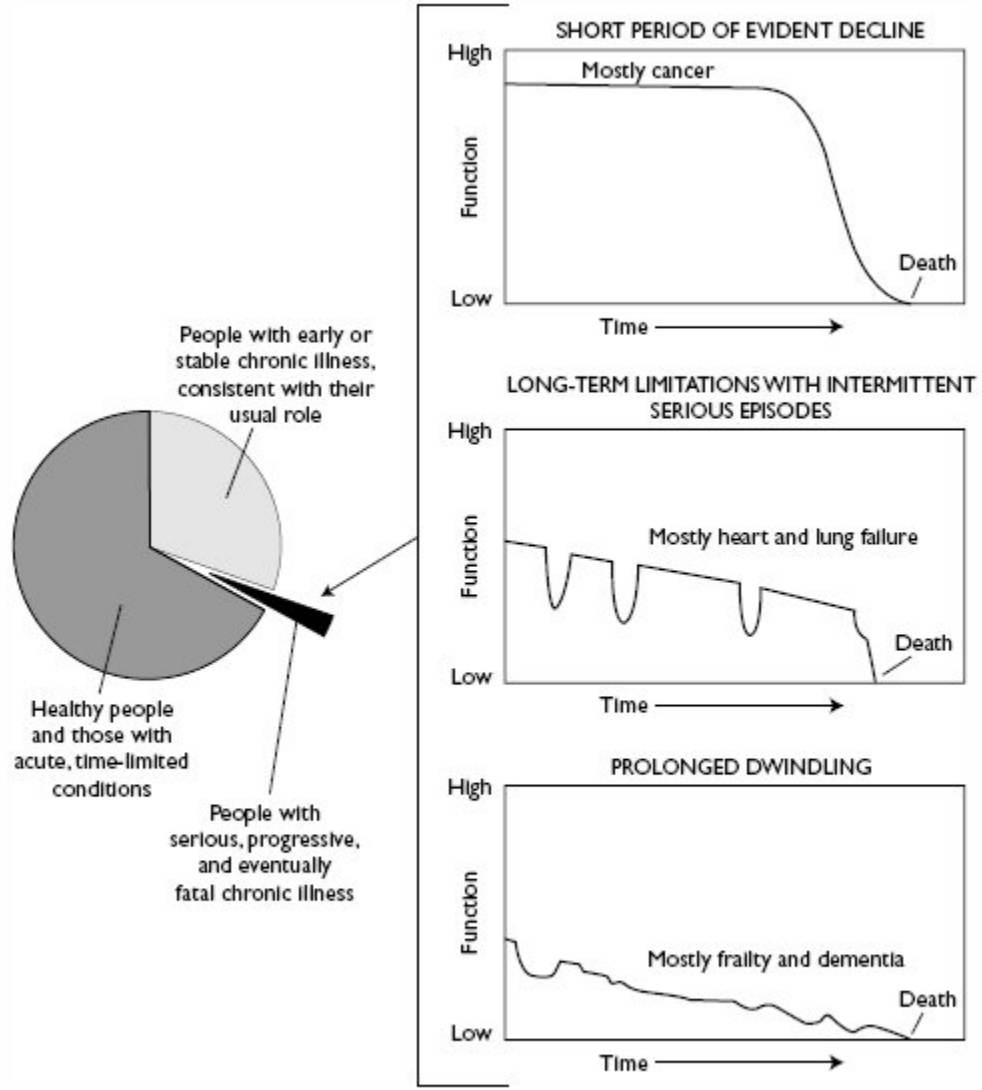


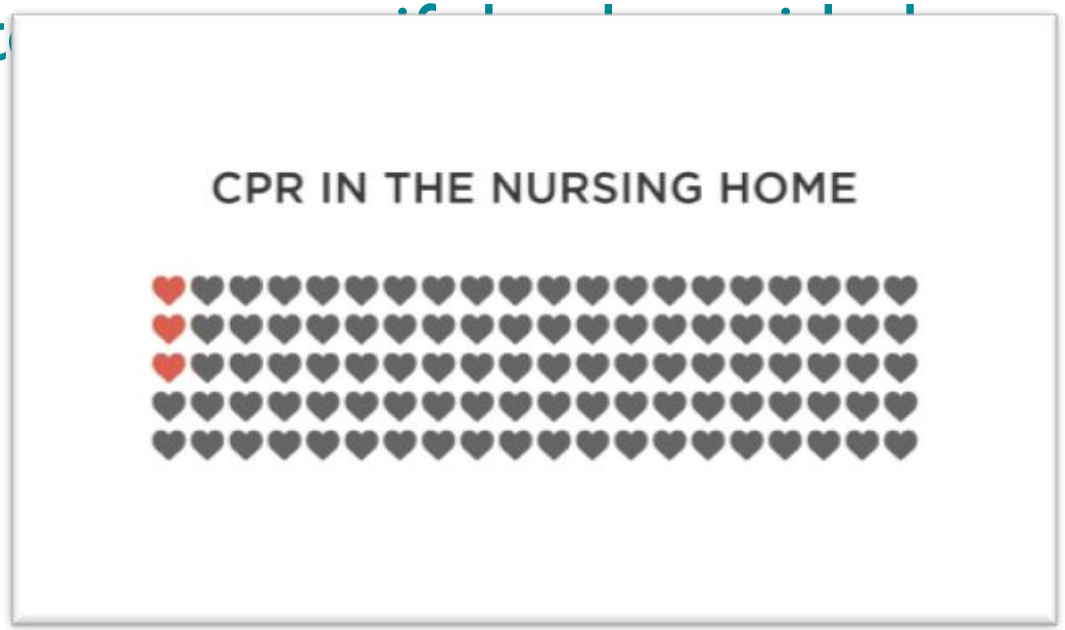
Figure 5. Trajectories of eventually fatal chronic illnesses. Source: Lynn and Adamson 2003.

A framework for thinking about Goals of Care

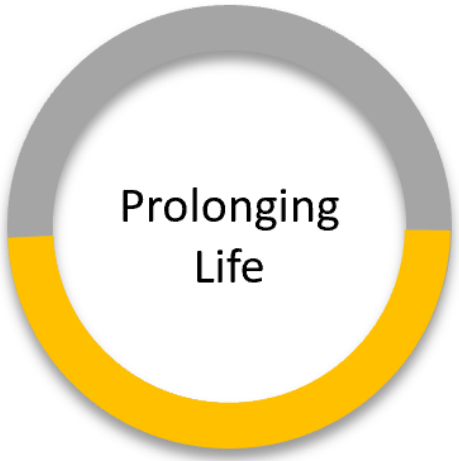
Understanding which goal is most important to a resident and/or the family will help them make treatment decisions that reflect these goals.

CPR – Key Information

- CPR survival rates are low in the nursing home, just 3 out of 100 residents (3%) will survive and long term prognosis generally poor
- CPR survival rates are believed to be lower for residents with COVID-19
- Usually requires intubation and ventilat
- 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.

