Virginia Long-Term Care Clinician Network Monthly Forum

November 20, 2024

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care.

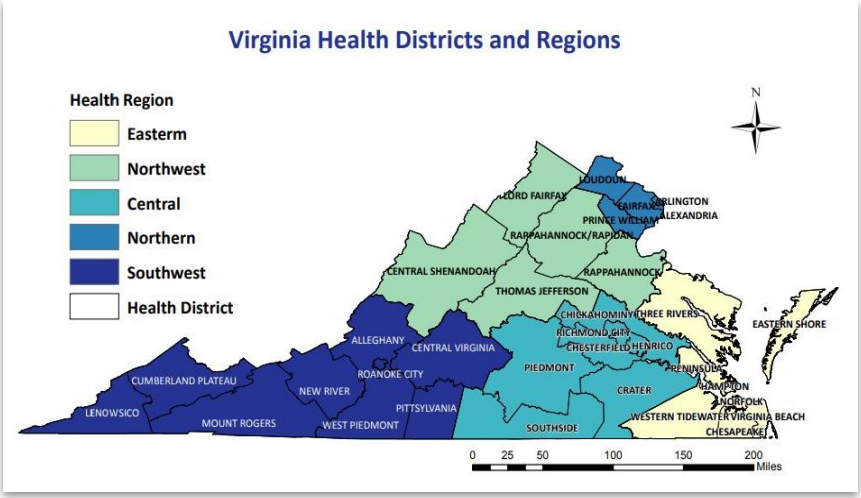
Please use the chat box:

- **Your name, practice and areas of practice**
- **Favorite hike/walk in Virginia**

Welcome New Members!

Alisha Shields, LPN - Central Region

Invite your work colleagues to join so they can get Education, Support and CME



For great resources: look for previous slide sets and newsletters under *Forums & Events* and *Resources* on our website.

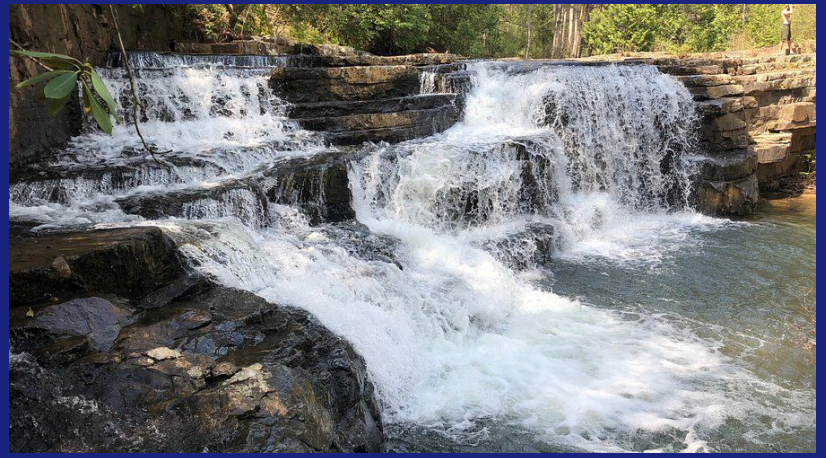
ltccn.vcu.edu

Chat Waterfall

In Chat, respond to the question below, but don't hit the send button yet! Wait for the countdown…

How long does it usually take to discuss DNH, CPR or similar decision making with a new admission?

1. 20-30 minutes
2. 31-45 minutes
3. over 45 minutes



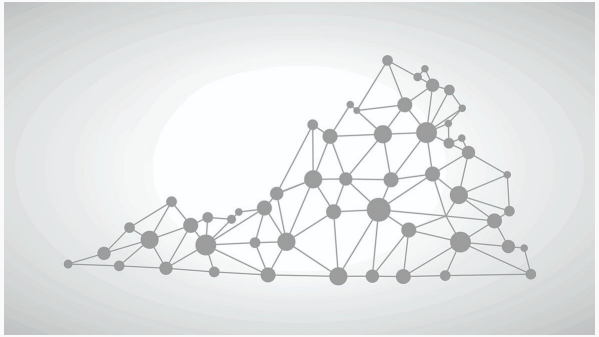
Dismal Falls
Bland, Virginia

ePrognosis Calculator
https://eprognosis.ucsf.edu/calculators/

Poll

What outside medical specialist do you partner with most for LTC residents?

