
Project
ECHO
JOIN US FOR OUR NEW SERIES:
CARE HOMES ECHO

Project ECHO®

John A. Burns School of Medicine · University of Hawaii Manoa

ALOHACARE

UnitedHealthcare

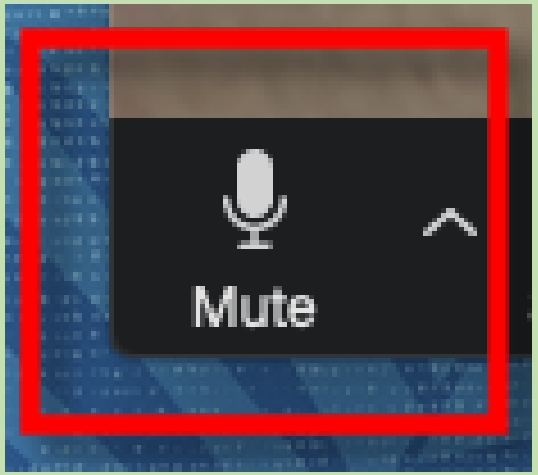
This Series is made possible through funds from United Healthcare, AlohaCare, and the University of Hawaii Department of Geriatric Medicine from the GWEP grant (Health Resources and Services Administration (HRSA): Grant Nos. U1QHP28729)

Confidential & Safe

- ✓For case presentations- Do not share patient names or birthdates.
- ✓Your questions can be anonymous.
- ✓SAFE learning and sharing- no shame or blame.
- ✓ECHO case discussions are not official doctor consults. This is for teaching purposes only.

zoom LOGISTICS

- ✓ Click on the Chat Tool (bottom of screen).
- ✓ **Enter your name(s) and others joining today's session.**
- ✓ Press Enter.



- ✓ Click on Mute (bottom left) when you are not speaking.
- ✓ You may click again to Unmute to speak.

What Matters Series- 4 Parts

Care Homes ECHO Schedule

3rd Thursday of each month
2:00- 3:00 pm

DATE	TOPIC
Feb	Who Knows What Matters?
Mar	Understanding What Matters
Apr	Addressing What Matters
May	Care Plans that Matter

** Session Topics subject to change

Continuing Education Credits

You can receive Certificates of Attendance, CMEs, and NASW continuing education credits!

1. Register: https://tinyurl.com/register-ch-echo
2. Complete an Evaluation: https://geriatrics.jabsom.hawaii.edu/care-homes-echo/

** Some systems do not allow access to google forms. Fillable PDFs can be found on our website. Please send to Jon at Nakasone@hawaii.edu

INTRODUCTIONS- HUB TEAM

Aida Wen, MD
Department of Geriatric Medicine, Associate Professor, Course Director for ECHO Geriatrics Clinic

Wannette Gaylord (President, Care Home Operator Association)

Maribel Tan (President, Foster Family Homes Association)

Juliana Caldwell (AlohaCare Service Coordinator)

Leila Ventar (United Healthcare Health Coordinator Manager)

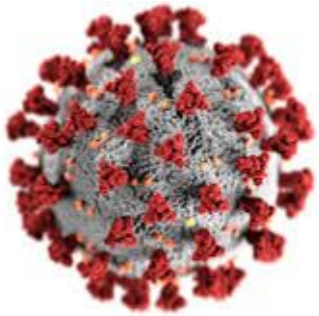
INTRODUCTIONS- GUEST SPEAKER

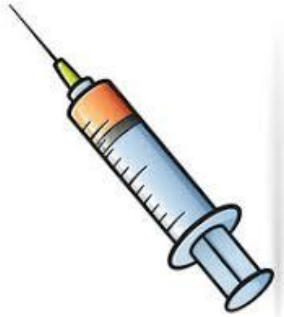
Karen Lubimir, MD, DMD- Department of Geriatric Medicine

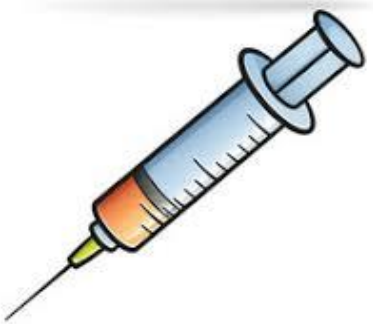
Wellness

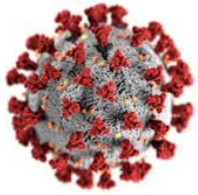
1. *Rest* — Allow yourself to rest–not just for when you have time-- sometimes you need to schedule it in.
2. *Restore* — Random acts of kindness helps restore your faith in humanity- and boosts well-being!
3. *Create* — Small acts of creativity (having fun) in everyday life increases our sense of wellbeing!
4. *Connect* — re-kindle or strengthen old friendships

These are important to put back into your life – Which one will you choose?
DO IT THIS WEEK!