Hospitalization

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

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.

Goals of Care and COVID-19 Considerations

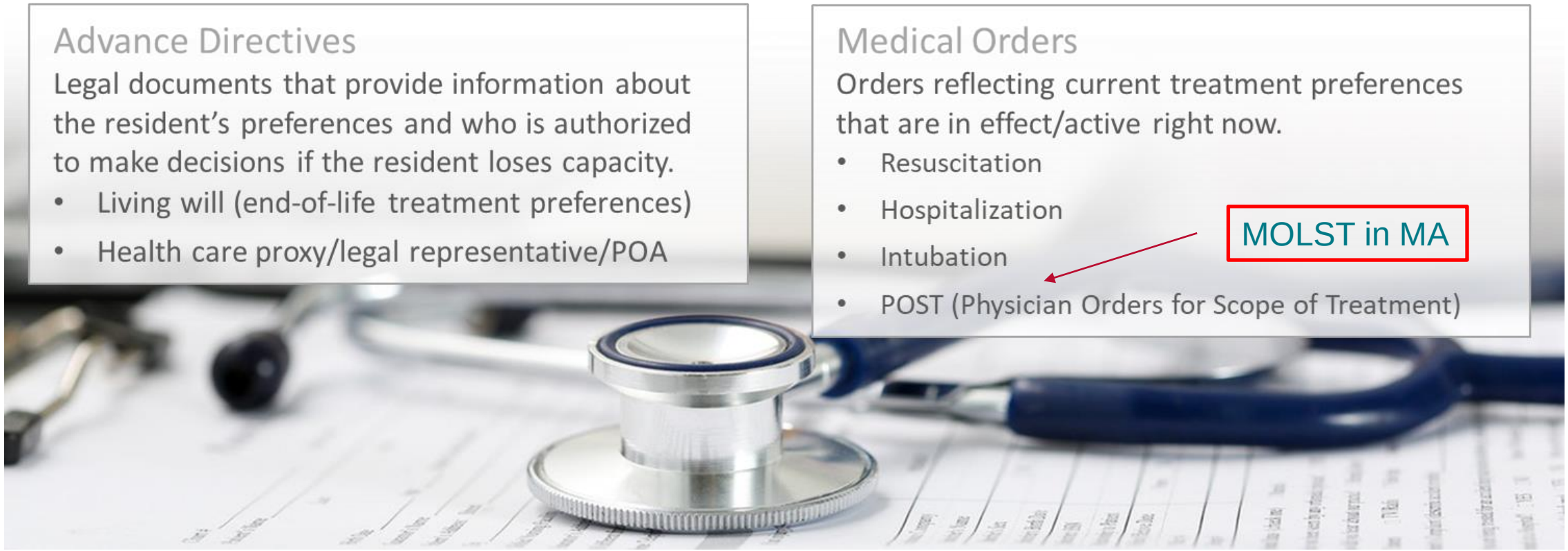
- We should assure residents and families we will do all we can to honor realistic preferences.
- Residents who transfer to the hospital may face cohorting restrictions on their return due to the risk of exposing other residents to the virus.
- Residents with possible or confirmed COVID-19 may be moved in order to isolate them from other residents even if care goals is comfort
- Residents and families need reassurance that symptoms including cough, shortness of breath, and fever can be effectively managed

