EXPERT PANEL WEBINAR
Monday, April 20, 2020 | 3:00pm Eastern; 2:00pm Central; 12:00 Noon Pacific

Transitions Between Nursing Homes and EDs in the Age of COVID-19

MODERATOR: Don Melady, MD

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COVID-19 Resources
gedcollaborative.com/article/covid-19-resources/
Vision
A world where all emergency departments provide the highest quality of care for older patients.

Mission
We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine.

We build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.
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Zoom Webinar Pointers

1. All microphones have been muted.

2. Hover your mouse over the Zoom window to bring up five icons in the bottom center.

3. Q & A Function will NOT be used.

4. Click on Chat function, the icon on lower right.

Webinar RECORDING & SLIDES will be available at gedcollaborative.com
Transitions Between Nursing Homes and EDs in the Age of COVID-19

Geriatric Emergency Department Collaborative
April 20, 2020

@theGEDC
COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals

Stacie Levine, MD, Alice Bonner PhD, RN, FAAN, Adam Perry, MD, Donald Meadly, MSc Ed, MD, Kathleen T Umroe, MD, MHA

Box 1: Patient Scenario

In a 90-year-old nursing home patient with moderate dementia, COPD, and HTN presents with acute cough and low-grade fever on Friday evening. She has been in isolation for COVID-19 since the beginning of the new year. The nurse calls the on-call physician who orders placement of patient in isolation, respiratory mask weekly rounds (WMR), pulse oximetry, and finger waves vital signs. At the time of the call, the patient has slight tachypnea noted that day and appears clinically stable. The nurse asks the patient’s family about any potential exposures. The patient has been in isolation with no medical history or clinical syndrome consistent with COVID-19. The patient had no travel history in the prior month. She had no contact with healthcare workers who tested positive. She lives in isolation with her daughter. The patient is discharged from the rehabilitation wing of a facility in the same building. In addition, the patient is admitted to the hospital for acute coronary syndrome and is transferred to the emergency department. The patient is discharged from the hospital and is admitted to a skilled nursing facility.

INTRODUCTION

The COVID-19 pandemic is uniquely devastating for older adults who live in commercial settings, such as nursing homes. Mortality rates are highest in persons > 65 years, ranging from 10-25%. From a March 2019 reference, approximately 30% of American deaths from COVID-19 have been among nursing home patients.

This article describes the COVID-19 demand and ongoing collaboration between acute care and community facilities. The crisis is spreading through nursing homes nationwide, creating simultaneously downshifted staffing and decreased ability to accept admissions. Many nursing homes are not admitting new patients, and are not accepting patients back from the ED or hospital without negative testing. Older nursing homes are choosing to stop admitting collapses citing the need to reduce exposure during the physical assessment, or for a fear that they will struggle to maintain sufficient staff to care for patients already in the home.

This article describes the impact of COVID-19 on this diverse, vulnerable population living in commercial facilities. We outline key issues that will predictably arise between nursing homes and EDs in the COVID-19 era. Recommendations including preparing for nursing home ED communication, coordinating hospital and non-hospital-based emergency care, and considerations in acute resource limitation are discussed. Though these issues are universal, evolving solutions are necessarily local. This manuscript may guide conversations and planning now between nursing homes, health care systems, EDs, and state agencies.

BACKGROUND

The initial American nursing home COVID-19 outbreak was noted on February 29th, 2020. As of March 20th, 80% of patients in the home treated positive and 10% of those treated have been hospitalized. While outbreaks have occurred in facilities in other states and are expected to rise. In a recent JAMA article detailing ICU outcomes in a large nursing home cohort, the authors reported that survival is unlikely.
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Dr. Zia Agha
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Dr. Mike Wasserman

President
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Dr. Leah Steinberg

Palliative care consultant
Mount Sinai Hospital
Toronto
Dr. Stacey Levine
and
Dr. Kathleen Unroe
Caring for Older Adults in Nursing Homes during COVID-19

Kathleen Unroe MD, MHA
Nursing Homes and COVID-19

Unfortunately, nursing homes are a perfect storm for this virus.