A. Cardiology
B. Pulmonology
C. Renal
D. Urology
E. Other (chat in)



CAPACITY DETERMINATION IN THE LONG-TERM CARE AND POST-ACUTE SETTING

Jim Wright, MD PhD, CMD
Medical Director, Lakewood Manor,
Richmond, VA

SPEAKER DISCLOSURES

Dr. Wright has no relevant financial relationships to report.

LEARNING OBJECTIVES

By the end of the session, participants will be able to:

1. Name the four required elements of capacity
2. Determine capacity in common situations in the PALTC setting
3. Develop practical skills in Advance Directive discussions in the PALTC setting

CAPACITY DETERMINATIONS

- Early Discharges
- Advance Directives
- Financial Capacity in LTC

Competency vs. Capacity

Competency is a *legal determination*.

Capacity is a *medical determination*.

CAPACITY IS DECISION SPECIFIC

Decision specific

Risk/ benefit determines threshold for capacity

One may have decisional capacity for simple decisions like flu vaccine, but not for complicated decisions such as choosing chemotherapy for cancer

Racine CW, Billick SB. Journal of Psychiatry & Law 2012;40:243-263.
Moberg PJ, Kniele K. Applied Neuropsychology 2006;13(2):101-114.

CAPACITY IS TIME SPECIFIC

Time specific

Capacity may be lost or regained depending on illness, medication side effects.
No capacity today? They may have capacity next week (or tomorrow)!

4 ELEMENTS OF CAPACITY

- Communication: Must be able to communicate a choice
- Understanding: must be able to recall conversations about treatment
- Appreciation: must appreciate how it affects the patient
- Reasoning: patient needs to be able to weigh the risks and benefits

THE ACE: AID TO CAPACITY EVALUATION

Strengths

- Measures all four elements of capacity:
- Quick (10-15 mins)
- Available online for free

http://www.jcb.utoronto.ca/tools/documents/ace.pdf

AID TO CAPACITY EVALUATION

- Each Question

❑ Yes
❑ No
❑ Unsure
❑ Other impressions

- Final Outcome

❑ Definitely Capable
❑ Probably Capable
❑ Probably Incapable
❑ Definitely Incapable

AID TO CAPACITY EVALUATION

1. Medical Problem
2. Proposed Treatment
3. Alternative
4. Options for refusing proposed treatment?
5. Consequences of accepting proposed treatment?
6. Consequences of refusing proposed treatment?
7. Is the decision influenced by psychosis or depression?

DETERMINING CAPACITY IN EARLY DISCHARGES

THE CASE OF MR. G

- 58 year old male with peripheral arterial disease
- Osteomyelitis of left foot, admitted on IV Zosyn and IV vancomycin for 6 weeks
- Has been caught smoking in the parking lot twice and in his room once, cigarettes and lighter have been removed from his room.
- Following confiscation of his cigarettes, he demands to be discharged
  - “I’m not staying in this god(forsaken) place another minute”

THE CASE OF MR. G

- Physician says “I’m worried about you, Mr. G. Do you know why?”
- Mr. G says “My blankety-blank foot is infected. Y’all want to give me antibiotics and you think that my foot’s going to fall off or I’ll die if I don’t take them or something like that!”
- Physician: “that’s exactly right – so why do you want to leave?”
- Mr. G – “I’m going to go someplace where I can smoke. And if I can’t smoke, I’m not going to take those blankety blank antibiotics!”

4 ELEMENTS OF CAPACITY

- Communication: Must be able to communicate a choice
- Understanding: must be able to recall conversations about treatment
- Appreciation: must appreciate how it affects the patient
- Reasoning: patient needs to be able to weigh the risks and benefits

DOES MR. G HAVE CAPACITY?

- Was he able to communicate a choice?
- Did he express understanding of the treatment options for the disease?
- Did he appreciate how it could affect him?
- Did he give reasons for his decision and acknowledge the risk/benefit?

DIGRESSION #1:
NAVIGATING EARLY DISCHARGES (AND MAYBE PREVENTING ONE)

1. Patients are at your facility because they have consented to treatment. An early discharge is simply a withdrawal of that consent.
2. Acknowledge patient **autonomy** – they can always “leave anytime you want” (this is the first thing I say).
3. Remind them that someone thought (the doctors at the hospital) they might be too weak to go home immediately and a short stay in your facility can prevent a return to the hospital.

