# COVID-19 Advance Care Planning and Serious Illness Conversations

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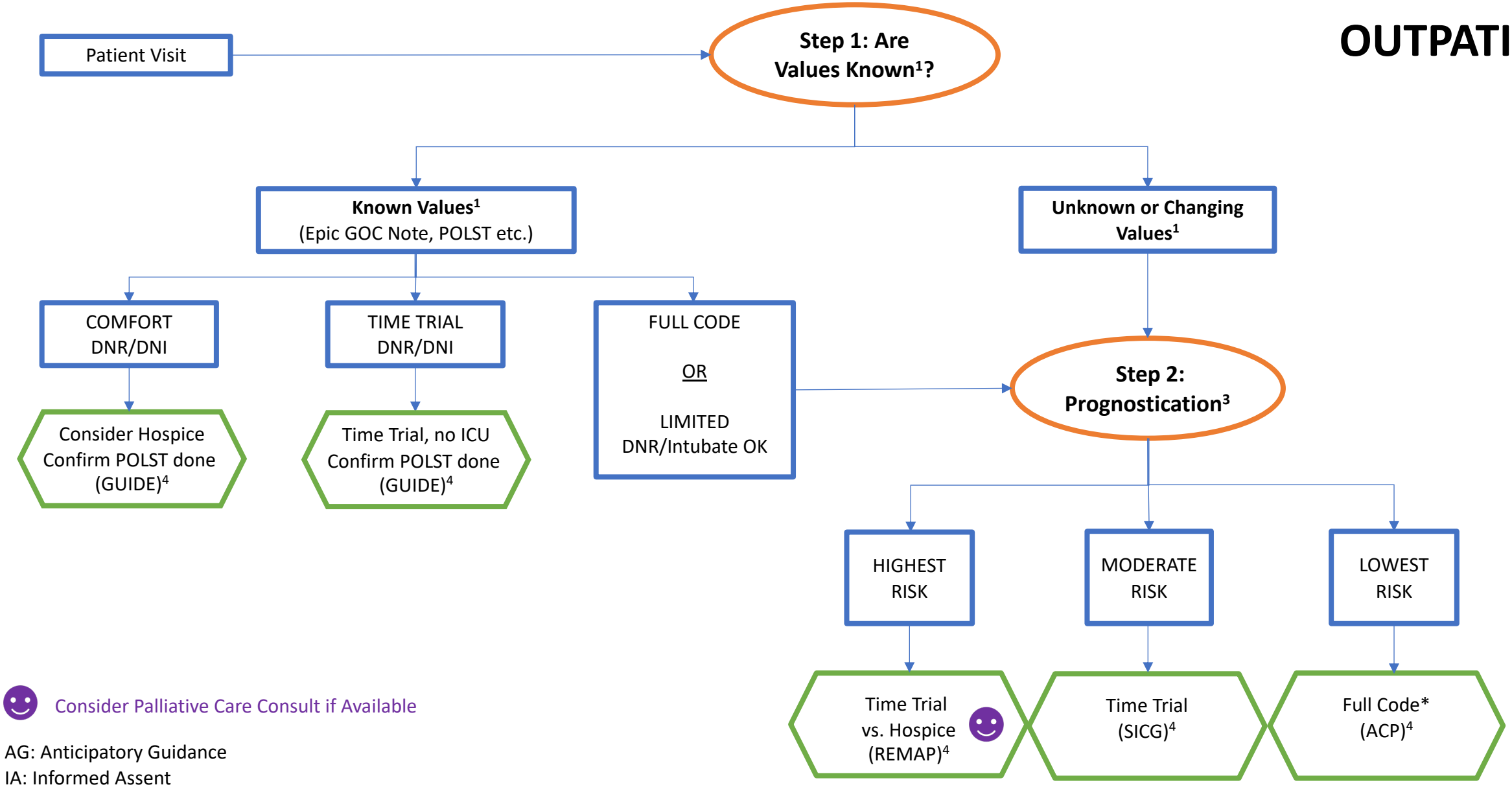
# OUTPATIENT and LONG TERM CARE