Typical nursing homes:

• Two residents per room, four residents per bathroom

• Aides care for 10+ residents per shift, nurses care for 20+ residents

• With shared staff and space, contact tracing is difficult

• Vulnerability of residents

Multiple other congregate settings to consider
Nursing Homes are Focused on Protecting Patients

- Limiting visitation and social distancing in facility
- Telehealth provider visits
- Employees screened upon entry
- Additional PPE and hygiene training
- All staff wearing masks
- Monitoring all residents – look for uncommon presentations
- Cohorting/isolating COVID+ residents
Once you have a positive case

- Isolation and cohorting
- Communication (health dept, staff, residents/families)
- Staffing – dedicated staff
- PPE
- Clarity about monitoring, treatment plan and goals
Transferring to the Nursing Home

• Challenging situation to navigate

• States and health systems are handling transfers differently

• Medical professionals are balancing offloading the acute care system with their duty to protect vulnerable residents

[Image: COVID-19: Hospital Hand-Off to Nursing Home]

https://www.optimistic-care.org/docs/pdfs/Hosp_Hand_Off_to_NH_BW.pdf
Transferring to the Hospital

• Critical information is often lost during a transition to the hospital
  • Unsure who to contact
  • Goals of Care are unclear
• Best practice tools and tips have been rapidly modified

Best Practices When Transferring to the Hospital

Decision to transfer a resident to the hospital should be based on:

Clinical considerations
Is the resident clinically stable?
Can we provide the diagnostic tests or treatments needed to care for this resident here?
If COVID-19 is suspected, how will we isolate the resident and do staff have needed PPE?
Goals of care
Any medical orders regarding hospitalization, intubation, code status (such as POST form)?
Have goals been re-addressed in the context of COVID-19?

https://www.optimistic-care.org/probari/covid-19-resources/
COVID-19 and Advance Care Planning Documents

Sending advance care planning documents with residents needs to be a high priority when transferring to another facility or the hospital.

- There is a heightened risk that resident preferences may not be known by other health care providers because of staffing changes and the need to move patients to different care settings.

- It is especially important to document and communicate if a resident has a preference to avoid treatment (e.g. intubation, ventilation, or ICU care). This increases the likelihood preferences will be honored in an emergency.

- Include the name and phone number of the resident’s health care proxy/representative and family members.
Dr. Don Melady and Dr. Adam Perry
When you say, “nursing home,” I hear . . .

- Assisted living
- Long-term care home
- Personal Care
- Acute rehabilitation
- Age in place residence
- Post acute care
- Hospice
- Senior Living
- LTAC
- Group home
- Board and care
- Continuing Care Retirement Community
- Retirement residence
Whisper Down the Lane
Communication Is Revolutionary
Prognosis -- Goals -- Trajectory

- ED Goals Conversations
- Process and Language for COVID
- [https://www.vitaltalk.org](https://www.vitaltalk.org)
- [https://www.capc.org](https://www.capc.org)
- COVID "COMFORT CARE"
Collaborative Dispo Planning: Admit or Return?
Addressing Healthcare needs in Post-Acute and Long-Term Care

PAST, PRESENT, AND FUTURE OPPORTUNITIES

DR. ZIA AGHA, MD
Chief Medical Officer
Where we’ve been

STAR PILOT

Senior Telehealth to Assist Residents (STAR program)

- 3 post-acute and long-term care (PALTC) facilities throughout San Diego with access to:
  - 24/7 Urgent Care visits
  - Geriatrician (*scheduled*)
  - Pharmacy (*scheduled*)
  - Psychiatry (*scheduled*)

PRACTICAL IMPLEMENTATION MANUAL

*The need:* Comprehensive implementation guide incorporating best practices from leading experts

*Topics:* Readiness & Needs assessment, Financial & reimbursement models, Implementation, Legal & Contracting, Policy, Performance Monitoring & Sustainability
Where we are now

SAN DIEGO COUNTY SENIOR EMERGENCY CARE INITIATIVE

Public/private partnership between West Health, County of San Diego, and Hospital Association of San Diego and Imperial County

December 9th, 2019 – All health systems in San Diego County pledged to become more senior friendly by 2021

Become the first county in the country to have the majority of ED’s recognized as senior-friendly

SAN DIEGO COUNTY COVID-19 RESPONSE

Connect PALTC’s with local ED’s to address acute care needs of seniors during the global pandemic
Publicly available resources

Download the free guide: www.westhealth.org/resource/telehealth-paltc-guide

Download the free toolkit: www.westhealth.org/covid-19-resource-center/
Long Term Care Quadruple Aim and ICOS Proposal for COVID-19 Response

Michael Wasserman, MD
Adam Wolk, MD
April 20, 2020
• Congregate living centers are proving **UNSAFE** for high risk community (and post-discharge) COVID-19 patients

• **Growing number** of examples across the US of rapid spread of COVID-19 in senior congregate living settings

• **PPE shortage** exacerbating infection control in high density senior housing/care centers

• **Testing** of staff and suspected cases in residents critical to isolation response
Long Term Care Quadruple Aim for COVID-19 Response

• Stellar Infection Prevention
• Sufficient and properly used PPE
• Readily available testing of staff and residents
• Emergency Preparedness/Incident Command Mode
• Non-hospitalized high risk COVID-19 patients need close monitoring