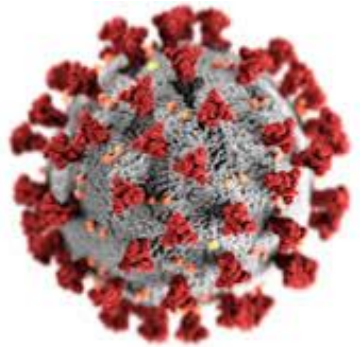




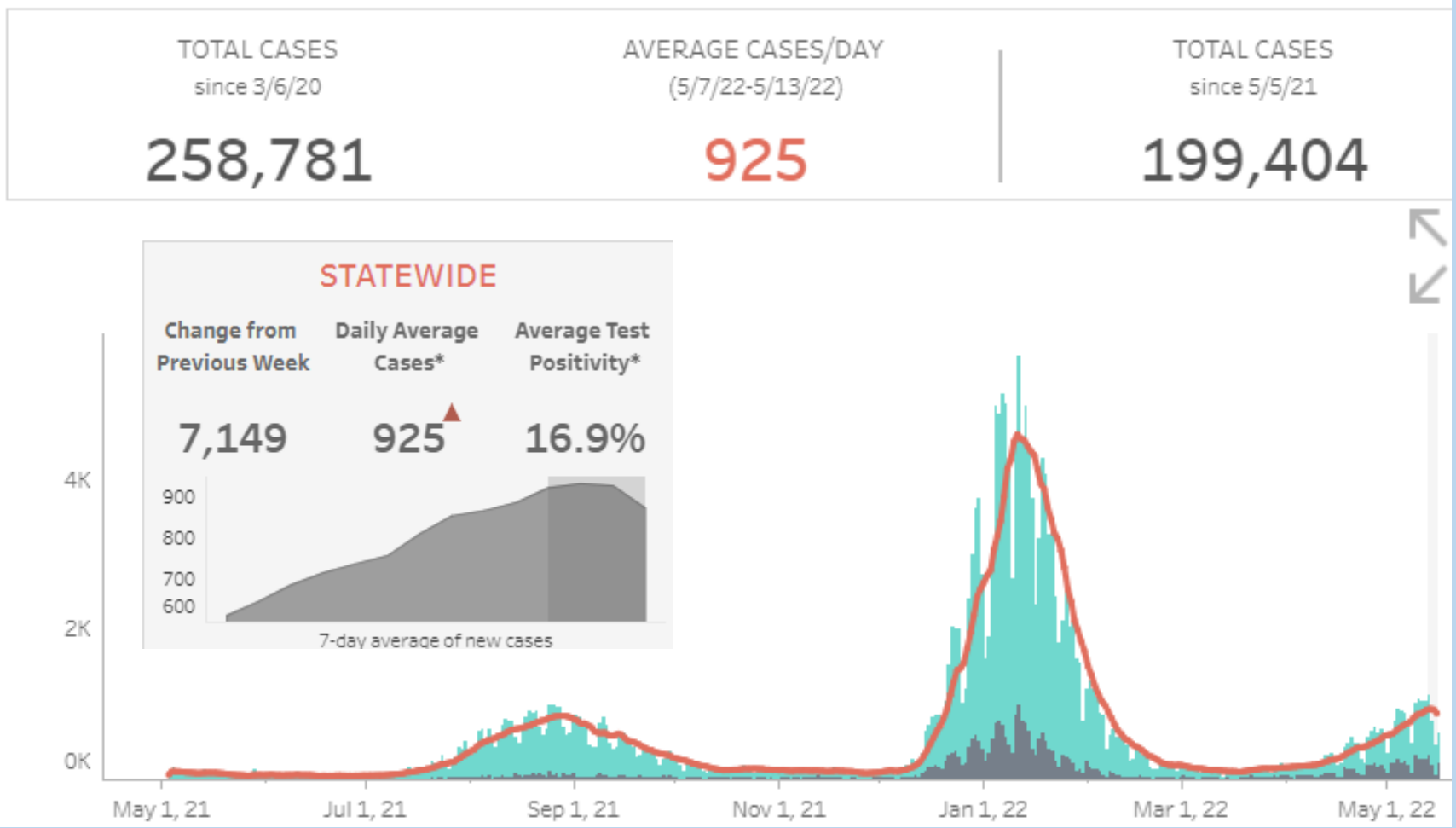
COVID CORNER

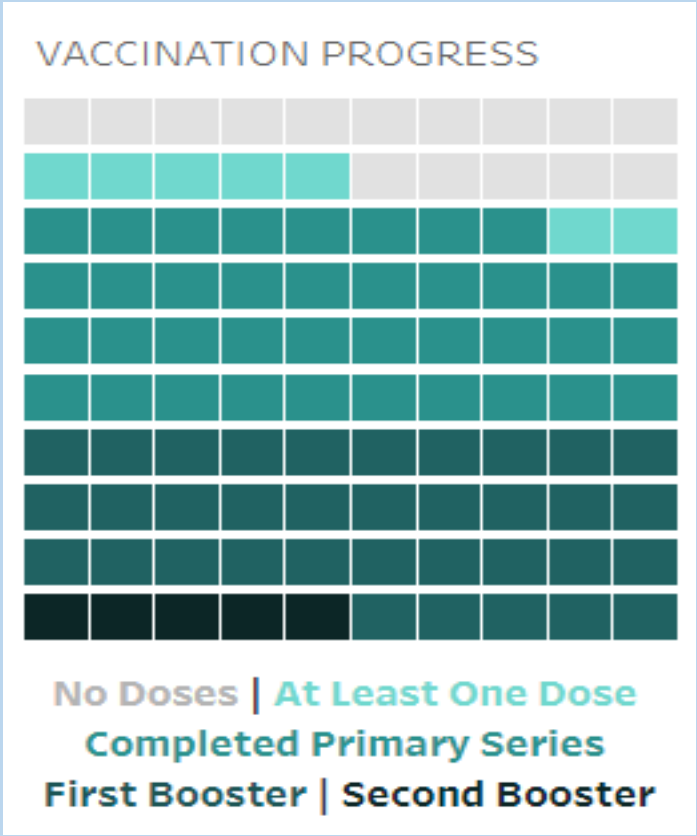
Aida Wen, MD

5/19/2022



Infection Rates





Hospitalization and ICU admissions for COVID are now on the rise as well.

