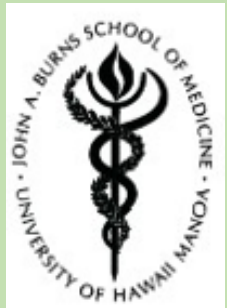




JOIN US FOR OUR NEW SERIES:

**CARE HOMES ECHO**



*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

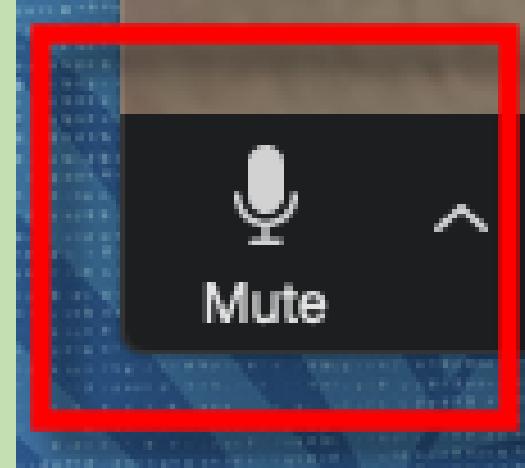


- ✓ For case presentations- Do not share patient names or birthdates.
- ✓ Your questions can be anonymous.
- ✓ SAFE learning and sharing- no shame or blame.
- ✓ ECHO case discussions are not official doctor consults. This is for teaching purposes only.

# zoom LOGISTICS



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

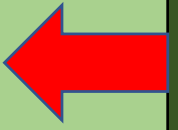


- ✓ Click on Mute (bottom left) when you are not speaking.
- ✓ You may click again to Unmute to speak.

# What Matters Series- 4 Parts

**Care Homes  
ECHO Schedule**  
**3<sup>rd</sup> 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](mailto: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*

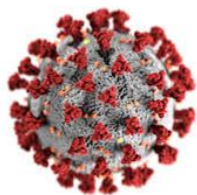
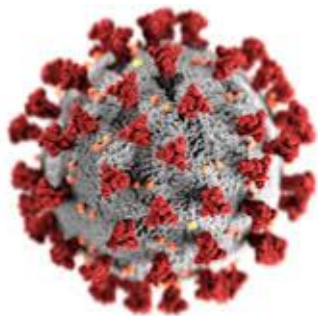
Small acts of creativity (having fun) in everyday life increases our sense of wellbeing!

## 4. *Connect*

re-kindle or strengthen old friendships



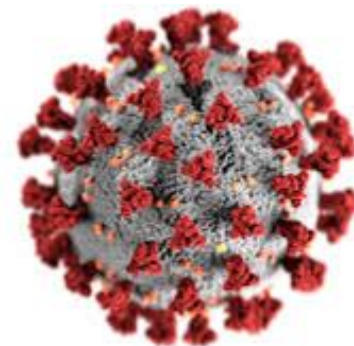
*These are important to put back into your life – Which one will you choose?  
DO IT THIS WEEK!*



