GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

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

Please visit gedcollaborative.com

COVID-19 Resources gedcollaborative.com/article/covid-19-resources/

EXPERT PANEL

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THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

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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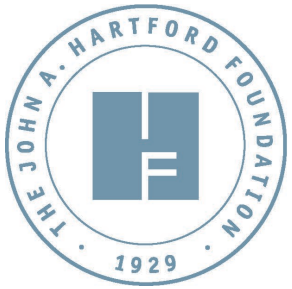

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Zoom Webinar Pointers

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

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

Geriatric Emergency Department Collaborative
April 20, 2020

@theGEDC

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

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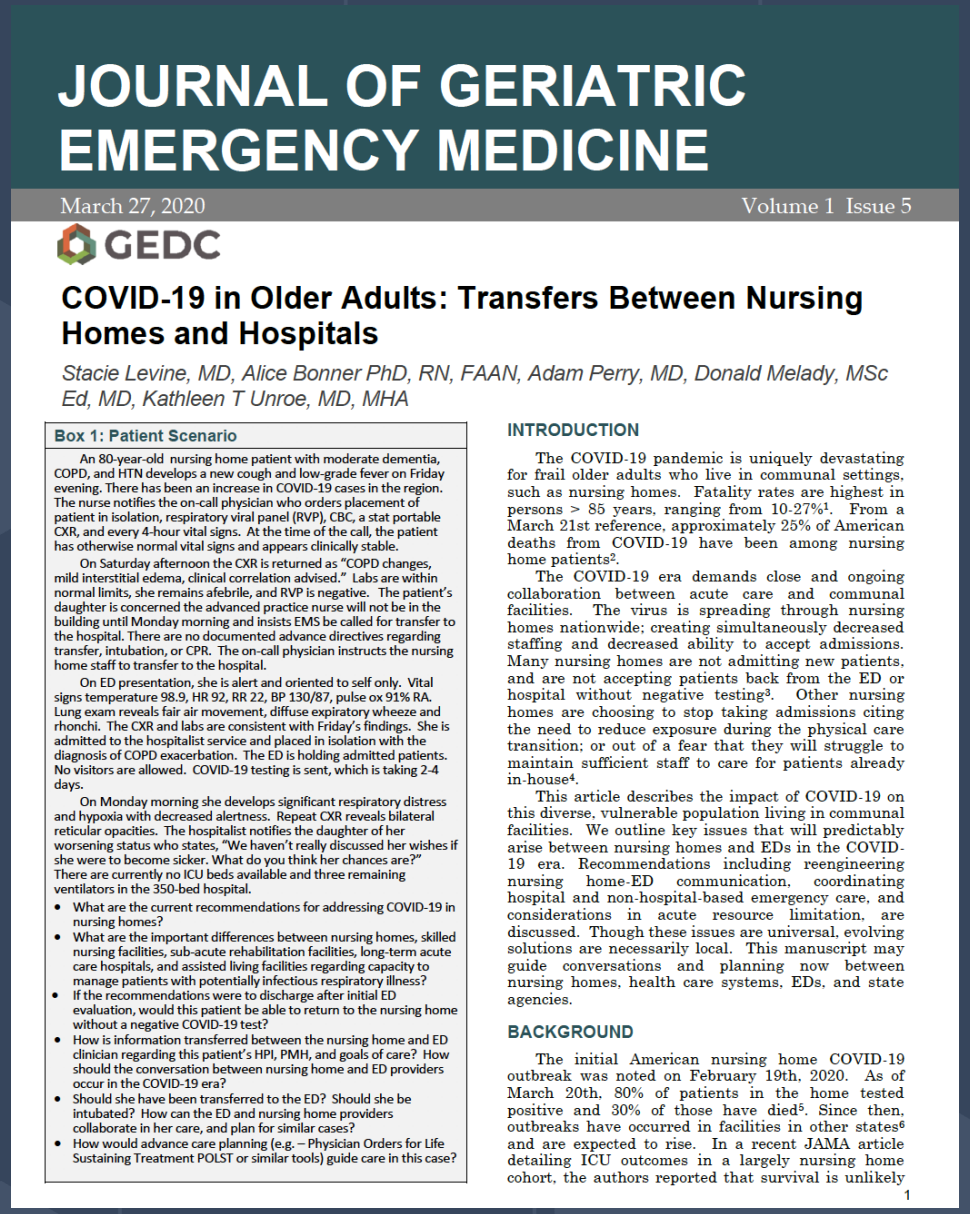
Journal of Geriatric Emergency Medicine

gedcollaborative.com/article/jgem-volume-1-issue-5/



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GEDC

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

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

Box 1: Patient Scenario

An 80-year-old nursing home patient with moderate dementia, COPD, and HTN develops a new cough and low-grade fever on Friday evening. There has been an increase in COVID-19 cases in the region. The nurse notifies the on-call physician who orders placement of patient in isolation, respiratory viral panel (RVP), CBC, a stat portable CXR, and every 4-hour vital signs. At the time of the call, the patient has otherwise normal vital signs and appears clinically stable.

On Saturday afternoon the CXR is returned as "COPD changes, mild interstitial edema, clinical correlation advised." Labs are within normal limits, she remains afebrile, and RVP is negative. The patient's daughter is concerned the advanced practice nurse will not be in the building until Monday morning and insists EMS be called for transfer to the hospital. There are no documented advance directives regarding transfer, intubation, or CPR. The on-call physician instructs the nursing home staff to transfer to the hospital.

On ED presentation, she is alert and oriented to self only. Vital signs temperature 98.9, HR 92, RR 22, BP 130/87, pulse ox 91% RA. Lung exam reveals fair air movement, diffuse expiratory wheeze and rhonchi. The CXR and labs are consistent with Friday's findings. She is admitted to the hospitalist service and placed in isolation with the diagnosis of COPD exacerbation. The ED is holding admitted patients. No visitors are allowed. COVID-19 testing is sent, which is taking 2-4 days.

On Monday morning she develops significant respiratory distress and hypoxia with decreased alertness. Repeat CXR reveals bilateral reticular opacities. The hospitalist notifies the daughter of her worsening status who states, "We haven't really discussed her wishes if she were to become sicker. What do you think her chances are?" There are currently no ICU beds available and three remaining ventilators in the 350-bed hospital.

- What are the current recommendations for addressing COVID-19 in nursing homes?
- What are the important differences between nursing homes, skilled nursing facilities, sub-acute rehabilitation facilities, long-term acute care hospitals, and assisted living facilities regarding capacity to manage patients with potentially infectious respiratory illness?
- If the recommendations were to discharge after initial ED evaluation, would this patient be able to return to the nursing home without a negative COVID-19 test?
- How is information transferred between the nursing home and ED clinician regarding this patient's HPI, PMH, and goals of care? How should the conversation between nursing home and ED providers occur in the COVID-19 era?
- Should she have been transferred to the ED? Should she be intubated? How can the ED and nursing home providers collaborate in her care, and plan for similar cases?
- How would advance care planning (e.g. – Physician Orders for Life Sustaining Treatment POLST or similar tools) guide care in this case?

INTRODUCTION

The COVID-19 pandemic is uniquely devastating for frail older adults who live in communal settings, such as nursing homes. Fatality rates are highest in persons > 85 years, ranging from 10-27%[1]. From a March 21st reference, approximately 25% of American deaths from COVID-19 have been among nursing home patients[2].

The COVID-19 era demands close and ongoing collaboration between acute care and communal facilities. The virus is spreading through nursing homes nationwide; creating simultaneously decreased 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[3]. Other nursing homes are choosing to stop taking admissions citing the need to reduce exposure during the physical care transition; or out of a fear that they will struggle to maintain sufficient staff to care for patients already in-house[4].

This article describes the impact of COVID-19 on this diverse, vulnerable population living in communal facilities. We outline key issues that will predictably arise between nursing homes and EDs in the COVID-19 era. Recommendations including reengineering 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 19th, 2020. As of March 20th, 80% of patients in the home tested positive and 30% of those have died[5]. Since then, outbreaks have occurred in facilities in other states[6] and are expected to rise. In a recent JAMA article detailing ICU outcomes in a largely nursing home cohort, the authors reported that survival is unlikely

