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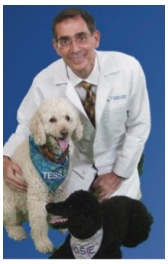
Webinar Series
COVID-19: CALTCM Weekly Rounds

April 13, 2020

Webinar Faculty & Moderator

Michael Wasserman, MD, CMD
Geriatrician, President, CALTCM,
Medical Director, Eisenberg Village,
Los Angeles Jewish Home



Webinar Faculty

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President-Elect, AMDA: The Society for Post-Acute and Long-Term Care Medicine;
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Infection Prevention & Control Resources
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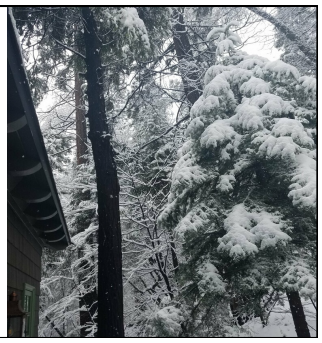
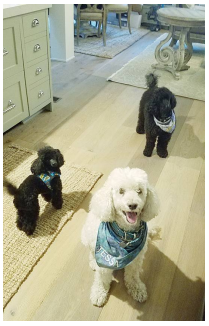
Advance Care Planning in PALTC:

Even More Vital Now



This Pandemic Affects Everyone!



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Why is Advance Care Planning Important?

- Good for patients and families
  - Allows for reflection, bonding, informed decision-making
- Good for health care providers
- Avoids crisis-based decisions
- Prevents unnecessary and unwanted suffering
- Helps ensure people get wanted treatments, and not get unwanted treatments

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Why More Important Now?

- In light of unique aspects of COVID pandemic, decisions may change (re: hospitalization, intubation/ventilation)
- Nursing home residents (LTC) may choose to stay at "home" with known staff over hospitalization
- Prognosis obviously worse for patients who are frail and have multiple comorbidities

- Note: *Not everyone will be receptive!*

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Who Should do ACP in SNFs?

- Ideally, attending physician, medical director
  - We know this is not always happening in a meaningful way (before or now)
  - POLSTs completed and signed with minimal (or no) meaningful discussion/conversation
- Can be done via telemedicine or phone
- Best to include family, even in residents with decisional capacity
- Usually most credible and reliable source of info

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Who Should do ACP in SNFs?

- If staff (RN, SW) trained and available, reasonable to have them bring up the topic in light of the pandemic—consider decision guides, ensure it is presented in a positive light
  - Then contact physician to revisit orders/POLST
- Involve family whenever possible
- For incapacitated, unrepresented residents, consider IDT decisions (in California under HSC 1418.8)

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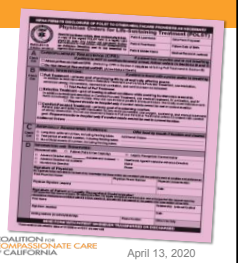
Indications for POLST During COVID Crisis

- What are the indications?
- Are they different from usual?
- Have the conversation!!
- COVID-specific POLST?
- Probably expand the population who could be offered POLST
- Specific chronic conditions
- Ventilator issues



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Section A

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

EMSA #111 B (Effective 1/1/2016)*

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

When does Section A apply?

*DN(A)R does **not** mean "just let me die"!!*

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Section B

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

- ☐ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ ***Trial Period of Full Treatment.***
- ☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*
- ☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

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Key Elements in Conversations

- Patient willingness to talk
- Patient preferences for information
- Patient understanding of their illness
- Patient preferences for family disclosure and/or decision-making
- Personal life goals, including upcoming milestones

CALTCM *VitalTalk, Ariadne Labs & others* April 13, 2020

Key Elements in Conversations

- Fears and anxieties
- Unacceptable states of health/function (vs.)
- …Tradeoffs they are willing to accept
- Recognizing that people can change their minds
- Exploring emotional and spiritual factors
- Mutual trust and a willingness to listen

Coronavirus Conversations

- Prepare by determining if there is an AHCD, **POLST** or other documentation of treatment preferences already in chart/EHR
- If so, familiarize yourself with the contents—and if there is an agent/proxy designated, offer to include them in the conversation when broaching subject
- "Take your own pulse."

Coronavirus Conversations

- Is it OK if we talk about what's important to you and how the new coronavirus might affect you, so we can be sure we can give you the kind of care you'd want if you got the virus?
- This conversation can help your family and help us, your health care team, if that ever happened
- Have you chosen a person to make decisions for you if you were unable to speak for yourself? Who is it? Are you confident they can do it?

Coronavirus Conversations

- What do you know about the coronavirus?
  Is there anything you'd like me to tell you about it?
- What can you tell me about your other medical conditions and how they affect you?
- Have you thought about what might happen if you were to get this virus? Do you have any specific fears about it? (e.g., hospital, vent)

Coronavirus Conversations

- "It can be difficult to predict what would happen if you got the virus, already being at risk from your [medical conditions]. Many patients get mild cases, and I hope you would be one of them, but I'm worried that you could get very sick quickly, and I think it's important for us to prepare for that possibility."

Coronavirus Conversations

- Goal clarification:
  - What are your
    - …most important goals if you get ill?
    - …biggest fears about the future?
    - …abilities that you can do now that you can't imagine living without in the future?
- Does your family know about these values?
  - It's a hard subject, but best to talk about them

Coronavirus Conversations

Summarize

- Acknowledge emotion, allow for silence
- Thank you for having this hard conversation
- What I'm hearing you say is that what's most important to you is ……., and that if you weren't able to……., you would not want to live that way. Is that right?
- Based on that, and based on your condition and what I know about the virus, I would recommend…. because…..

Coronavirus Conversations

Summarize

- I hope things don't get worse, but I am glad we talked about this, in case they do
- We will do everything we can to make sure we give you the care you want to receive, and I will make sure orders are written that reflect that
- Is there someone else you'd like me to talk to about our conversation?
- ***I care about you. We will walk this path together***

Transfer/Treatment Decisions

- Risks of going to hospital are greater than they usually are because of the virus
- Even without COVID, preferable to treat patients in "lowest" safe care location (home, SNF, AL)
- Issues around access to family visits, may influence choice of location to receive care
  - No-visitor rules can be waived in some locations for actively dying patients

Transfer/Treatment Decisions

- During surge→crisis, triage decisions may change usual access to care (CPR, ventilation).
  - Reassure patient/family that rules are applied fairly and not capriciously or based on individual physician judgment, age, etc.
  - Is it ethical to ask people in advance to forgo treatment they would otherwise have wanted?
- Ability to provide adequate comfort/palliative interventions in non-hospital locations

Managing Documents

- Give copy to the healthcare agent
- Make copies for other loved ones
- Discuss with provider/doctor/hospital and place in medical record
- Keep a copy
- Bring for hospital admission/surgery

Remember: Photocopies/faxes/scans of POLST are just as valid as the original.

What if the patient changes his/ her mind?

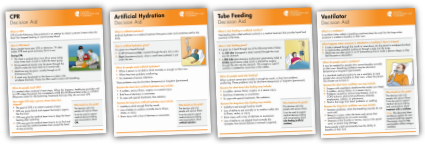
- Anyone can revoke their healthcare directive or appoint a new healthcare agent or state new treatment preferences at any time
- **POLST** can be modified by a patient with capacity, and by legally recognized decisionmaker when appropriate
- Best practice is to execute a new document

CCCC's COVID Page

- https://coalitionccc.org/covid-conversations-toolbox/

Tools for Decision Making

Revised Decision Aids



ACP Resources: COVID

- **CAPC**: https://www.capc.org/toolkits/covid-19-response-resources/
- **Conversation Project**: https://theconversationproject.org/wp-content/uploads/2020/04/tcpcovid19guide.pdf
- **Prepare:** https://prepareforyourcare.org/covid-19
- **Respecting Choices:** https://respectingchoices.org/covid-19-resources/
- **Ariadne:** https://www.ariadnelabs.org/wp-content/uploads/sites/2/2020/04/1.-COVID-19-Conversation-Guide-for-Outpatient-Care.pdf

The Basics of AHCD Execution

Probate Code 4673

1. Principal with Capacity (can sign or direct a signature)
2. Witnesses
   a. Two witnesses. Only one can be related, neither witness can be an agent or a health care provider
   b. Or notary public
3. Special for SNF residents: Ombudsman must witness

Overcoming the Unavailable Witness

- Make the witness available (window witness, socially distant, video streaming, use other residents)
- Use acknowledgement
- Other Alternatives
  - No witnesses but can use the directive as health care instructions (Probate 4623) and the agent designation as a Probate 4711 surrogate designation
  - Have the principal sign it anyway - it's better than not
  - POLST does not require witnessing

Capacity Concerns

- Witnesses are crucial because they validate integrity so without them documented provider observations of capacity are wise
- Default surrogates still available
- No capacity, no surrogate - Unrepresented Resident's
  - Health & Safety Code 1418.8
  - CANHR v. Smith: added notice requirements

Other Legal Documents

- Financial Powers of Attorney (agent disqualified, notary if there is real property)
- Trusts (notary if there is real property)
- Wills (beneficiaries are disqualified)

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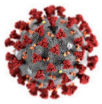

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https://www.caltcm.org/covid-19

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