# OUTPATIENT




Consider Palliative Care Consult if Available

AG: Anticipatory Guidance
IA: Informed Assent
REMAP/GUIDE: See Conversation Maps

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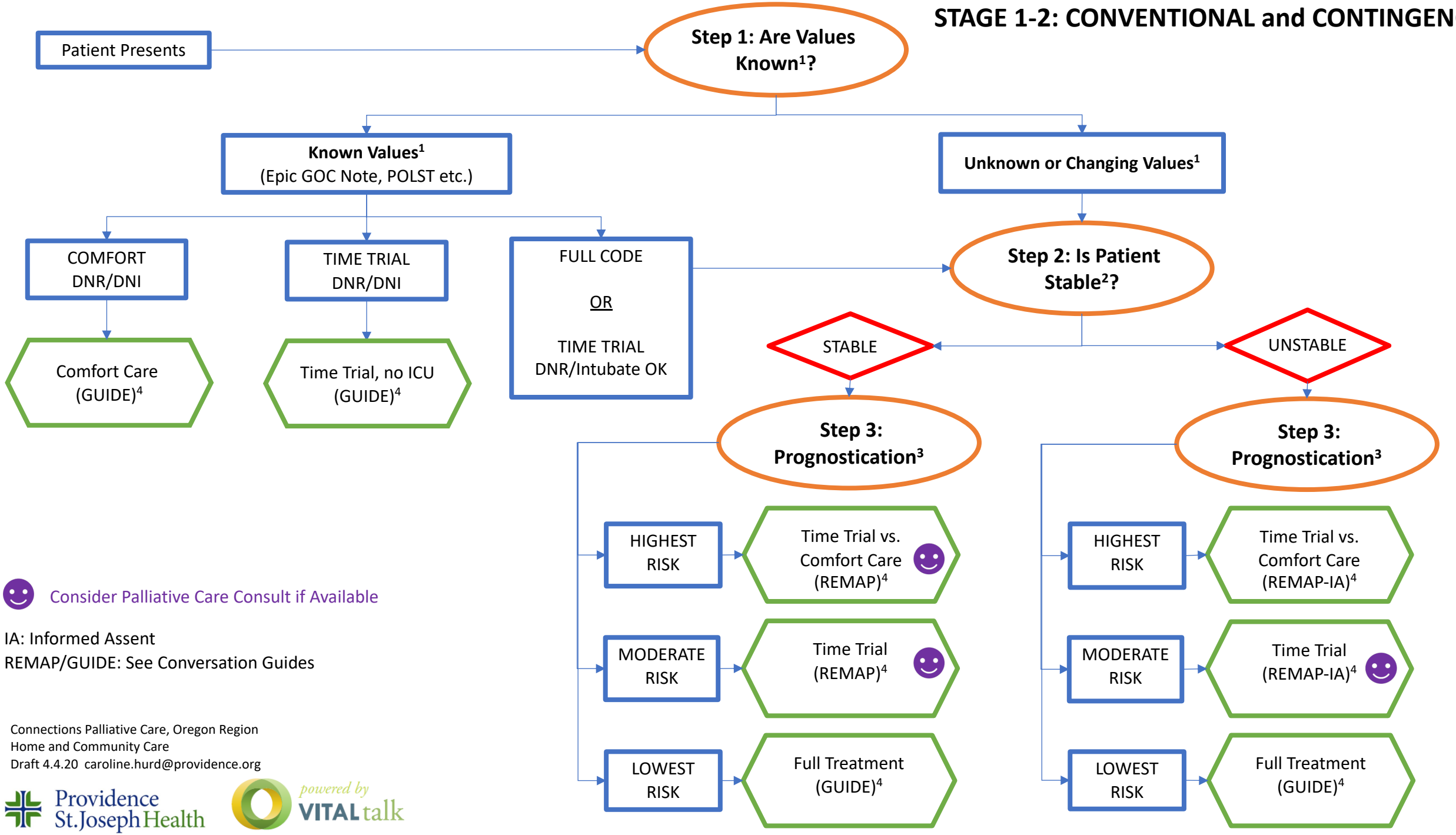
# INPATIENT and EMERGENCY DEPARTMENT