1

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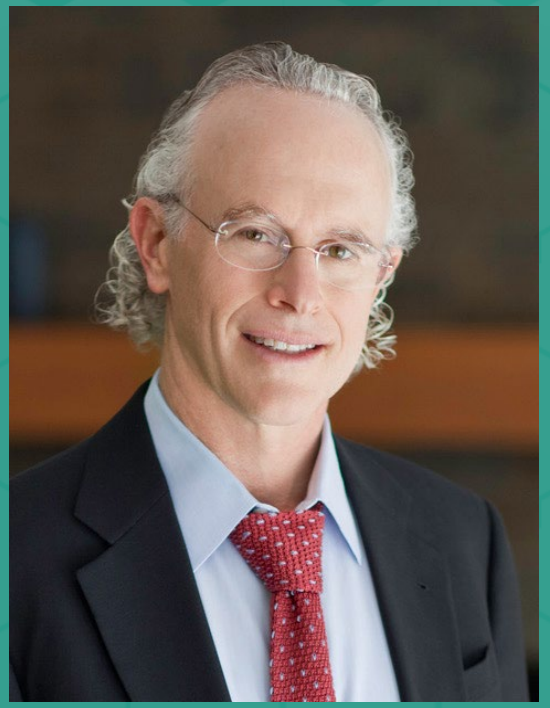

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Dr. Stacey Levine
and
Dr. Kathleen Unroe

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

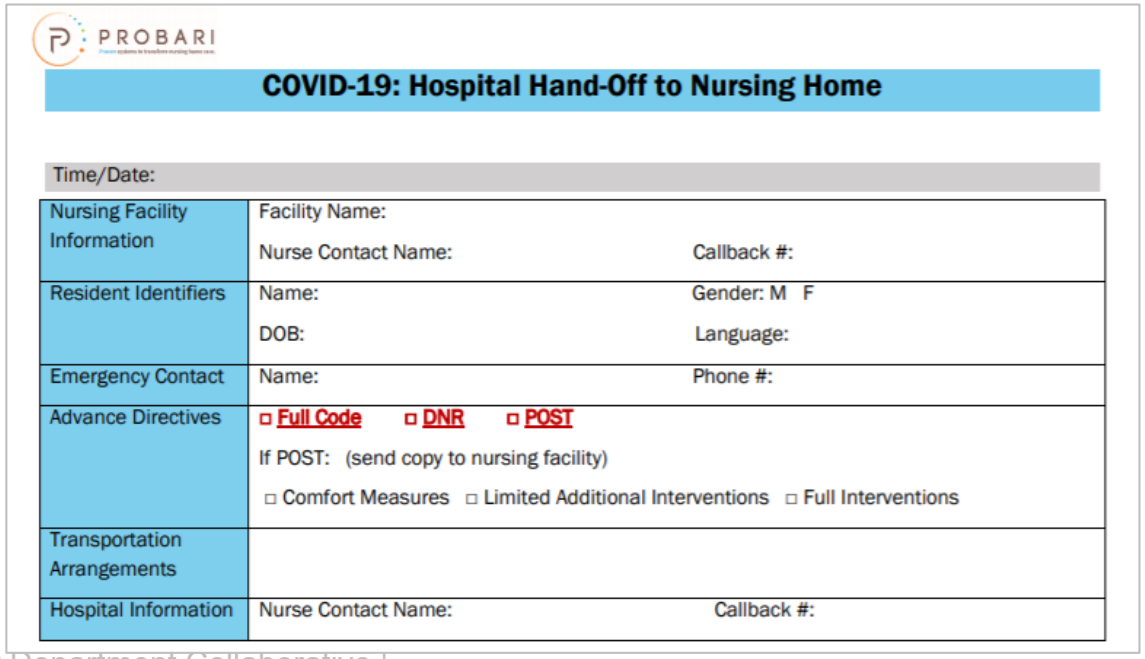
- ❑Limiting visitation and social distancing in facility
- ❑Telehealth provider visits
- ❑Employees screened upon entry
- ❑Additional PPE and hygiene training
- ❑All staff wearing masks
- ❑Monitoring all residents – look for uncommon presentations
- ❑Cohorting/isolating COVID+ residents

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



PROBARI

COVID-19: Hospital Hand-Off to Nursing Home

Time/Date:

Nursing Facility Information	Facility Name: Nurse Contact Name:	Callback #:
Resident Identifiers	Name: DOB:	Gender: M F Language:
Emergency Contact	Name:	Phone #:
Advance Directives	☐ Full Code ☐ DNR ☐ POST If POST: (send copy to nursing facility) ☐ Comfort Measures ☐ Limited Additional Interventions ☐ Full Interventions	
Transportation Arrangements		
Hospital Information	Nurse Contact Name:	Callback #:

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

PROBARI

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?

PROBARI

Assessment Form

Symptoms in red & underlined are potential COVID-19 relevant risk factors or indicators.
Use this for patient assessment before calling medical provider.