https://health.hawaii.gov/coronavirusdisease2019/

Community Transmission in Hawaii is still High

State or territory: Hawaii

County or metro area:

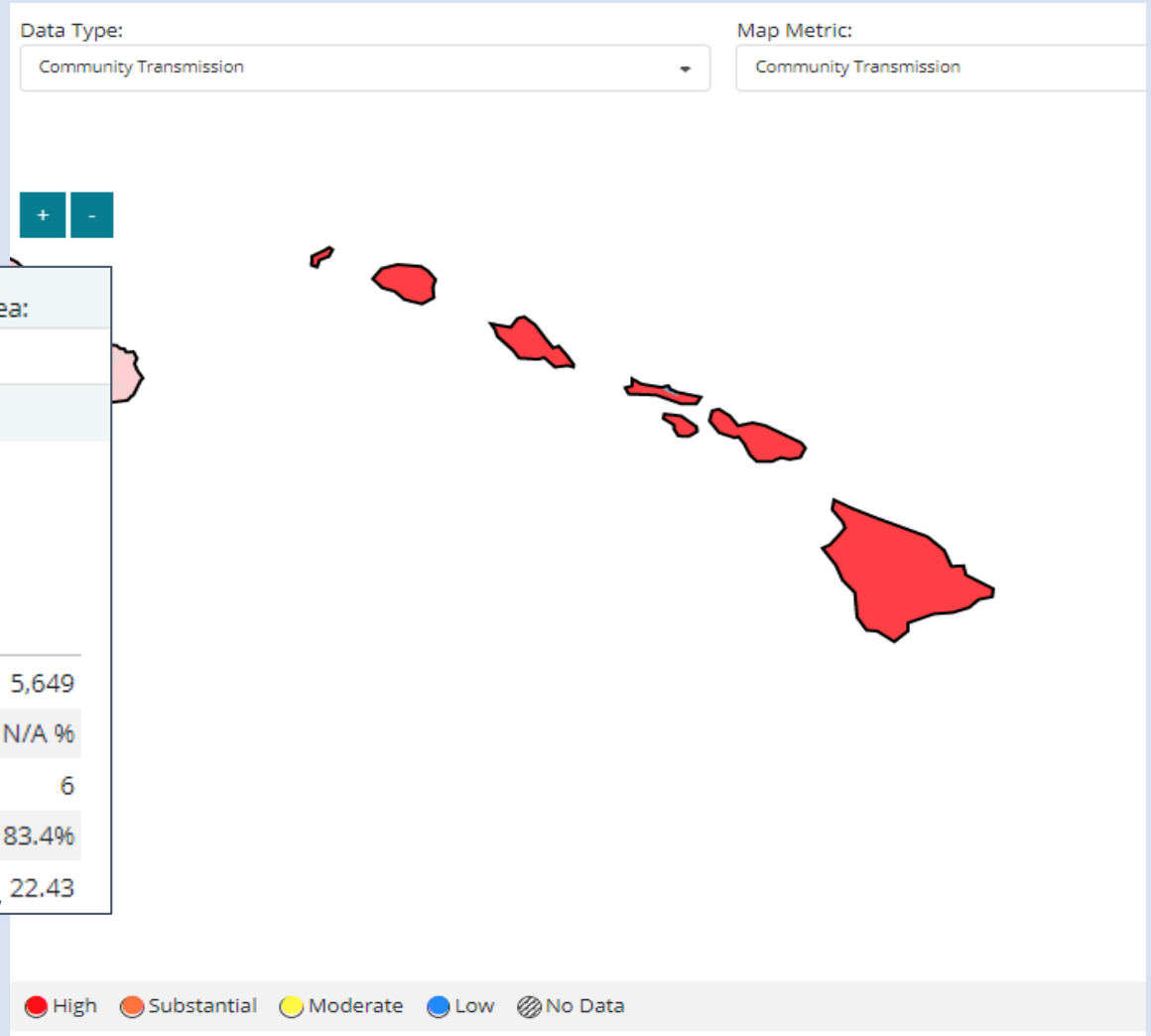
Hawaii

State Health Department

(as of 5/18/2022)

7-day Metrics

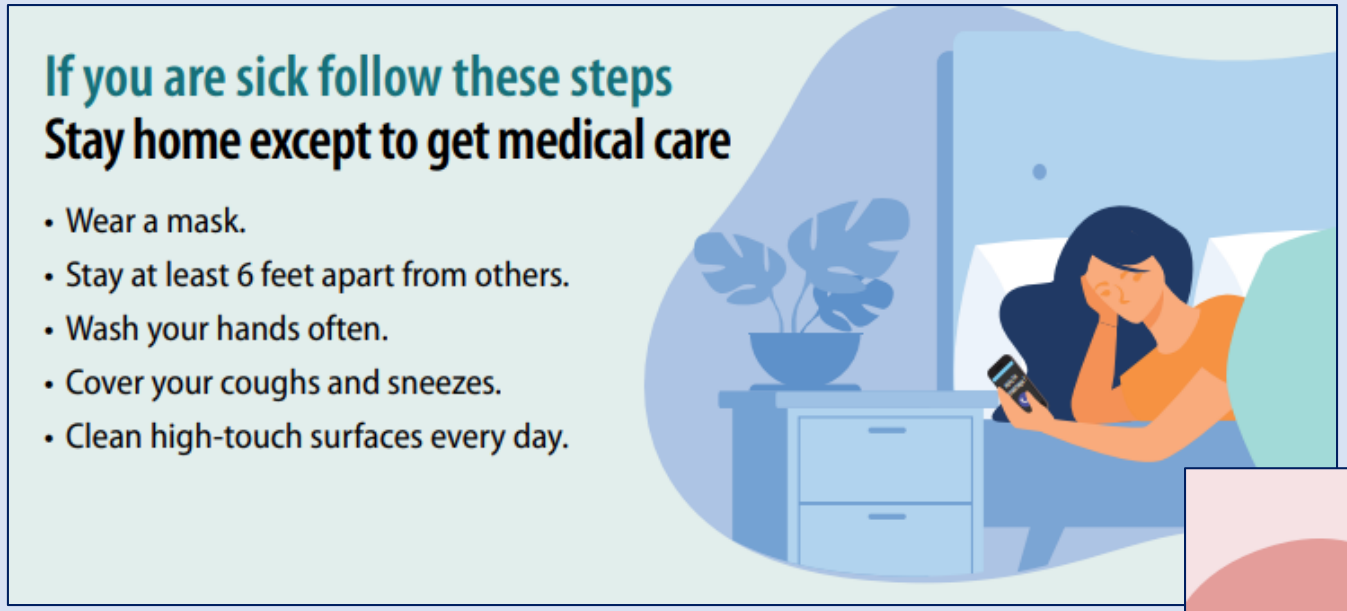
Cases	5,649
% Positivity	N/A %
Deaths	6
% of Population ≥ 5 Years of Age Fully Vaccinated	83.4%
New Hospital Admissions (7-Day Moving Avg)	22.43

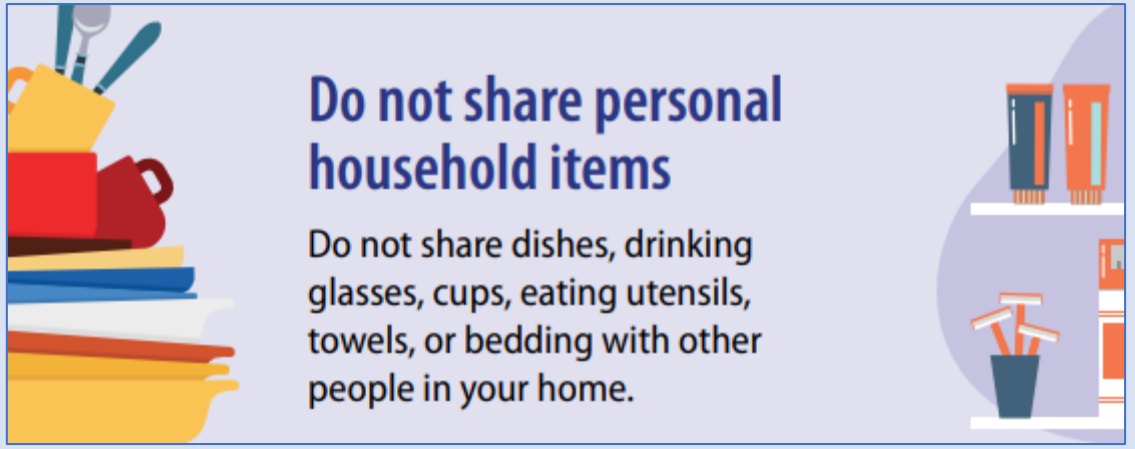


https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=Hawaii&data-type=CommunityLevels&null=Risk

What to do if someone tests COVID-19 +

(regardless of vaccination status or even if no symptoms!)





If possible, improve ventilation:

- Open windows, doors
- Use fans by the window to blow outside
- Use air filters (HEPA)

https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

Recommendations for People with COVID-19 (for the general public)

Have you tested positive for COVID-19 or have mild symptoms and are waiting for test results?

Here's What To Do:

Isolate. Stay at home for at least 5 days.*

STAY HOME

To keep others safe in your home, wear a mask, stay in a separate room and use a separate bathroom if you can.

Do not travel for **10 days**.

If you can't wear a mask, stay home and away from other people for **10 days**.

To calculate the recommended time frames, **day 0** is the day you were tested if you don't have symptoms, or the date your symptoms started.

Contact your healthcare provider to discuss your test results and available treatment options. Watch for symptoms, especially fever. If you have an emergency warning sign, such as trouble breathing or persistent chest pain or pressure, seek emergency medical care immediately.

Day 6: Do a self-check. How are you feeling?

You could have loss of taste or smell for weeks or months after you feel better. These symptoms should not delay the end of isolation.

SELF CHECK

No symptoms or symptoms improving. No fever without fever-reducing medication for 24 hours: You can leave isolation. Keep wearing a mask around other people at home and in public for **5 more days** (days 6-10).

Symptoms not improving and/or still have fever: Continue to stay home until 24 hours after your fever stops without using fever-reducing medication and your symptoms have improved.

After you feel completely better, keep wearing a mask around other people at home and in public through **day 10**.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

*If you are moderately or severely ill (including being hospitalized or requiring intensive care or ventilation support) or immunocompromised, please talk to your healthcare provider about when you can end isolation. Please refer to COVID-19 Quarantine and Isolation for guidance on isolation in healthcare settings and high risk congregate settings (such as correctional and detention facilities, homeless shelters, or cruise ships).

https://www.cdc.gov/coronavirus/2019-ncov/downloads/your-health/QI-Guidance-Isolation.pdf

Recommendations for COVID-19 Close Contacts

Have you been in close contact with someone who has COVID-19? You were a close contact if you were less than 6 feet away from someone with COVID-19 for a total of 15 minutes or more over a 24-hour period (excluding K-12 settings).

Here's What To Do:

To calculate the recommended time frames, **day 0** is the date you last had close contact to someone with COVID-19.

If you can't wear a mask, **stay home** (quarantine) and away from other people, and do not travel for **10 days**.

Protect Others

Take these steps to keep others safe.

Quarantine if you are not up to date with COVID-19 vaccines or didn't have COVID-19 in the past 90 days. Stay home and away from other people for at least **5 days**.
If you are up to date or had COVID-19 in the past 90 days you do not have to quarantine.

Avoid travel through **day 10**.

Wear a mask around other people for **10 days.**

Watch for symptoms of COVID-19 for **10 days.**

Up to date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Please refer to COVID-19 Quarantine and Isolation for guidance on quarantine in healthcare settings and high risk congregate settings (such as correctional and detention facilities, homeless shelters, or cruise ships).

https://www.cdc.gov/coronavirus/2019-ncov/downloads/your-health/QI-Guidance-Quarantine.pdf

(for the general public)

-based on a 10-day incubation period for the virus

Get Tested

Get a COVID-19 test on or after **day 5** or if you have **symptoms**.

People who had COVID-19 in the past 90 days should only get tested if they develop symptoms.

You tested **negative**. You can leave your home.

Keep **wearing a mask** in public and when traveling through **day 10**.

You tested **positive** or have **symptoms.**

Isolate away from other people. Stay home for at least **5 days** and follow steps for isolation.

Do not travel for **10 days.**

If you are unable to get tested, you can leave your home after **day 5** if you have not had symptoms. Keep wearing a mask in public and avoid travel through **day 10**.

COVID-19 in High-risk congregate settings (ex: Care Homes)

ISOLATION

- If you cannot cohort, the **CDC recommends a 10-day isolation** period for residents.
- During periods of critical staffing shortages, facilities may consider shortening the isolation period for staff to ensure continuity of operations- But you should consult with your state DOH.

OTHER MEASURES

- Everyone who lives there should wear a **well-fitting mask** inside the home.
- **Limit close contacts** (ONE caregiver for infected person)

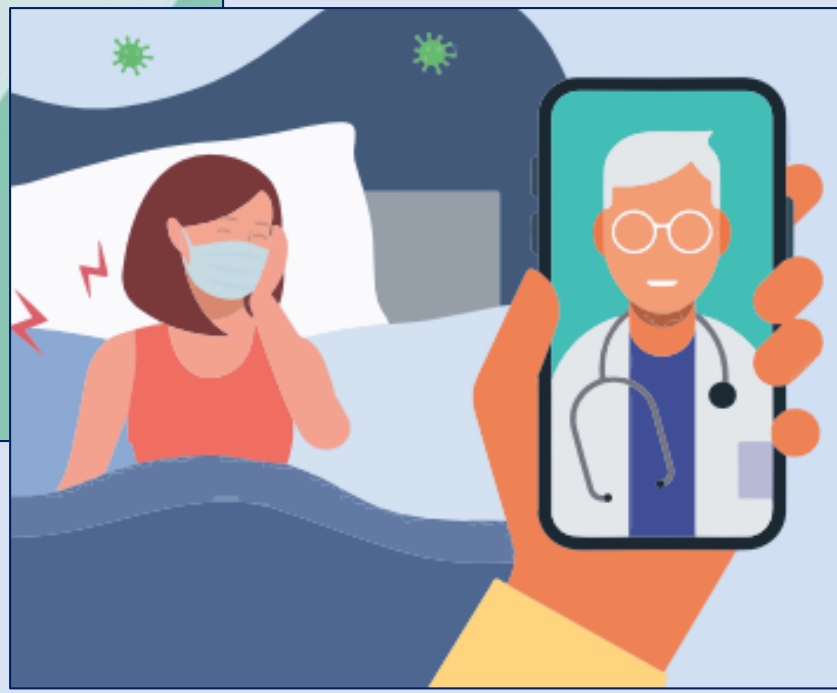
https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html

What to do if someone gets COVID-19

Monitor your symptoms

Symptoms of COVID-19 include fever, cough, shortness of breath and more.

Follow instructions from your healthcare provider and local health department.



When to seek emergency medical attention

If someone is having

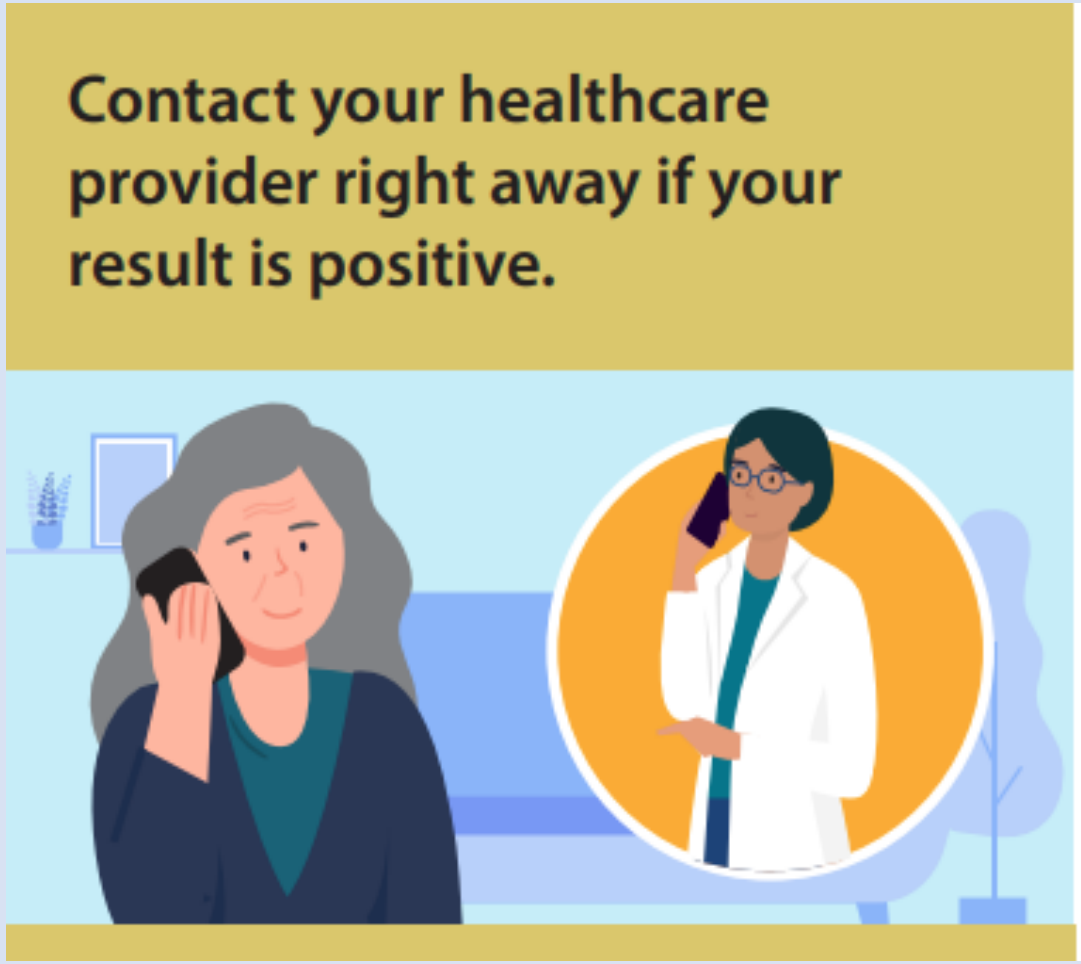
- Trouble breathing.
- Persistent pain or pressure in the chest.
- Inability to wake or stay awake.
- Pale, gray, or blue-colored skin, lips, or nail beds depending on skin tone.

https://www.cdc.gov/coronavirus/2019-ncov/downloads/sick-with-2019-nCoV-fact-sheet.pdf

Don’t Delay: TEST Soon and TREAT Early!

Cancer
Stroke
COPD
Liver disease
Diabetes
Disabilities (including ADL dependent)
Heart conditions
HIV
Smoking
Obesity
Pregnancy
Steroids/Immunosuppressive drugs

Don’t Delay: TEST Soon and TREAT Early!



https://www.cdc.gov/coronavirus/2019-ncov/downloads/communication/print-resources/Test-Soon-Treat-Early.pdf

Current Treatment for Mild to Moderate Symptoms
(Not hospitalized)

Oral Antivirals (OAV)

- Paxolvid (Pfizer) #1
  - Nirmatrelvir + ritonavir
  - Take within 5 days
  - Safety depends on weight, kidney, and possible drug interactions
  - Multiple pills twice a day x 5 days

- Lagevrio (Merck) #3
  - Molnupiravir
  - Take within 5 days
  - 4 capsules twice a day x 5 days

Monoclonal Antibody Treatment (mAb)

- Bebtelovimab (Lilly) #2
  - For this Omicron variant so far
  - Within 5-7 days
  - IV injection x1

LIMITED SUPPLY…
so depends on availability

What Matters Series – Part 4

Care Plans that Matter

Meet Mr. Tayana

- 87 yr. old divorced male of Puerto Rican and Chinese heritage who is recently became a resident of your Foster/Care Home due to progression of his dementia, w/ incontinence and frequent falls and behaviors that family couldn’t manage.

- Other Medical conditions include:
  - High blood pressure
  - COPD- still smoking 1-2 cigarettes/day pre-admission
  - GERD
  - Constipation
  - Osteoarthritis of knees and shoulder
  - Diabetes
  - Weight loss- 10# in last 3 months

Mr. Tayana

- Social history
  - Divorced from the wife of his 5 children, from whom he is estranged (except one dtr who had been his primary caregiver for 4 years before admission).
  - High school graduate , retired construction foreman, Hx of heavy alcohol use.
  - Parents deceased, Eldest of 8 siblings , 2 are still alive , living on Oahu.

Upon Admission…

You find out what he was like at home

WHAT MATTERS:

- Mr T: *"I like to have a smoke"* and *"eat plate lunch w/Pepsi"*
- Dtr: *"We just want him to be happy"; "not cause too much problems"*

  "So, basically I just give him whatever he wants"

MEDICATIONS:

Miralax 17 g /daily mix in 8 ounce liquid

Famotidine 20 mg in am

Metformin 1000mg twice /daily

Docusate 100mg twice daily

Budesonide /Formoterol INH 2 puff/ twice daily

Glipizide 5 mg daily

Albuterol INH2 puff every 4-6 hr as needed for wheezing

Tylenol 500mg 1-2 tabs every 6 hours as needed for pain

MOBILITY (Functional status):

- Not using his FWW, holds on to furniture around house
  - Falls 3x in last one month- preadmission
  - Feeds himself but food falls off spoon
  - Can use urinal w/ assistance , wears diapers at night

MENTATION (Dementia/Behaviors):

- Dementia w/ behavior related problems
- Cannot tell what date day month or year is, frequently thinks his dtr. is ex-wife
- Frequently refused bathing or changing clothes,
- Yells or strikes out at caregivers trying to help him
- Sleeping much of the day , then “up at night”

Since Admission…

Under Nursing Facility care

“I Want to Go Home!”

FIRST WEEK in your care

MENTATION (Dementia/Behaviors)**:**

- He is VERY unhappy, and tells everyone that every day.
- Declines to participate in activities- incl. bathing/ changing clothes- undergarments
- Spits out food, pushes lips together, or hits you- if you try to feed him
- Only wants “sweets”, soda or *plate lunch*-which family brings for him

MOBILITY

- Keeps trying to get out of bed- “wants to smoke”
- Cannot stand on own w/o one person assistance/ gait belt needed for walking w/FWW.
- Getting “weaker”
- Weight loss of 4 # since admission 1 weeks ago (132->128#)

FIRST WEEK in your care

MEDICATIONS:

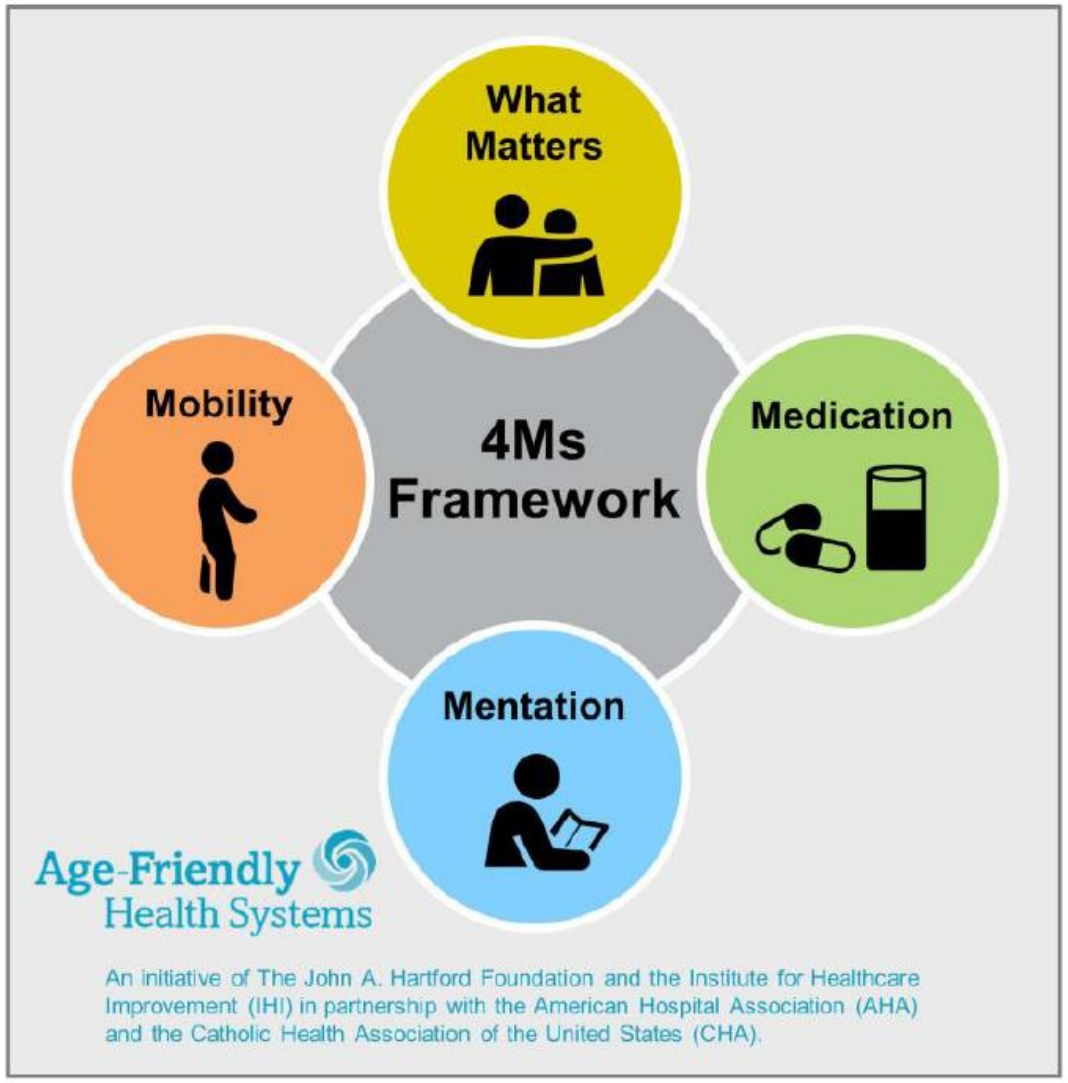
- Spits out pills
  - Med reconciliation review – he takes about ½ of all medication doses
- If crushed, will refuse to finish food it is mixed with
- Blood pressures average ~150/90
- He hates fingersticks and curses staff or pushes them away when attempted. Only able to check sugars about half the time.
  - Blood sugars 140-190 every morning, > 200 if family brought “treats”

WHAT MATTERS:

- Resident *“I want to go home” “ it’s like prison”*
- Family c/o *“he’s not happy”* and losing weight
- Staff concerned for fall risk, malnutrition /poorly controlled diabetes and hypertension, medication nonadherence, behaviors

Create a 4Ms Careplan

Figure 1. 4Ms Framework of an Age-Friendly Health System



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

WHAT WOULD YOU DO?

Next steps in care plan for Mr. Tayana

WHAT MATTERS:

What are his wishes?

How do you meet goals for resident/family?

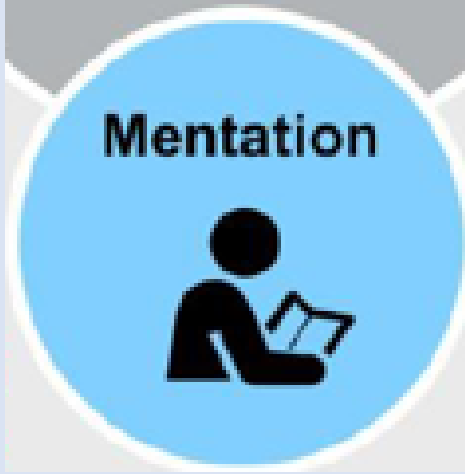
How do you balance these with resident safety and well being?

What about Advanced Care Planning?

- ACP- DPOA
- ACP- DNAR, no Artificial nutrition and hydration (ANH), no hospitalization. Just be comfortable.

WHAT WOULD YOU DO?

Next steps in care plan for Mr. Tayana



- **MENTATION**
  - What are his issues regarding Mood?
  - What are his issues regarding Dementia Behaviors?
  - Can we address these with What Matters to him?

WHAT WOULD YOU DO?

Next steps in care plan for Mr. Tayana

- **MOBILITY (function/fall risk)**
  - What are his issues regarding Mobility?
  - Can we address these with What Matters to him?

WHAT WOULD YOU DO?

Next steps in care plan for Mr. Tayana

- **MEDICATIONS (refuses to take; diabetes control)**
  - What are his issues regarding Medications?
  - Can we address these with What Matters to him?
  - Will this be consistent with his Advance Care Planning wishes?

DISCUSSION & SHARING

THANKS FOR CARING!

LOOK FOR 3 THINGS:

#1

GENERAL POWER OF ATTORNEY

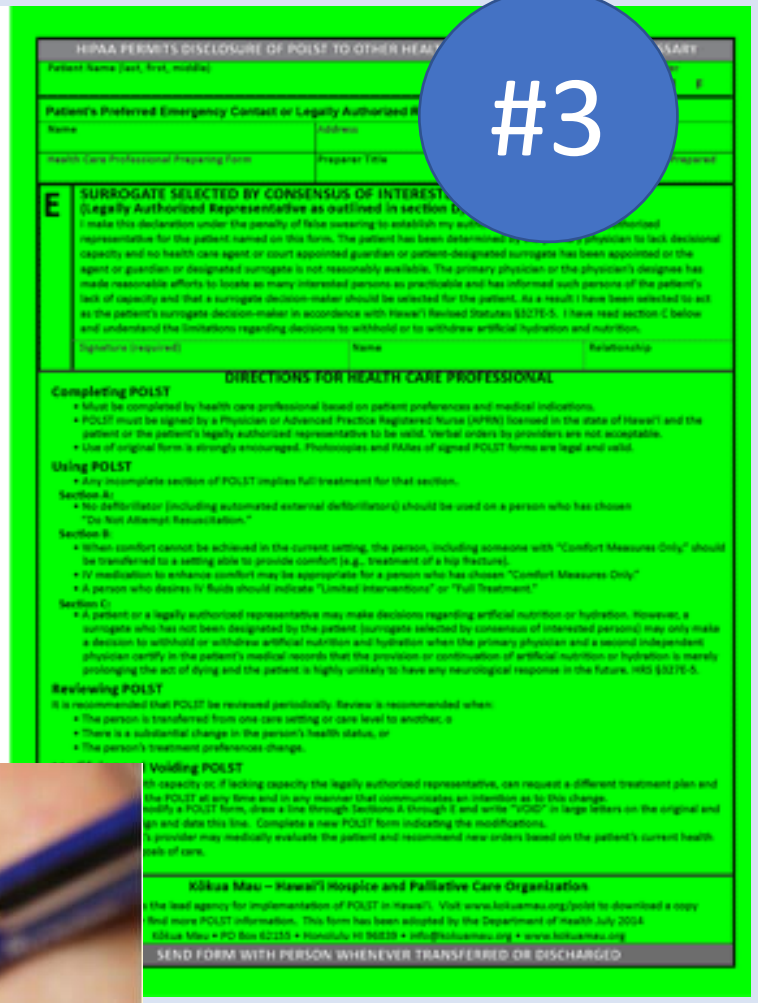
OF

Jane Doe

I, _____, the Principal, of _____ [street address], City of _____, State of _____, hereby designate _____, [attorney-in-fact's name], of _____ [street address], City of _____ State of _____, my attorney-in-fact (herein to act as set forth below, in my name, in my stead and for my benefit, all powers of attorney I may have executed in the past.

#2

#3



Please Share with our Team:

You will receive a link to fill out an online survey form to share how many of your residents have these 3 documents.

Please try have someone screen all your residents before our next session.

Please try to complete this, it helps us demonstrate that you are doing a good job helping residents achieve their wishes!

DOCUMENT	HOW MANY HAVE?	TOTAL# RESIDENTS
Power of Attorney		
Advanced Care Planning (e.g. DPOA HC)		
POLST form		

NEED HELP?

- FRIDAY, 5/20/22
  - 10am
  - 2pm
- MONDAY, 5/23/22
  - 2pm

Mibrao@hawaii.edu