Brief Overview: Advance Care Planning in Geriatric Population Amid COVID19 Pandemic

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Why ACP is important during the COVID19 pandemic?

- COVID-19 is spreading in our community (even though it’s getting slow in HI thanks to social distancing)
- The geriatric population is high risk for becoming severely ill if they got COVID-19.
  - These patients typically become very ill rapidly (i.e. in hours to days)
- Congregate senior living settings are especially vulnerable for the rapid spread of infection
- Care situation in hospital and nursing homes changed significantly
  - No visitors policy
  - They may die alone in hospital
  - Communication barriers between staff and families
  - They may get COVID while they are in hospital
- Hope for the best, prepare for the worst
Preparring for COVID-19: Three Things to Know

1. Pick someone to be your health care decision-maker.
   Choose someone you trust to make decisions for you if you become too sick to make them yourself.

2. Talk about what matters most to you.
   Talk to those who matter most to you about what matters most to you.

3. Think about what you would want if you became seriously ill with COVID-19.
   Think about what worries you most about becoming seriously ill, what's most important to you, and what kind of treatments you would want.
Advance Care Planning Specific to COVID-19
(What would you want if you become seriously ill from COVID-19?)

- Especially recommended for patients with high risk
  - Any patient who you believe would NOT benefit from resuscitation and/or critical care.
  - Surprise question: “Would I be surprised if this patient died in the next year?”

- This conversation should include advanced providers (doctors, APRNs)

- Things to be specifically addressed
  - Hospitalization
  - Intubation
  - CPR

- Should incorporate not only patients’ preferences/values but also patient’s current condition, prognosis, available care options

- POLST forms are helpful to secure orders
(If you are not a doctor or APRN)
How Can You Assist the Conversation?

- Review existing document in the file
  - POLST
- Confirm the contents of the documents
- Help to designate HC-POA
- Help to explore what matters most
- Encourage/facilitate conversation about treatment preference for COVID-19
How to Honor Previously Determined Preferences for Care

Reminder of previously documented decisions

Do you remember talking with your healthcare professional about the type of medical care you would want if you were to become very sick?

-or-

Do you remember completing a POLST (and/or Advance Directive)?

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<td>Have your wishes changed since then?</td>
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Align preferences and medical situation

I respect that you are now feeling differently...

I worry that we are now in a place where we need to act on these decisions.
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?”
(Just listen)

Lay out issues

“How is something I want us to be prepared for.” / “You mentioned COVID. I agree.”
“Is there anything you want us to know if you got COVID / if your COVID gets really bad?”
Motivate them to choose a proxy and talk about what matters

“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?)
Make a recommendation—if they would be able to hear it. “Based on what I’ve heard, I’d recommend [this]. What do you think?”

Expect emotion

Watch for this – acknowledge at any point
“This can be hard to think about.”

Record the discussion

Any documentation—even brief—will help your colleagues and your patient
“I’ll write what you said in the chart. It’s really helpful, thank you.”
C – Check for comprehension
  o “I had a chance to read your chart and talk to the other doctors involved in your care. It would help me, however, if you could tell me what the other doctors are saying.”
  o “What have the doctors told you might happen with this infection?”

P- Permission to proceed
  o “One of the things I like to do with all patients in the hospital is talk to about what if they get sicker. That allows me to make sure the care is focused on their values. Would it be ok if we spend a couple of minutes talking about what if you get a lot sicker?”

R- Restrict the conversation to CPR
  o “If something should happen and cause your heart to stop and you stopped breathing, regardless of what doctors do, there is only a 10% chance of you getting out of the hospital home and a 90% chance of dying. Some people wouldn’t want to go through all the machines, being in the ICU and CPR. They would say ‘Just keep me comfortable and let me go.’ Other people would say, ‘I would be willing to go through anything for a chance to get through this and get home. “What kind of person are you?””
What Do These Mean in COVID Crisis?

- **DNR/DNI**
  - Reassure that pt’s symptoms are to be managed

- **No hospital transfer**
  - Review the facility policy (Can pt stay in the facility? Needs to be transferred?)
  - How the symptoms will be managed in the facility?
  - Can pt be referred to hospice if appropriate?
  - Can family visit pt if they are near the end?
  - Can pt stay home? How to control infection spread at home?

- **Full treatment**
  - Explain to pt what to expect if pt is admitted to hospital
  - No visitors
  - May not survive and die alone
  - May die while on a machine
Take Home Message

- ACP conversations specific to COVID (COVID-ACP) are important especially for high risk patients
- COVID-ACP needs to involve patients, HC-POA and doctors (or APRNs)
- CPR, (intubation), and hospital transfer need to be addressed in COVID-ACP (POLSTs are helpful)
- Other IDT members can do a lot to facilitate COVID-ACP
Things to Keep in Mind

● Always involve HC-POA in ACP
  ○ Regardless whether pt has capacity or not
  ○ Have them on phone (or telemedicine) while having conversations if appropriate

● HC-POA’s role is to be the voice of the patient
  ○ Do: “What would the patient say if they could speak?”
  ○ Don’t: “What do you want?”

● Empathy is the key (NURSE statement)
  ○ Family is already nervous by not being able to see their loved ones

● Reassure them that you are not giving up
  ○ Emphasize on what you “Do” rather than listing what you “Don’t”
  ○ You are doing this conversation to honor their wishes

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<td>Naming</td>
<td>“It sounds like you are frustrated”</td>
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<td>Understanding</td>
<td>“This helps me understand what you are thinking”</td>
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<td>Respecting</td>
<td>“I can see you have really been trying to follow our instructions”</td>
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<td>Supporting</td>
<td>“I will do my best to make sure you have what you need”</td>
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<td>Exploring</td>
<td>“Could you say more about what you mean when you say that…”</td>
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Decision-Making Capacity

- Capacity refers to the ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one’s own values and preferences (from UpToDate)
- Capacity is specific to topic and time
- Composed of four components (understanding, expression, reasoning, appreciation)
- Many nursing home residents lack capacity for complex medical decision-making (e.g. CPR, ICU admissions)
- If the patient does not have capacity, the patient should not be asked to make the decision. In that case, HC-POA will be the decision maker.