Hospitalizations and COVID-19 Considerations

- Hospital transfers:
  - Changing caregivers and environment, can be especially unsettling to frail individuals with cognitive impairment
  - May trigger a cascade of treatments some of which may be futile/uncomfortable not aligned with prior care goals
  - Should be avoided if possible for residents who prefer comfort care

Advance Care Planning Documentation Tools

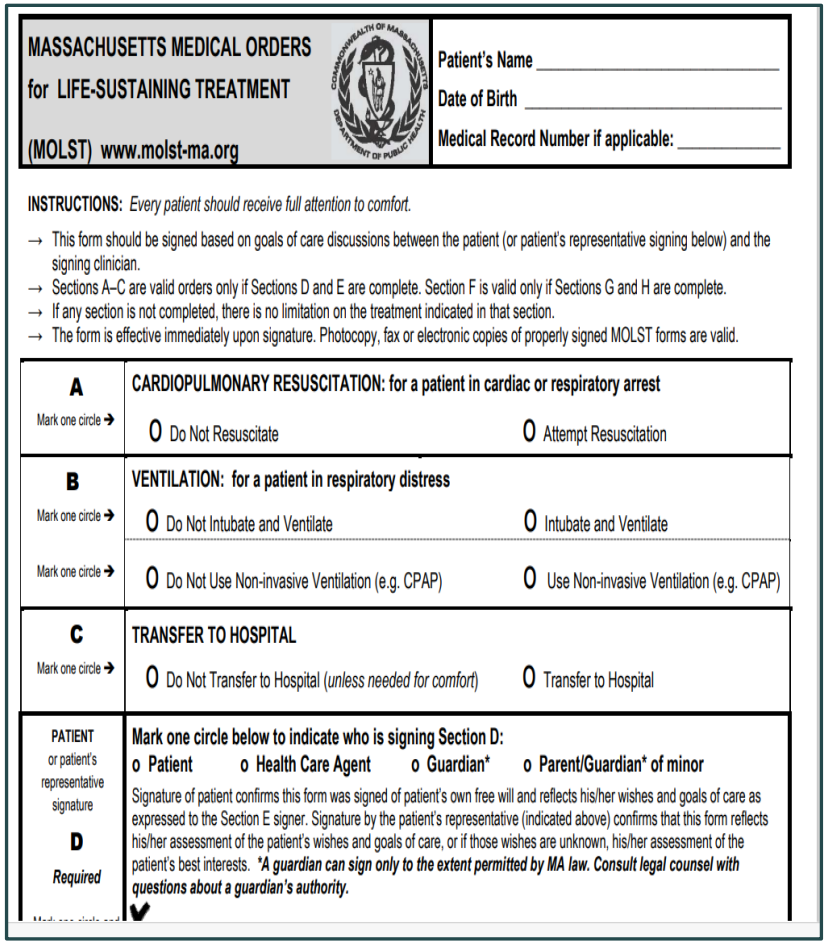
There are two kinds of advance care planning documentation tools:



The MOLST Program

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

- Records treatment preferences as actionable medical orders that EMS can follow
- Documents preferences to have or decline treatments
- Valid across treatment settings
- HCP form and MOLST should travel with patient at all care transitions and EASILY ACCESSIBLE



MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT

(MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A Mark one circle →	**CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest** O Do Not Resuscitate O Attempt Resuscitation
B Mark one circle →	**VENTILATION: for a patient in respiratory distress** O Do Not Intubate and Ventilate O Intubate and Ventilate
Mark one circle →	O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP)
C Mark one circle →	**TRANSFER TO HOSPITAL** O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital
PATIENT or patient's representative signature **D** *Required*	**Mark one circle below to indicate who is signing Section D:** o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*** ✔

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."