• Cohort post-discharge and high risk patients in COVID-19 Positive SNFs and Wings

• Reduce healthcare worker risk by concentrating PPE and ramping up training for staff

• Apply Best Practices to enhance outcomes

• Eliminate hospital bottle necks by providing a safe discharge path for high risk COVID-19 patients.
ICOS:  
Infrastructure  
Clinical  
Operations  
Staffing

• **Infrastructure**
  • Utilize existing emergency preparedness capability
  • Incorporate appropriate SNF physical plant info
  • Specific to COVID-19
  • Sufficient PPE
ICOS: Infrastructure Clinical Operations Staffing

- Clinical
  - Virtual Support and Guidance Center disseminating Best Practices
  - Rapid Cycle Expert Information
  - Modified Delphi Process
  - Multidisciplinary approach
ICOS:
Infrastructure
Clinical
Operations
Staffing

• Operations
  • Virtual Support and Guidance Center disseminating Best Practices
  • Incident Command Mode
  • Department Focus
  • Drink through a straw, not a firehose
• **Staffing**
  • Volunteers
  • <Age 65
  • No diabetes/heart disease/or lung disease
  • No immunocompromising conditions
  • Antibody evidence of previous COVID-19 immunity (eventually)
  • Willingness to stay in hotel (and willingness not work anywhere else for the duration of duties)
Dr. Leah Steinberg
At Sinai Health System

Two things we are doing in the ED:

• Embedding palliative care MD into emergency

• Training staff to have GOC conversations
  • Scripts available to support conversations
## Goals of Care Conversation

### Prepare
- Prepare yourself
- know medical information
- not your agenda – it is to guide and support your patient

### Explore
- Explore illness understanding
- Many people don’t understand trajectory of their medical conditions

### Inform
- Give information about illness
- Speak slowly and be clear about impact on life
- Pause often and expect emotional responses

### Values
- Ask about values
- What is most important to you?
- What are you most worried about?

### Recommend
- Make recommendations
I’m calling to tell you about your father…
As you know, he has COVID, he needs oxygen and his blood work shows that he is very sick…
Since he came to the emergency, he is getting worse. His oxygen requirements are increasing…we have increased the amount of oxygen we are giving him. His chest x-ray shows…
I’m worried and want to talk about what we should do now – I’d like to talk to you about taking an approach where we focus on…or prioritize his comfort….that means stopping his blood work…etc…
I wish I had better news (warning)

**Your father has pneumonia and it is very serious** (news)

We are giving him all the treatment possible, but I am worried that **if he doesn’t improve, he may die from this** (meaning)

Wait for the response – let it guide you…
Inform

How: Use few words, pause, wait for response and support response

Why is it important?

Patients are scared – emotions trump cognition every time – listening to you for what is going to happen!
# COVID-19 GOALS OF CARE COMMUNICATION GUIDE FOR CLINICIANS

The aim of a Goals of Care (GOC) discussion is to align available treatment and care options with the patient’s goals and values. This document has been prepared to assist you in communicating with your patients with COVID-19 and their Power of Attorney (POA)/Substitute Decision Maker (SDM).

## STEP | WHAT TO SAY OR DO

### PREPARE YOURSELF & INTRODUCE CONVERSATION:
- Know clinical status
- Know treatment options
- Leave your agenda aside so you can really listen

- Ensure POA/SDM present in-person or virtually
  - “I’d like to make sure you get the best care possible. To do this, we need to have a serious conversation.”

### EXPLORE ILLNESS UNDERSTANDING:
- Listen and clarify

- “What have the doctors been able to share about what is going on?”
- “Tell me what you know about your loved one’s illness.”

### INFORM:
- Fill in any information gaps
- Speak slowly
- Pause often to let information get absorbed
- Expect & respond to emotion with empathetic statements

- “Despite giving your father oxygen, his lungs are getting worse. This makes me concerned that he may die from this infection.”
- “I wish you were able to have visitors. It is too dangerous for them to be here with you now.”

### EXPLORE YOUR PATIENT’S VALUES:
- Ask about:
  - Goals and values
  - Hopes, fears and worries

- “What concerns or worries do you have about what lies ahead for you?”
- “What do you think would be most important for you father now?”
- “What else should we know about your father to take best care of him now?”

### RECOMMEND & DOCUMENT A PLAN:
- Based on your clinical assessment AND patient goals, recommend a treatment plan

- “You’ve said your goal is to live long enough to see your brother who is coming to visit from overseas”...“I think we can work together on that...I’d suggest treating...and also I wonder when your brother is coming...that sounds important...can I help with that?”
- “Your goal is to focus on comfort and being near family... in that case, I’d recommend...”
Dr. Leah Steinberg

Palliative Care Physician,
Mount Sinai Hospital,
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