Resident Name_____ **Condition Change**_____

Associated medical conditions include *(check all that apply)*

- ☐ CHF
- ☐ chronic pressure ulcer
- ☐ diabetes
- ☐ ESRD/hemodialysis
- ☐ HTN
- ☐ CAD or hx of MI
- ☐ COPD/asthma
- ☐ Dementia
- ☐ Hospitalized within past 30 days
- ☐ Surgery within past 30 days
- ☐ Other _____

☐ Full code ☐ DNR ☐ Do not hospitalize

Goals of Care	Antibiotic Use	Artificial Nutrition
⌋ Comfort Measures ⌋ Limited Intervention ⌋ Full Intervention	⌋ Use antibiotics only if comfort cannot be achieved fully through other means ⌋ Use antibiotics consistent with treatment goals	⌋ No artificial nutrition ⌋ Defined trial of artificial nutrition ⌋ Long-term artificial nutrition

Temp	Pulse	Resp. Rate	O2 Sat	On O2 ?	B/P	Blood Sugar	Weight/ Change?	Most recent BM

Symptom-Based Exam Guide	
If presenting this symptom:	Do this assessment:
Abdominal pain or Nausea/Vomiting/Diarrhea/ Constipation	Abdominal/Genital/Urinary
Chest pain	Lungs/Heart
Cough or Shortness of breath	Lungs/Heart
Altered mental status	Full Exam
Fever	Full Exam
Rash/ Itching	Skin
Facial droop/ arm or leg weakness, or headache/ blurry vision	Neurological
Leg swelling	Lungs/Heart/Skin
Hematuria or vaginal discharge	Genital/Urinary
Fall	Neurological/Skin
Muscle or Joint Pain	Musculoskeletal

Mental Status/Mood/Behavior

- ⌋ *not pertinent*
- ⌋ depressed
- ⌋ agitated
- ⌋ malaise/fatigue
- ⌋ nonresponsive
- ⌋ withdrawn
- ⌋ increased aggression (*physical or verbal*)
- ⌋ personality change
- ⌋ restless
- ⌋ hallucinations (*worse or new*)
- ⌋ increased confusion
- ⌋ lethargy

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

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 . . .

Long-term care home

Assisted living

Personal Care

Acute rehabilitation

Age in place residence

Post acute care

Hospice

Senior Living

LTAC

Group home

Retirement residence

Board and care

Continuing Care Retirement Community

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Whisper Down the Lane

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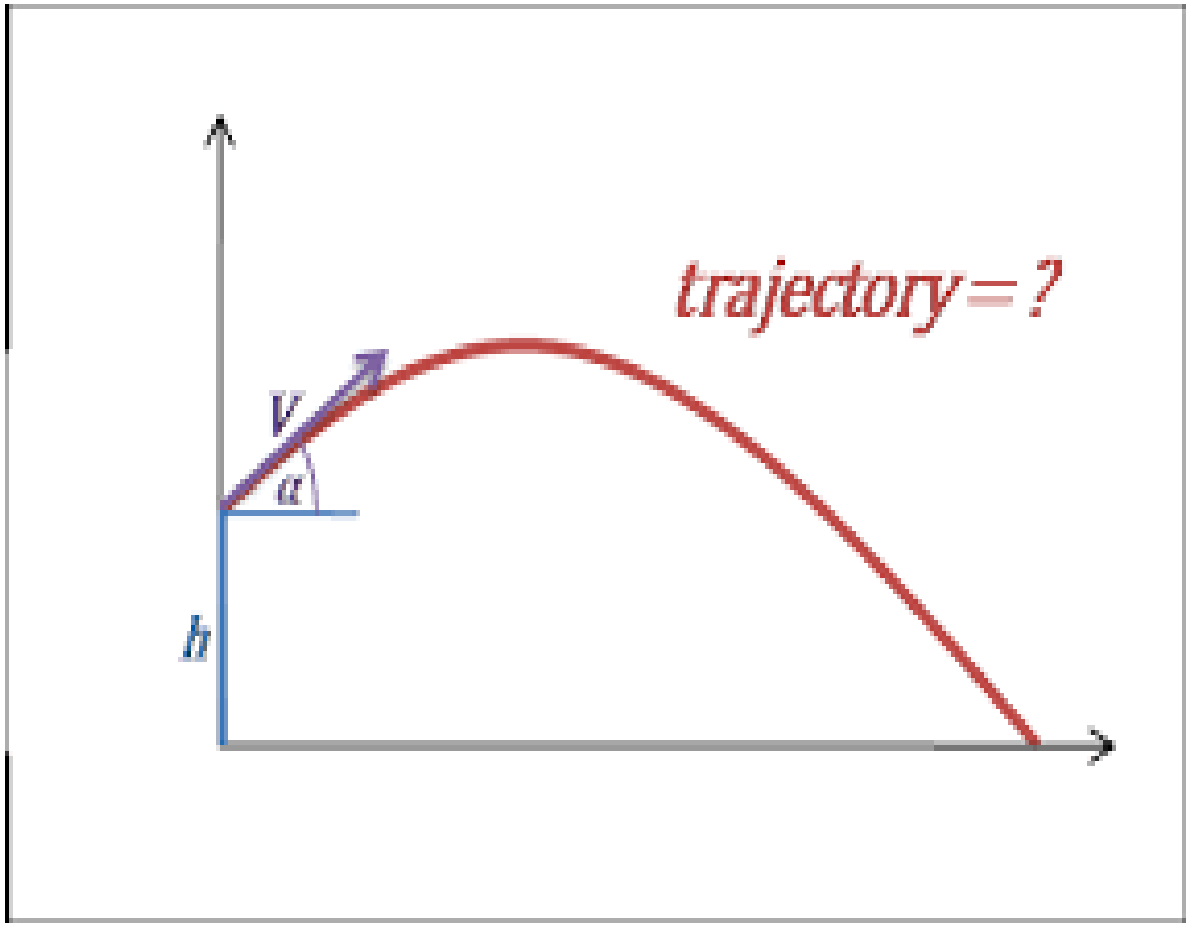
Communication Is Revolutionary

Prognosis -- Goals -- Trajectory



- ED Goals Conversations
- Process and Language for COVID
- https://www.vitaltalk.org
- https://www.capc.org
- COVID ”COMFORT CARE”
- https://emottawablog.com/2020/03/end-of-life-care-in-the-ed-related-to-covid-19/

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Collaborative Dispo Planning: Admit or Return?

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Dr. Zia Agha

Addressing Healthcare needs in Post-Acute and Long-Term Care

PAST, PRESENT, AND FUTURE OPPORTUNITIES

DR. ZIA AGHA, MD
Chief Medical Officer

westhealth

Where we've been

STAR PILOT

Senior **T**elehealth to **A**ssist **R**esidents (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

UC San Diego Health

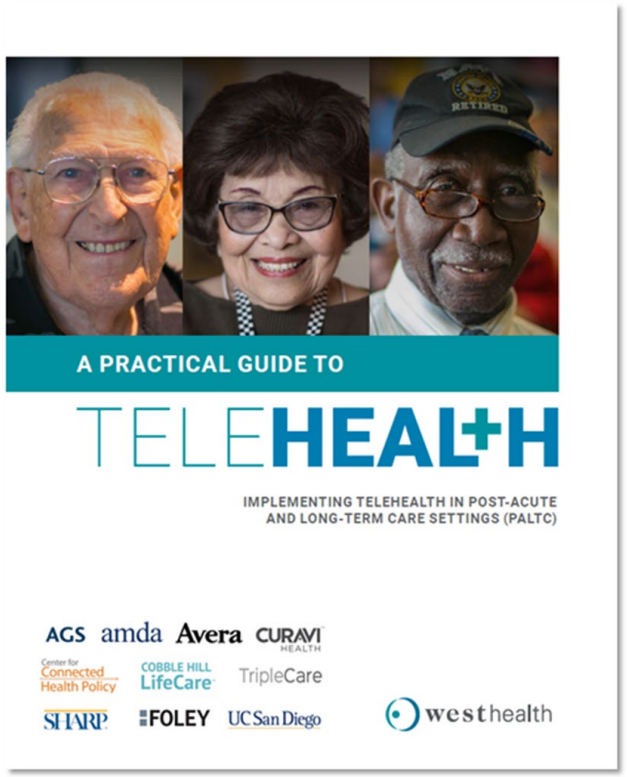
Alvarado Hospital Medical Center

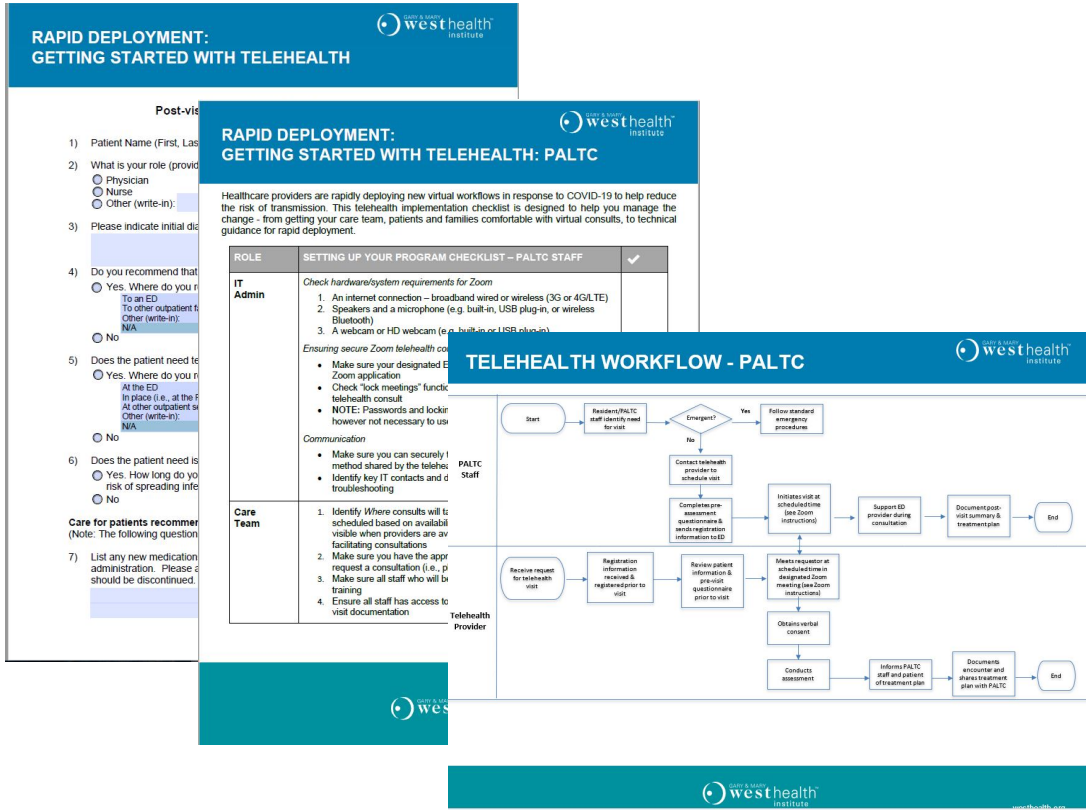
front porch

SERVING SENIORS

SEACREST VILLAGE RETIREMENT COMMUNITIES

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/

Dr. Mike Wasserman

Long Term Care Quadruple Aim and ICOS Proposal for COVID-19 Response

Michael Wasserman, MD

Adam Wolk, MD

April 20, 2020

Background

- 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

Proposal

- **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

ICOS: Infrastructure Clinical Operations **Staffing**

- **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

Sinai Health System

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

Sinai Health System

Inform: 92-year-old with pneumonia

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…

Sinai Health System

Inform: Headline and meaning

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…

Sinai Health System

Inform

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

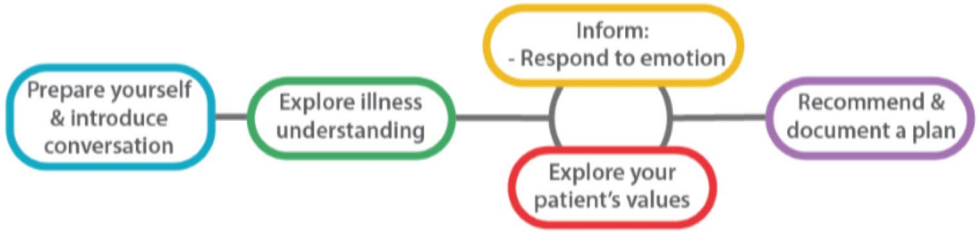
Why is it important?

Patients are scared – emotions trump cognition every time – listening to you for what is going to happen!

Sinai Health System

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..."

HPCO Speak Up

Sinai Health System

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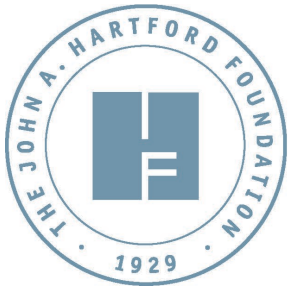

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