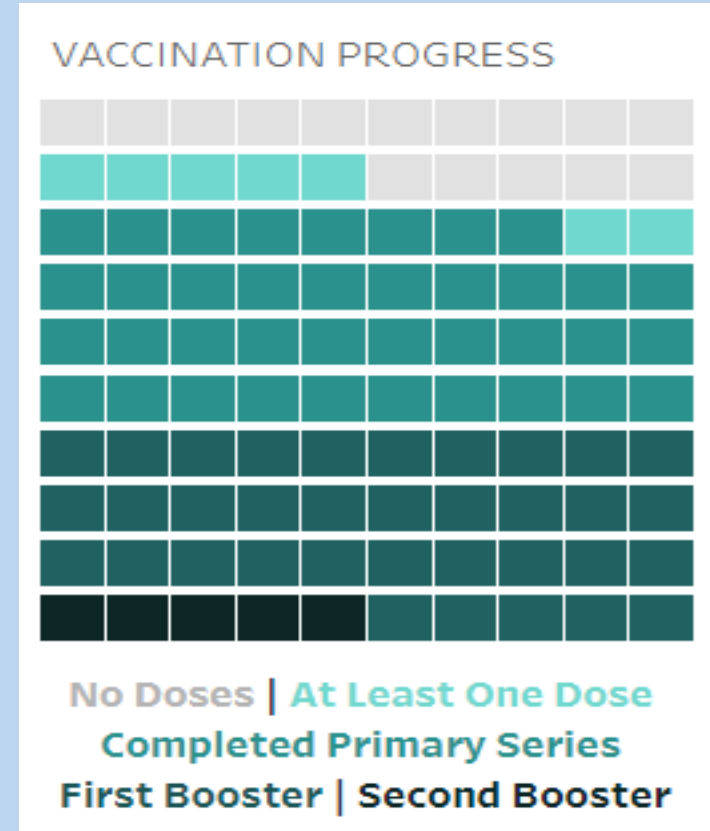
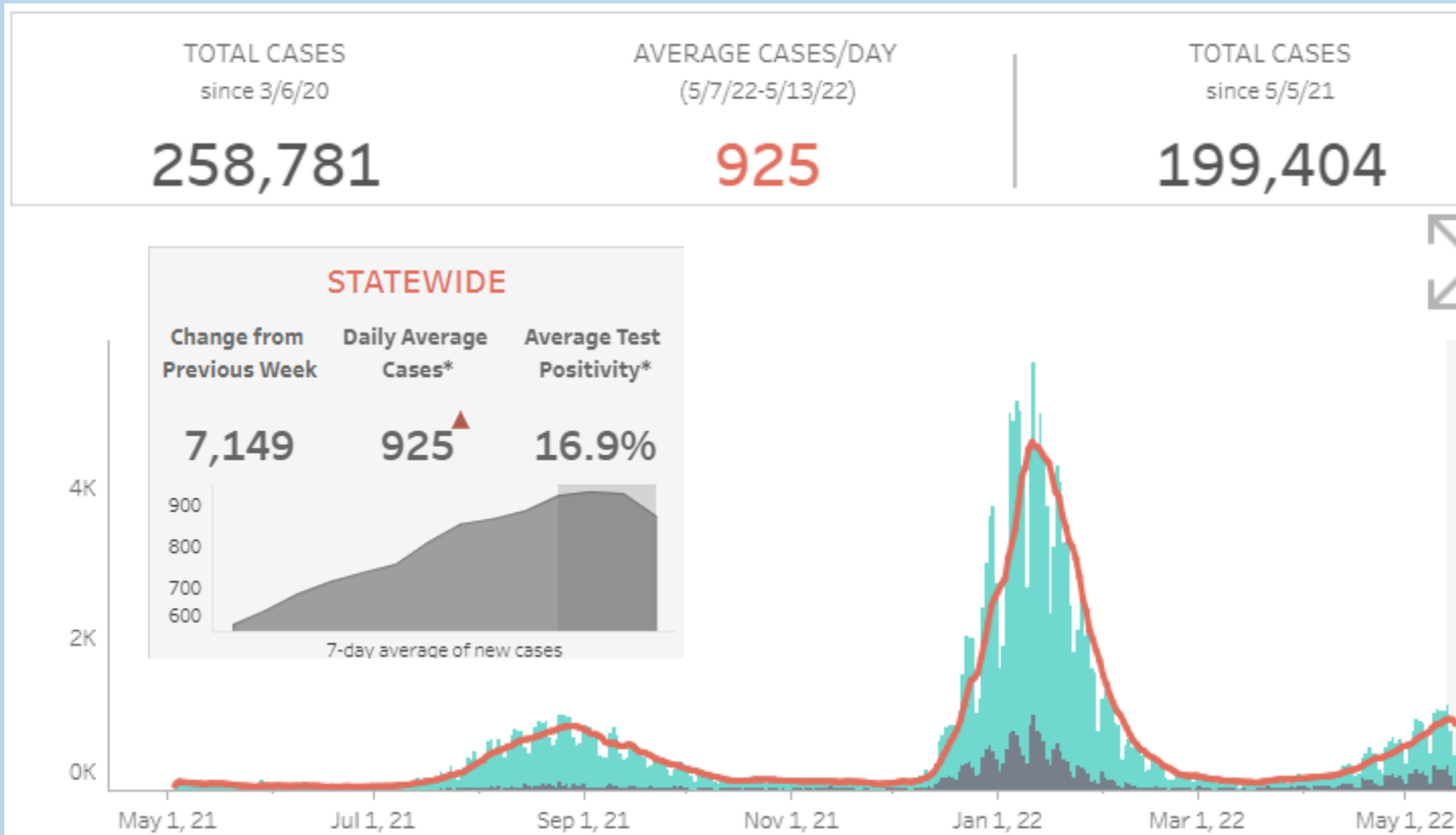
# COVID CORNER

Aida Wen, MD

5/19/2022



# Infection Rates



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

# Community Transmission in Hawaii is still High

State or territory:  
Hawaii

County or metro area:

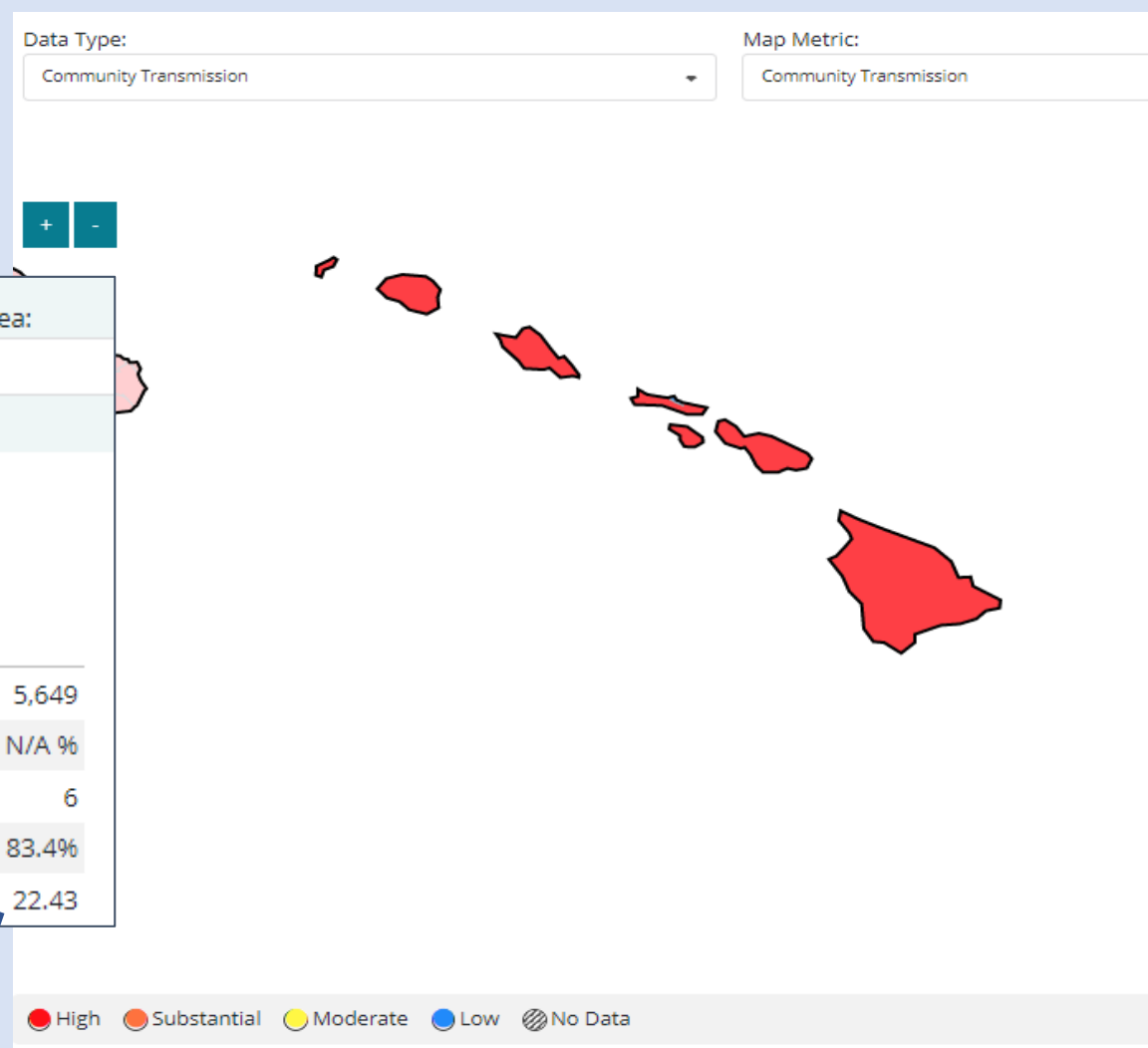
## Hawaii

[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

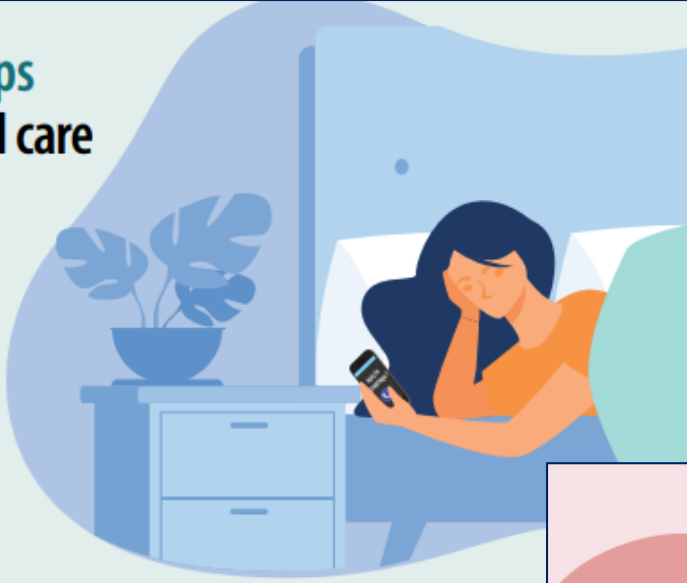


# What to do if someone tests COVID-19 +

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

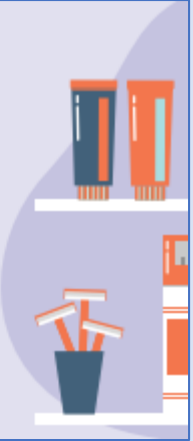
## If you are sick follow these steps Stay home except to get medical care

- Wear a mask.
- Stay at least 6 feet apart from others.
- Wash your hands often.
- Cover your coughs and sneezes.
- Clean high-touch surfaces every day.



## Do not share personal household items

Do not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people in your home.



## If possible, improve ventilation:

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

## Stay separate from other people and pets in your home

- Stay in a specific room as much as possible.
- Stay away from other people and pets in your home.
- If possible, you should use a separate bathroom.
- If you need to be around other people or animals in or outside of the home, wear a mask.



<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.\***



**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.*

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.

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).

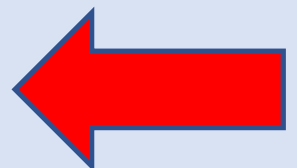


Symptoms not improving and/or still have fever: Continue to stay home until 24 hours after your fever stops without using fever-reducing medication and your symptoms have improved.

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

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

\*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).



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

# Recommendations for COVID-19 Close Contacts

(for the general public)

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

## Here's What To Do:



### 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.*



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**.



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).

### 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)



# 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.

# Don't Delay: TEST Soon and TREAT Early!

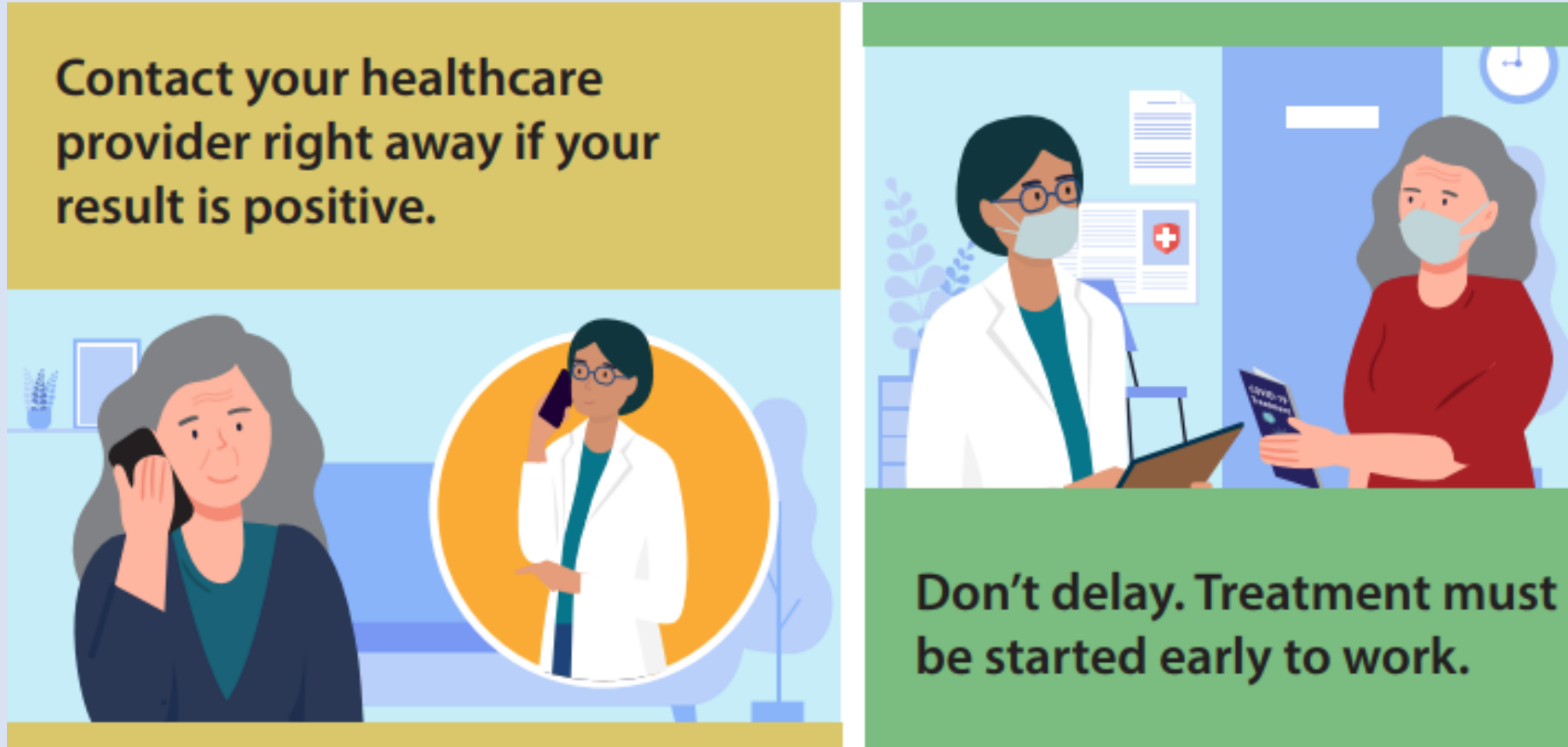
Cancer  
Stroke  
COPD  
Liver disease  
Diabetes  
Disabilities (including  
ADL dependent)  
Heart conditions  
HIV  
Smoking  
Obesity  
Pregnancy  
Steroids/Immunosup  
pressive drugs

If you are at high risk of  
getting very sick from  
COVID-19, and test positive,  
treatment may be available.



Get tested as soon as possible  
after your symptoms start.



# Don't Delay: TEST Soon and TREAT Early!




# Current Treatment for Mild to Moderate Symptoms

(Not hospitalized)

## Oral Antivirals (OAV)

- Paxlovid (Pfizer) 
  - 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) 
  - Molnupiravir
  - Take within 5 days
  - 4 capsules twice a day x 5 days

## Monoclonal Antibody Treatment (mAb)

- Bebtelovimab (Lilly) 
  - 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 INH 2 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