# STAGE 1-2: CONVENTIONAL and CONTINGENCY




Consider Palliative Care Consult if Available

IA: Informed Assent
REMAP/GUIDE: See Conversation Guides

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# STAGE 3: CRISIS

Patient Presents

**Step 1: Are Values Known[1]?**

**Known Values[1]** (Epic GOC Note, POLST etc.)

Crisis-REMAP[4]

**Step 2: Rapid Prognostication[3]**

**Unknown or Changing Values[1]**

COMFORT DNR/DNI

Comfort Care (GUIDE)[4]

TIME TRIAL DNR/DNI

Time Trial, no ICU (GUIDE)[4]

FULL CODE

OR

LIMITED DNR/Intubate OK

**Step 3: Resource Allocation Per State Protocol[5a] (Prognosis and Resource Dependent)**

YELLOW Lowest Benefit[5b]

Time Trial Vs. Comfort Care (Crisis-GUIDE)[4]

ORANGE Intermed Benefit[5b]

Time Trial (Crisis-GUIDE)[4]

RED Highest Benefit[5b]

Full Treatment* (Crisis-GUIDE)[4]

Consider Palliative Care only AFTER triage decision made

**Step 4: Reassess Values Prognosis and Resources**

Consider Palliative Care Consult if Available

Crisis REMAP/GUIDE: See Conversation Guides

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# Conversation by Crisis Stage

# Conversation by Location and Crisis Stage

| PROGNOSIS | CLINICIAN | STAGE 1: CONVENTIONAL | STAGE 2: CONTINGENCY | STAGE 3: CRISIS | DOCUMENTATION |
|---|---|---|---|---|---|
| **OUTPATIENT/LONG TERM CARE** | | | | | |
| Lowest Risk | PCP/Specialist | ACP | ACP | ACP | Advance Directive |
| Moderate Risk | PCP/Specialist | SICG | SICG | SICG | Advance Directive<br>GOC Note |
| Highest Risk | PCP/Specialist<br>+/- Pal Care | REMAP-Outpatient | REMAP-Outpatient | REMAP-IA | Advance Directive<br>GOC Note<br>+/- POLST (if DNR) |
| **INPATIENT/EMERGENCY ROOM** | | | | | |
| Lowest Risk | Primary Teams | GUIDE | GUIDE | Crisis-REMAP<br>Crisis GUIDE | GOC Note<br>Code Status |
| Moderate Risk | Primary Teams<br>+/- Pal Care | REMAP-Inpatient | REMAP-Inpatient | Crisis-REMAP<br>Crisis-GUIDE | GOC Note<br>Code Status |
| Highest Risk | Primary Teams<br>+/- Pal Care | REMAP-IA | REMAP-IA | Crisis-REMAP<br>Crisis-GUIDE | GOC Note<br>Code Status |

PCP: Primary Care Provider
ACP: Advance Care Planning
SICG: Serious Illness Conversation Guide
POLST: Portable Orders for Life Sustaining Treatment

GOC: Goals of Care
IA: Informed Assent
GUIDE: Get ready, Understanding, Inform, Demonstrate empathy, Equip
REMAP: Reframe, Empathize, Map Values, Align, Plan

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# Prognostication

# PROGNOSTICATION

Note: One tool cannot provide enough answer to determine prognosis, these tools should be used together to create your best estimate

| Component | Tool/Question | Lowest Risk | Moderate Risk | Highest Risk |
|---|---|---|---|---|
| **Acute Illness** | SOFA score[1] | ≤ 7<br>(Low potential for death) | 8-11<br>(Intermediate potential for death) | ≥ 12<br>(High potential for death) |
| **Functional Status**<br>**Functional Trajectory** | Frailty Scale[2] | 0 Criteria | 1-2 Criteria | 3+ Criteria |
| | Has the patient had any unplanned hospital admissions in the last 6 months?[3] | No<br>Or<br>Yes but age is <65y | Yes, and age is 65-85 | Yes, and age is ≥ 86y |
| | 2 yr "Surprise Question"<br>"Would I be surprised if this patient died in the next 2 years?"[4] | Yes, I would be surprised | No, I would not be surprised | No, I would not be surprised |
| **Disease Specific** | Does the patient have any of the following and what is the severity?[5]<br><br>Dementia<br>Malignancy<br>Heart Failure/CAD<br>Pulmonary Disease<br>ESRD<br>Cirrhosis<br>Progressive Neurologic Conditions (ALS etc.) | None<br><br>OR<br><br>Minor, well controlled, or earlier stage comorbidities | Major Comorbidities<br>(associated with significantly decreased long term survival)<br>• Moderate dementia<br>• Malignancy with a < 10 year expected survival<br>• NYHA Class III heart failure<br>• Severe multi-vessel CAD<br>• Moderately severe chronic lung disease (e.g., COPD, IPF)<br>• ESRD in patients <75y<br>• Cirrhosis with history of decompensation | Severe Comorbidities<br>(associated with >1 year survival)<br>• Severe dementia<br>• Cancer being treated with only palliative interventions<br>• NYHA Class IV heart failure plus evidence of frailty<br>• Severe chronic lung disease plus evidence of frailty<br>• ESRD ≥ 75y<br>• Cirrhosis with MELD score ≥20, ineligible for transplant |



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# SOFA SCORE

| ORGAN SYSTEM | SCORE = 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **RESPIRATORY Pa02/Fi02** | > 400 | ≤ 400 | ≤ 300 | ≤ 200 with resp. support | ≤ 100 with resp. support |
| **HEMATOLOGIC Platelets** | > 150 | ≤ 150 | ≤ 100 | ≤ 50 | ≤ 20 |
| **HEPATIC Bilirubin (mg/dl)** | < 1.2 | 1.2 – 1.9 | 2.0 – 5.9 | 6 – 11.9 | ≥ 12 |
| **CARDIOVASCULAR Hypotension** | None | Mean Arterial Pressure <70mmHg | Dopamine ≤ 5 or any Dobutamine | Dopamine > 5 or Epi < 0.1 or Nor-Epi ≤ 0.1 | Dopamine > 15 or Epi > 0.1 or Nor-Epi > 0.1 |
| **CNS Glasgow Coma Score** | 15 | 13 - 14 | 10 - 12 | 6 - 9 | <6 |
| **RENAL Creatinine** | <1.2 | 1.2 - 1.9 | 2.0 - 3.4 | 3.5 - 4.9 | ≥5.0 |

Taken from: Minnesota Health Care Preparedness Program:
HTTPS://WWW.HEALTH.STATE.MN.US/COMMUNITIES/EP/SURGE/CRISIS/INDEX

# FRAILTY SCALE

| FRAIL | SCORE = 0 |
|---|---|
| **F**atigue | *"Are you fatigued throughout the day?"* (yes=1pt) |
| **R**esistance | *"Can you walk up a flight of stairs?"* (no=1pt) |
| **A**mbulation | *"Can you walk a block?"* (no=1pt) |
| **I**llness | Does the patient have ≥ 5 of the following: HTN, DM, cancer (other than skin cancer), chronic lung disease, h/o MI/CAD/stent, CHF, angina, asthma, arthritis, h/o stroke/TIA, CKD? (yes=1pt) |
| **L**oss of weight | *"Have you lost weight unexpectedly in the past 6 months?"*<br>OR: If weights are in Epic, have they lost more than 5% body weight (yes=1pt) |
| **SCORE: 0 criteria = Robust \| 1 or 2 criteria = pre-frail \| 3+ criteria = frail** | |

Adapted from: Brigham and Women's Geriatric Resource for Front Line Clinicians Guide and
Ref: Morley et. al. www.ncbi.nlm.nih.gov/pmc/articles/PMC4515112/

# Role of Palliative Care

# Palliative Care in Stage 1 and 2 (Conventional and Contingency)

1. **Palliative Care Screening** for COVID19/PUI inpatients (ER or hospital) with serious chronic comorbidities and/or ≥ *65y* with:
   - Chart review to identify previously documented GOC/ACP (POLST registry, GOC Epic notes, advance directives etc.)
   - Call PCP/physician of trust as time allows
   - Proceed with palliative care intervention as indicated-ranging from assisting primary clinicians to palliative care specialty team intervention like formal patient care conference.
   - Rounding/Check-in with hospitalist and ICU teams to assess for unmet palliative care needs

2. **Advice and Coaching for Staff, Primary and Other Specialty Teams:**
   - **Prognosis**: Initial prognosis assessment
   - **Communication**:
     - How to deliver serious news and how to convey what beneficial/appropriate treatments are available for patients.
     - Giving anticipatory guidance and basic goals of care conversations (code status, POLST, SICG, REMAP)
   - **Whole Person Symptom management**
     - For patients at any level of care/intervention.
     - For patients on comfort care, including use of comfort care orders and managing end of life trajectory, symptoms to ensure comfort in dying, and support patient and family.
   - **Clinician Moral Distress**

3. **Specialty Consultation**
   - **Prognosis assessment** in patients with serious chronic illness that considers patient's entire health status (acute illness(es), chronic illness(es), and frailty). Assessment includes disease trajectory with estimated life expectancy/survival, functional status, and the likelihood of available treatments achieving an acceptable health state.
   - **Communication: Goals of care conference with patient/family** when communication is difficult, there are discordant values, family dynamics are challenging, or when there are other barriers to establishing a care plan moving forward.
   - **Whole Person Symptoms:** Complex or refractory symptom management or psychosocial/spiritual distress

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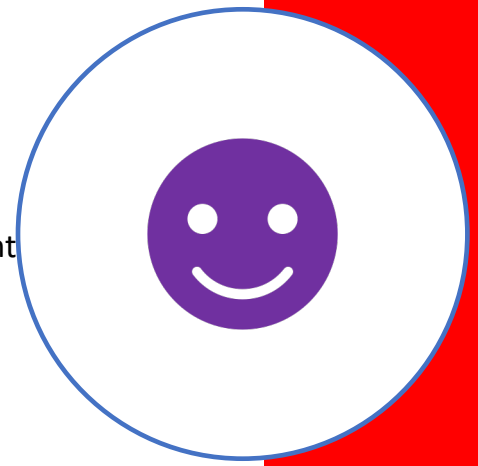
# Palliative Care in Stage 3 (Crisis, Resource Allocation)

- **The Palliative Care Team will continue to provide the same services that are provided in Stages 1 and 2, as staffing and conditions allow***
- **The Palliative Care Team will NOT be involved in Triage Decisions about Resource Allocation. This will be done by the Triage Officer and the Triage Team**

**The following <u>additional</u> services will be offered in Stage 3 as staffing allows:**

1. **Palliative Care Screening**:
   - Assist primary teams in rapid assessment of prior documented goals of care in Epic in high risk patients
   - Assist primary teams in rapid assessment of prognostication in high risk patients
   - Proceed to full palliative care consultation as indicated based on communication, whole person symptom management needs and staff availability
2. **Palliative Care Communication**
   - Although resource allocation will be determined by the Triage Team/Triage Officer, Palliative Care can be consulted, **AFTER a triage decision is delivered, to support the patient/family.** For particularly challenging communication situations, Palliative Care can be consulted to coach the Triage Officer and/or Primary Team Attending Physician in person-centered communication and conflict management.
3. **Palliative Care Whole Person Symptom Management**
   - Assist with end of life symptom management, psychosocial/spiritual distress related to pandemic



*Formal Palliative Care specialty team interventions may be dependent on patient acuity (stable vs unstable) and staffing availability, making coaching and support of primary clinicians in primary palliative skills crucial.

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