4. Acknowledge their **autonomy** – let them know that your role is only to offer them expert advice. It is up to them to accept it or not

5. BUT: autonomy and capacity are linked. A patient can't make an informed decision if they don't have capacity. YOU MUST DETERMINE AND DOCUMENT CAPACITY IN YOUR ENCOUNTER NOTE.

6. If a patient leaves early, the best protection for your patient and yourself is to make the discharge as safe as possible. Get home health involved, do a quick discharge note and give to patient, call in meds, have your unit secretary make necessary follow up appointments.

CAPACITY IN ADVANCE DIRECTIVES

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

☐ 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

☐ 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

☐ A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

☐ B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

☐ C. The patient has not executed a written advanced directive (living will or durable power of attorney for healthcare). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name	Physician's Signature	Emergency Phone Number

Patient's Signature	Signature of Person Authorized to Consent on the Patient's Behalf

Copy 2 – To be kept in patient's permanent medical record

CAPACITY IN ADVANCE DIRECTIVES DETERMINATION

- Capacity for Code Status:
  - “CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment”
  - Specifically: “cardiopulmonary resuscitation (**cardiac compression**, endotracheal **intubation** and other advanced airway management, artificial ventilation, **defibrillation**, and related procedures)”

CAPACITY IN ADVANCE DIRECTIVES DETERMINATION

- Capacity for Code Status:
  - When in doubt, make sure POA is on the same page (make that phone call!)

DIGRESSION #2:
AD DISCUSSIONS

CAPACITY IN ADVANCE DIRECTIVES DETERMINATION

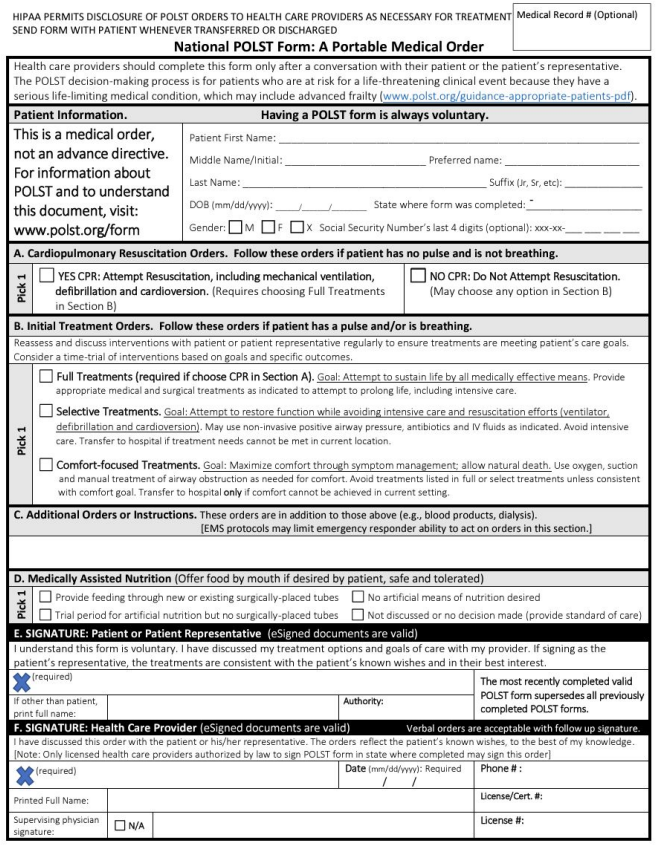
- Make it simple!
- Upon admission to PA Facility you are interested in 2 things:
  - Code Status
  - Hospitalization Status
- Avoid unnecessary complications in AD discussion
  - POLST – a good example of unnecessary complexity

POLST: Unnecessarily complicated for PALTC

Code Status

Hospitalization Status

It's like asking: "if you get sick, do you want antibiotics?"



HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) Date (mm/dd/yyyy): Required / / Phone # :

Printed Full Name: License/Cert. #:

Supervising physician signature: ☐ N/A License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

MY TECHNIQUE FOR AD DISCUSSIONS

- I want to make sure that no matter what happens, we're going to abide by your wishes ("we're going to do whatever you want us to do")
- Start with code status:
  - Don't alarm them ("we want to make sure we know the wishes of every person we're taking care of"), maybe defer till your second visit if you're still building trust.
  - Make sure they understand that the DNR form is a very limited document: "it's only for when your heart stops. If you get sick, you can still go to the hospital, you can still go to the ICU with a DNR".

MY TECHNIQUE FOR AD DISCUSSIONS

- “We need to know your code status”
- A code status is how to tell us what you want us to do if your heart stops beating and you stop breathing (or, “if we find you lifeless”).
- YOU HAVE 2 CHOICES:
  - either full code, where we would start chest compressions, call 911 and they could put you on a mechanical ventilator
  - Or do not resuscitate, where we would not start chest compressions, we would not call 911, and they would not put you on the mechanical ventilator
- Have you thought about this before? If so, have you made a decision?

MY TECHNIQUE FOR AD DISCUSSIONS

- We would assume you want to be full code unless you tell us differently
- Helpful nudges if needed:
  - You are not being monitored 24 hours a day. Understand that if your heart stops, it might be 30 minutes to an hour before we find you
  - If you've ever said "I don't want to be a vegetable on the ventilator, this is one way to protect yourself from that."

MY TECHNIQUE FOR AD DISCUSSIONS

- Hospitalization status (I usually ask this only for high risk of decline):
  - If something happens and you get really sick and you're not responding to what we're doing, we normally would assume that you would want to go back to the hospital. But sometimes people no longer want to go to the hospital, even if they might be dying of a disease. We call that comfort care or even hospice care. I wanted you to know that if you don't want to go back to the hospital, we can keep you here, even if you pass away from whatever's going on.
  - (again) We would assume you would want to go to the hospital, but I want you to let me know if you no longer want to go, and we'll do whatever you want.
  - Have you thought about this before or made any decisions about this?
  - You don't have to ask this if someone is full code, btw.

WHAT IF YOU'RE UNSURE?

- Call that POA!

WHAT IF THEY DON'T HAVE CAPACITY OR A POA?

- Facility can have a guardian ad-litem appointed
  - Relatively rare, an unwanted cost for facility
  - Usually appointed outside of facility (hospital)
- When in doubt, FULL CODE

FINANCIAL CAPACITY

WHY ARE WE THE ARBITERS OF SOMEONE'S FINANCIAL CAPACITY?

- Why are we asked to determine whether someone needs a particular type of wheelchair???
- Who else is going to do it?

IF YOU WANT TO BE SUPER THOROUGH…

- Clinical Interview Assessment of Financial Capacity in Older Adults with Mild Cognitive Impairment and Alzheimer's Disease

  J Am Geriatr Soc. 2009 Apr 21;57(5):806–814.

AUTHORS' CONCLUSION

"Financial capacity shows mild impairment in MCI, emerging global impairment in mild AD, and advanced global impairment in moderate AD"

MY ADMITTEDLY INFORMAL APPROACH

- Do they have moderate or worse dementia and are they in a LTC facility?
  - Chances are that they are unable to manage their finances
- MCI and mild dementia: can probably manage finances

4 ELEMENTS OF CAPACITY

- Communication: Must be able to communicate a choice
- Understanding: must be able to recall conversations about treatment
- Appreciation: must appreciate how it effects the patient
- Reasoning: patient needs to be able to weigh the risks and benefits

THANK YOU

Jim Wright
804-543-2120
wrightj@lakewoodwestend.org

Open Forum

Any questions or ideas from the talk?

Share a unidentifiable case to discuss

Driving between Virginia facilities? Get some CME-

GeriPal PODCAST

https://geripal.org/geripal-podcast/

Registration Open: Are you presenting at a meeting? Let us know!

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
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Submit Attendance

1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: *within **5** days of the event)* **#####**

Complete Evaluation & Claim Credit, *(within 60 days of the event)*

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

Thank you for joining us!

Updates and News - See News Updates via email

Next Monthly Forum: Wednesday, December 18, 2024, 4-5 pm Diabetes Management: An Update on GLP-1 and CGM, Dr. Christian Bergman

Your Calendar Link - In the Zoom Registration Confirmation email you received today, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Stay in touch! Email us at vcoa@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu