To the Editor: I applaud Drs D’Adamo, Yoshikawa, and Ouslander’s excellent article on the ABCDs of managing the coronavirus disease 2019 (COVID-19) epidemic in long-term care. A critically important decision that requires additional examination is transferring a resident to a hospital. Clinicians and nursing staff must be prepared to engage in a forthright discussion about the risks and benefits of a hospital transfer. I am especially concerned for those residents with advanced dementia, who likely will not benefit from hospital transfers. Simply obtaining a code status and writing do not resuscitate orders are not enough because it only addresses the care that is not going to be provided. Instead, proxy decision makers should be offered a meaningful alternative, which I call intensive individualized comfort care (IICC). IICC is a mode of care in which the entire healthcare team

**Hospital Care**

The hospital has services we cannot provide here at the nursing home, such as surgery, intensive care units, and ventilators.

*If the resident has advanced dementia you could add:* Because your loved one has advanced dementia she/he is unlikely to survive even with these services. If she/he is to survive, it will not improve her/his dementia.

There are also risks of going to the hospital. The risks include:

- It can be stressful
- Unfamiliar medical staff and surroundings
- Risk for skin breakdown and falls
- Exposure to infections

**Intensive Individualized Comfort Care (IICC)**

Another option is to keep your loved one here in the nursing home, and we will provide **intensive individualized comfort care**. Intensive individualized comfort care is a type of care in which our entire team, including the physician and nurse practitioner, work together to ensure that [name of resident] is comfortable and has the best quality of life for as long as possible. We will treat any condition that interferes with [name of resident]’s comfort. We will:

- Address physical aspects of care, including treating symptoms such as pain, shortness of breath, and nausea
- Encourage [name of resident] to eat and drink by offering frequent meals, snacks, and beverages
- Address psychological aspects of care, including anxiety, depression, and confusion
- Provide sensory stimulation, such as music, therapeutic touch, massage, and aromatherapy
- Will keep [name of resident] with familiar surroundings and with familiar staff
- Address spiritual aspects of care by including clergy or prayer

**End-of-life care / Do not resuscitate (DNR)**

If we see that [name of resident] is coming close to death, we will notify you. We will follow the facility’s policies regarding allowing you to visit with your loved one. We will do all we can to be sure your loved one is not alone. If [name of resident] dies, we will not do cardiopulmonary resuscitation and try to bring her/him back to life or try to restart her/his heart. We will allow natural death to occur.

*Figure 1.* Sample script to talk about intensive individualized comfort care (IICC). DNR, do not resuscitate.

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works together to ensure that residents are comfortable and have the best quality of life for as long as possible. Figure 1 provides an example of how to talk with proxy decision makers about IICC.

COVID-19 is a natural disaster, a major catastrophe, and a world crisis. It has produced a race to contain the spread, an amassment of ventilators, and a surge in intensive care unit (ICU) beds. All are critically important. However, in our haste to contain, amass, and surge, let us not forget that we must also relieve, treat, comfort, and support. We must provide an alternative to invasive, ineffective treatments. We must educate staff, stockpile medications for symptom control, and provide training in counseling and symptom management protocols. IICC is not abandonment. It is not hastening death. It affirms life and is care patients and families want. It is as critical during this time of crisis as are masks and gowns, ventilators, and ICUs.

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Reply to Ruth Palan Lopez, PhD, GNP-BC
To the Editor: We thank Dr Lopez for the comments on our article and for highlighting the opportunity the coronavirus pandemic and coronavirus disease 2019 (COVID-19) provide to further efforts on advance care planning (ACP) discussions and to obtain, document, and communicate advance directives.¹² We agree this is especially important at a time when many emergency departments and hospitals are overcrowded. Moreover, transferring a long-term care facility (LTCF) resident to the hospital incurs more than the usual risk of iatrogenic and hospital-acquired infections; the risk of acquiring COVID-19 disease and its complications are high if the resident does not already have the virus. Hospitalization also leads to the unfortunate need to quarantine LTCF residents after hospital discharge because of lack of testing and/or the false-negative rate of the tests. This can result in social isolation, which can be harmful, especially in those with dementia.

These issues were addressed in some detail in an editorial updating our article.³ Addressing ACP and executing, documenting, and communicating advance directives has been a fundamental strategy in the Interventions to Reduce Acute Care Transfers (INTERACT) program since its inception over 10 years ago. Root-cause analyses of thousands of hospital transfers have shown that one of the most common reasons LTCF staff and expert clinicians rate transfers as potentially avoidable is that for many LTCF facility residents the risks and discomforts of hospitalization outweigh the benefits, and adequate ACP has not taken place.⁴⁻⁶

We applaud Dr Lopez’s intensive individualized comfort care (IICC) approach.¹ There is too much focus on “do not resuscitate (DNR)” orders. For the vast majority of LTCF residents, basic cardiopulmonary resuscitation (CPR) is medically futile and results in fractured ribs and related pain and the need for respirator care. Meaningful survival with the same function and quality of life before CPR is rare at best. Residents and families should also be informed that a DNR order only applies to a situation when the resident is found without a pulse and/or respirations. CPR will be withheld, but all other care will continue. Thus, the real issue becomes agreeing on the appropriate goals of care. If it is comfort care, then a DNR order should also be accompanied by an order along the lines of “do not hospitalize unless necessary for comfort.” In most cases, comfort can be provided to people who are dying, even when respiratory distress occurs due to COVID-19, if the right medications are available in the facility’s emergency medication kit.

In addition to Dr Lopez’s tool for IICC,¹ the INTERACT website⁷ and several others⁸⁻¹⁰ have tools that can be used by staff and clinicians in LTCFs to enhance their capabilities and comfort with ACP. Some of these tools have been made more specific to COVID-19 disease. They can be helpful because some LTCF residents become sick rapidly after acquiring the virus, and it is best to not make these decisions at the time of such a crisis.

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