Session 11: Advance Care Planning during COVID-19

Key Takeaways:	
Person-centered (when possible, person-directed) goal-setting and advance care planning (ACP) are essential components of being prepared for and responding to COVID-19. This may include decisions about resuscitation, intubation, use of a feeding tube, dialysis, hospital transfer and other aspects of care and support. **Many people with COVID-19 have never been asked about their own goals, how they would like to be treated if they develop a serious or life-threatening illness, or about their end-of-life wishes.** **Part of ACP may involve a discussion of whether or not the person would want to be transferred to a higher level of care (e.g., hospital) if their condition worsens.** **Communication regarding palliative care options may enable some residents to be treated in the nursing home.** **Having leaders visible on units and supporting staff conducting ACP promotes communication and accountability.** **The following question set can be used to facilitate discussions and reveal opportunities across and within key members of interprofessional teams, residents and visitors. Please consider using/adapting them in your next huddles or team meetings.**	
Resources and Questions by Content	
Examples of Resources for Advance Care Planning	- Ariadne Labs Serious Illness Care Program: COVID-19 Response Toolkit (a guide for long-term care, implementation tips, and a demonstration video) - Respecting Choices COVID-19 Resources (for having conversations with older adults when planning care for COVID-19) - National POLST: Long-Term Care Facility Guidance for POLST and COVID-19 "What Matters" to Older Adults?: A Toolkit for Health Systems to Design Better Care with Older Adults - The Conversation Project and "Conversation Ready" - Create Your Care Plan: https://www.lgbtagingcenter.org/resources/resource.cfm?r=879 - My Personal Directions for Quality Living: https://www.lgbtagingcenter.org/resources/resource.cfm?r=916 - Go to the Hospital or Stay Here? A Nursing Home Guide: http://decisionguide.org/ Are there written materials and resources to support teams in having advance care planning conversations with residents and/or 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?
Key Concepts by Stakeholder Group	
What do Medical Directors Need to know and discuss with the team?	Medical directors must be familiar with updated resources such as those listed above. They must also be familiar with the most up-to-date published guidance and recommendations from CMS and State Departments of Public Health. Medical Directors must be prepared to respond to questions from attending physicians and other primary care providers, the Director of Nursing and/or Administrator, residents and care partners or family members.
What do DONs and nursing supervisors need to know?	DONs must have a system for assessing and monitoring staff knowledge and skills related to ACP and communication with primary care providers, residents, and care partners or family members. DONs must assess frequency and content of communication and updates among staff, residents, care partners or family members.
What does the interprofessional team need to know?	Team members must know where to find updated resources on ACP. Nursing Home policies should address ACP conversations with new admissions, readmissions, change in resident condition, monthly reviews/visits, or at the resident or health care proxy's request. Team members must consistently and reliably demonstrate that they document and report any concerns to their supervisor or leadership in a timely manner.