MOLST & COVID-19:

- Educate all staff to listen for resident and family fears AND preferences and to share with the health care team
- "What Matters Most" may be peppered throughout a conversation and not stated directly
- Be proactive – approach MOLST eligible residents at risk
- Maintain master list of patients who have MOLST during COVID-19 and regularly review

Your Entire Team Can Contribute to ACP Discussions with Residents and Proxies

- Social worker
- Case manager
- Nursing including/CNA
- Therapy
- Activities
- Executive director
- MD/APC/PCP/Specialist

Is Covid-19 a Palliative Care Team Building Opportunity?

- Palliative care focuses on
  - Advance care planning
  - Pain and symptom management
  - Spiritual/psychosocial support
  - Timely use of hospice
- Can be integrated in nursing facility structure and processes
- Team may include physician, APC social worker, chaplain, mental health

Hospice

- Hospice may provide palliative care consults to assist with complex ACP discussions, even virtually
- Faces challenges with COVID visitation restrictions but virtual visits are possible
- Can fill critical need for bereavement support for surviving loved ones

Effective Advance Care Planning Benefits

- Peace of mind to the patient/resident that their wishes will be honored and their loved ones will be supported
- Peace of mind to health care proxies that they are making the right decisions
- Reduce the risk of complicated grief of loved ones by proactive involvement in decision making and enlisting hospice bereavement services when needed
- Reduce stress and enhance satisfaction for health care providers

Case Study Resolution

- Fortunately Mr. Z's son, Bill, was named as alternate Heath Care Proxy on the form and, together he and Mrs. Z, determined that Mr. Z would not want to be separated from his caregivers, especially Marie, and would not want to have CPR or intubation.
- A MOLST was signed by the son indicated his wishes to be not have CPR or intubation performed or be hospitalized.
- Mr. Z recovered, his mental status improved and he is looking forward to getting the vaccine

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

Resources

- Honoring Choice MA
- https://www.honoringchoicesmass.com/
- Massachusetts MOLST
- https://www.molst-ma.org/
- Center to Advance Palliative Care
- https://www.capc.org/covid-19/
- Respecting Choices
- https://respectingchoices.org/covid-19-resources/#planning-conversations

Thank you!

Taking it to the Next Level

Resources and Responsibilities	Are there written materials and resources to support teams in having advance care planning conversations with residents and/care partners? Is it clear which team members may have these discussions? Are clinical team members able to access resources on all days/shifts?
Document and Report Advance Care Planning Discussions	Does each resident have a Goals of Care/Advance Care Planning conversation and decisions/preferences documented in their record? Who monitors resident records to determine if ACP is clearly documented? How is this information communicated to leadership and relevant stakeholders or decision-makers?
Follow-Up Plan (monitoring over time)	What actions are taken if ACP documentation is missing or inadequate for decision-making during an acute change in condition?
Improvement Concepts/Critical Questions for Leadership	Are there regular (daily or every other day) huddles or calls during which primary care providers (MD/NP/PA) discuss ACP with leaders, nurses, and social workers?

Using Quality Improvement to Address Staff Hesitancy

Martha Hayward

AHRQ ECHO National Nursing Home COVID-19 Action Network

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Training Hub Logo

Public Narrative and Intrinsic Motivation

- Public Narrative

Unleashes

- Intrinsic Motivation

Public Narrative – The Stories We Tell

- Self
  - Helps us to commit to each other
- Us
  - Reflects our shared values
- Now
  - Common call to action

Intrinsic Motivation – How we feel about our task

The act of doing something without any obvious external rewards. You do it because it's enjoyable and interesting, rather than because of an outside incentive or pressure to do it, such as a reward or deadline.

Making it Stick

- Meaningfulness
  - Reduce illness and death for our residents and staff
- Responsibility
  - Every vaccination reduces risk
  - We are aiming for 100% participation
- Knowledge of Results
  - # of vaccinations / #days w/out COVID infection

Performance Improvement Project – Staff Meeting

- Self
  - Share stories
- Us
  - Ask “What Matters Most?”
  - Listen. Ask Why.
- Now
  - Current Situation and goals

Performance Improvement

- Set your AIM
  - Covid free facility!
    - X% staff vaccinated by x date
    - X% residents vaccinated by x date
- Plan your meeting
  - Location, time, invitees, leaders, food, format, agenda
- Measure and report
  - # vaccinated, # hesitant, # accepting

What to expect next…

Next Session: **January 22, 2021**

Topics:

- Session 8: Staff Returning to Work Safely
- Session 9: Effective Leadership & Communication (January 29th)

Send in your facility's best practices/challenges by Thursday, January 19th to Tabitha Fineberg at TabithaFineberg@hsl.harvard.edu

Wrap Up and Poll

- Please watch your screen and respond to our 2 poll questions as they launch

Questions?