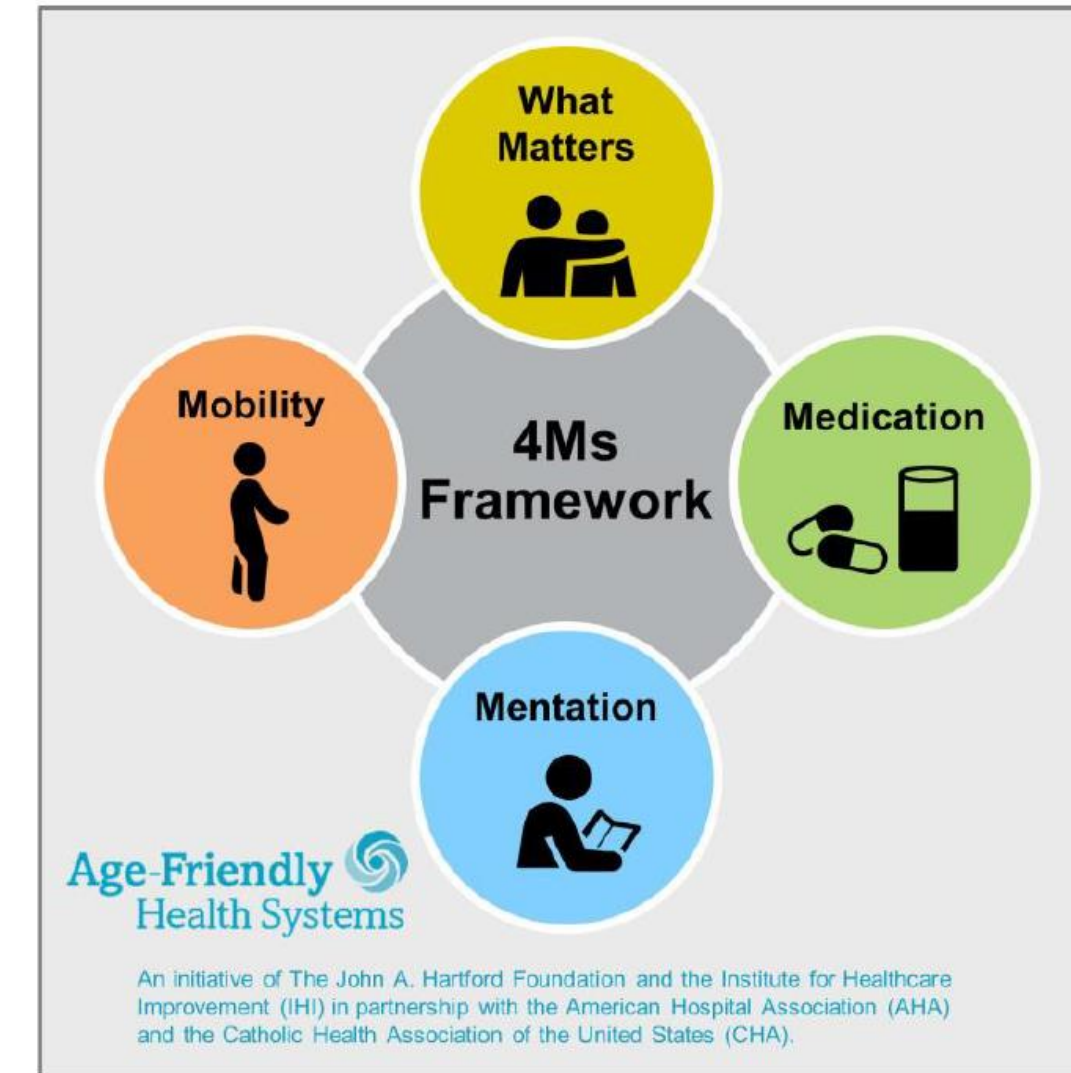
## MEDICATIONS:

- 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

**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.

Create a 4Ms Careplan



# ***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.

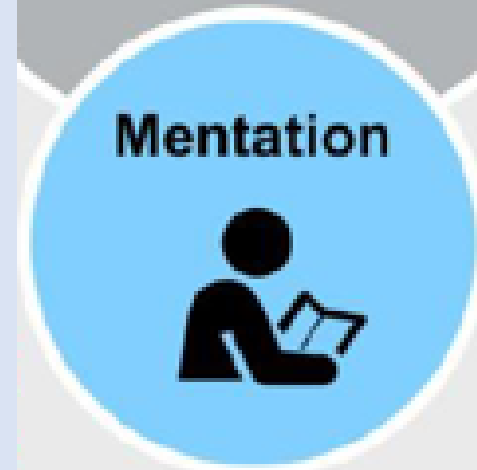


# *WHAT WOULD YOU DO?*

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

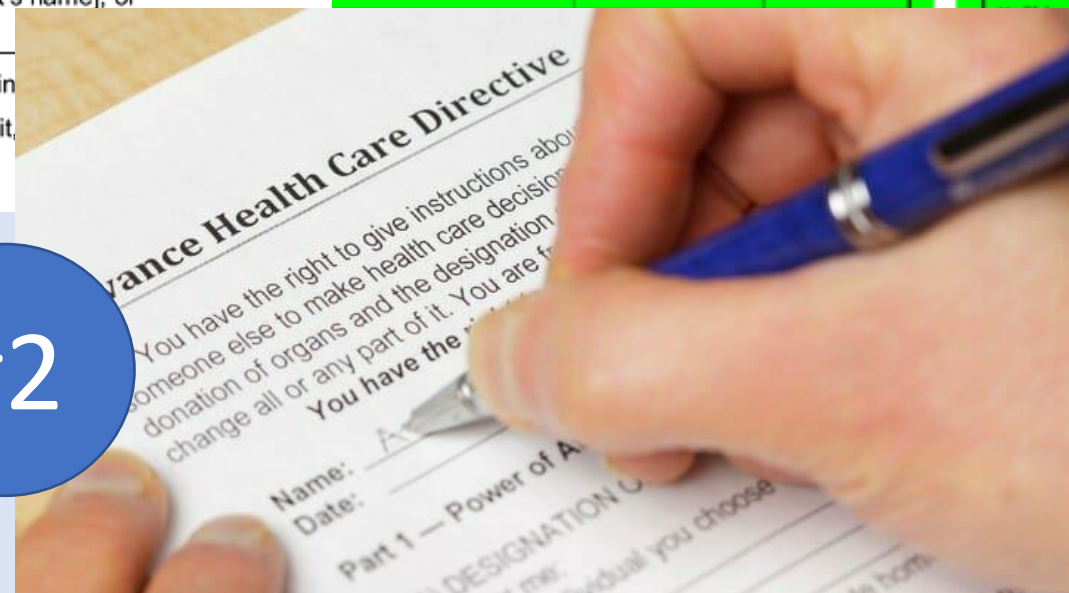
## GENERAL POWER OF ATTORNEY

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



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

### PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAII

First follow these orders. THEN contact the patient's provider. This Provider Order form is based on the patient's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone should be treated with dignity and respect.

Patient's Last Name: \_\_\_\_\_  
First/Middle Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Date Form Prepared: \_\_\_\_\_

**A CARDIOPULMONARY RESUSCITATION (CPR):** **"Person has no pulse and is not breathing"**  
☐ Attempt Resuscitation/CPR (Section B: Full Treatment required) ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)  
If the patient has a pulse, then follow orders in B and C.

**B MEDICAL INTERVENTIONS:** **"Person has pulse and/or is breathing"**  
☐ Comfort Measures Only: Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer if comfort needs cannot be met in current location.  
☐ Limited Additional Interventions: Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure) if indicated. Avoid intensive care.  
Transfer to hospital if indicated. Avoid intensive care.

**C FULLY ADMINISTERED NUTRITION:** Always offer food and liquid by mouth if feasible and desired  
If on next page for information on nutrition & hydration  
☐ Artificial nutrition by tube. ☐ Do not start period of artificial nutrition by tube. ☐ Do not start period of artificial nutrition by tube.

**D AGENT DESIGNATION AND SUMMARY OF MEDICAL CONDITION:** Discussed with:  
☐ Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:  
☐ Agent designated in Power of Attorney for healthcare ☐ Patient designated surrogate  
selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor  
Provider (Physician/APRN licensed in the state of Hawaii): \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Title: \_\_\_\_\_

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle): \_\_\_\_\_

Patient's Preferred Emergency Contact or Legally Authorized Representative:  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Health Care Professional Preparing Form: \_\_\_\_\_ Preparer Title: \_\_\_\_\_ Date: \_\_\_\_\_

**E SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)**  
I make this declaration under the penalty of false swearing to establish my authority as a legally authorized representative for the patient named on this form. The patient has been determined by a physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawaii's Revised Statutes §327B-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.  
Signature (required): \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**DIRECTIONS FOR HEALTH CARE PROFESSIONAL**

**Completing POLST**

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician or Advanced Practice Registered Nurse (APRN) licensed in the state of Hawaii and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST forms are legal and valid.

**Using POLST**

- Any incomplete section of POLST implies full treatment for that section.
- Section A:**
  - No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- Section B:**
  - When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
  - IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
  - A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- Section C:**
  - A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327B-5.

**Reviewing POLST**

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

**Voiding POLST**

In capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and the POLST at any time and in any manner that communicates an intention as to the change.  
To void a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and sign and date this line. Complete a new POLST form indicating the modifications.  
A provider may medically evaluate the patient and recommend new orders based on the patient's current health status of care.

Kāhala Maui – Hawaii's Hospice and Palliative Care Organization  
The lead agency for implementation of POLST in Hawaii. Visit [www.kahalamau.org/polst](http://www.kahalamau.org/polst) to download a copy and more POLST information. This form has been adopted by the Department of Health July 2024.  
Kāhala Maui • PO Box 62235 • Honolulu HI 96828 • [info@kahalamau.org](mailto:info@kahalamau.org) • [www.kahalamau.org](http://www.kahalamau.org)  
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

#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

