COVID-19 Advance Care Planning and Serious Illness Conversations

Caroline Hurd MD, Elke Lowenkopf MD, Lena Hillenburg MD, Linda DeSitter MD, MPH
Connections Palliative Care, Oregon Region
Providence Health and Services, Home and Community Care
OUTPATIENT and LONG TERM CARE
Consider Palliative Care Consult if Available

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

Patient Visit

Step 1: Are Values Known\(^1\)?

Known Values\(^2\)
(Epic GOC Note, POLST etc.)

- COMFORT DNR/DNI
- TIME TRIAL DNR/DNI
- FULL CODE
  - OR
  - LIMITED
  - DNR/Intubate OK

Unknown or Changing Values\(^1\)

Step 2: Prognostication\(^3\)

- HIGHEST RISK
  - Time Trial vs. Hospice (REMAP)\(^4\)
- MODERATE RISK
  - Time Trial (SICG)\(^5\)
- LOWEST RISK
  - Full Code* (ACP)\(^6\)

Consider Hospice Confirm POLST done (GUIDE)\(^4\)
Time Trial, no ICU Confirm POLST done (GUIDE)\(^4\)

Connections Palliative Care, Oregon Region
Home and Community Care
Draft 4.4.20 caroline.hurd@providence.org
INPATIENT and
EMERGENCY DEPARTMENT
Patient Presents

Step 1: Are Values Known?  
- Known Values (Epic GOC Note, POLST etc.)
  - COMFORT DNR/DNI
  - TIME TRIAL DNR/DNI
  - FULL CODE OR TIME TRIAL DNR/Intubate OK
    - Comfort Care (GUIDE)  
    - Time Trial, no ICU (GUIDE)

Step 2: Is Patient Stable?  
- Stable
  - Step 3: Prognostication
    - HIGHEST RISK  
      - Time Trial vs. Comfort Care (REMAP)
    - MODERATE RISK  
      - Time Trial (REMAP)
    - LOWEST RISK  
      - Full Treatment (GUIDE)
- Unstable
  - Step 3: Prognostication
    - HIGHEST RISK  
      - Time Trial vs. Comfort Care (REMAP-IA)
    - MODERATE RISK  
      - Time Trial (REMAP-IA)
    - LOWEST RISK  
      - Full Treatment (GUIDE)

Consider Palliative Care Consult if Available
IA: Informed Assent
REMAP/GUIDE: See Conversation Guides

Connections Palliative Care, Oregon Region
Home and Community Care
Draft 4.4.20 caroline.hurd@providence.org
Patient Presents

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

- Full Code
- OR
- Limited DNR/Intubate OK

**Step 3: Resource Allocation**
Per State Protocol
(Prognosis and Resource Dependent)

- Time Trial
- Full Treatment

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

- Consider Palliative Care Consult if Available
- Crisis REMAP/GUIDE: See Conversation Guides

Connections Palliative Care, Oregon Region
Home and Community Care
Draft 4.4.20 caroline.hurd@providence.org
Conversation by Crisis Stage
## Conversation by Location and Crisis Stage

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

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
Prognostication
### Prognostication

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

<table>
<thead>
<tr>
<th>Component</th>
<th>Tool/Question</th>
<th>Lowest Risk</th>
<th>Moderate Risk</th>
<th>Highest Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Illness</strong></td>
<td>SOFA score[^1]</td>
<td>≤ 7 (Low potential for death)</td>
<td>8-11 (Intermediate potential for death)</td>
<td>≥ 12 (High potential for death)</td>
</tr>
<tr>
<td><strong>Functional Status</strong></td>
<td>Frailty Scale[^2]</td>
<td>0 Criteria</td>
<td>1-2 Criteria</td>
<td>3+ Criteria</td>
</tr>
<tr>
<td><strong>Functional Trajectory</strong></td>
<td>Has the patient had any unplanned hospital admissions in the last 6 months[^3]</td>
<td>No Or Yes but age &lt;65y</td>
<td>Yes, and age is 65-85</td>
<td>Yes, age is ≥ 86y</td>
</tr>
<tr>
<td><strong>Disease Specific</strong></td>
<td>Does the patient have any of the following and what is the severity[^4]</td>
<td>None OR Minor, well controlled, or earlier stage comorbidities</td>
<td>Major Comorbidities (associated with significantly decreased long term survival)</td>
<td>Severe Comorbidities (associated with &gt;1 year survival)</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td></td>
<td>▪ Moderate dementia</td>
<td>▪ Severe dementia</td>
</tr>
<tr>
<td></td>
<td>Malignancy</td>
<td></td>
<td>▪ Malignancy with a &lt; 10 year expected survival</td>
<td>▪ Cancer being treated with only palliative interventions</td>
</tr>
<tr>
<td></td>
<td>Heart Failure/CAD</td>
<td></td>
<td>▪ NYHA Class III heart failure</td>
<td>▪ NYHA Class IV heart failure</td>
</tr>
<tr>
<td></td>
<td>Pulmonary Disease</td>
<td></td>
<td>▪ Severe multi-vessel CAD</td>
<td>plus evidence of frailty</td>
</tr>
<tr>
<td></td>
<td>ESRD</td>
<td></td>
<td>▪ Moderately severe chronic lung disease (e.g., COPD, IPF)</td>
<td>▪ Severe chronic lung disease</td>
</tr>
<tr>
<td></td>
<td>Cirrhosis</td>
<td></td>
<td>▪ ESRD in patients &lt;75y</td>
<td>plus evidence of frailty</td>
</tr>
<tr>
<td></td>
<td>Progressive Neurologic Conditions (ALS etc.)</td>
<td></td>
<td>▪ Cirrhosis with history of decompensation</td>
<td>▪ ESRD ≥ 75y</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>▪ Cirrhosis with MELD score ≥20, ineligible for transplant</td>
</tr>
</tbody>
</table>

[^1]: References:  
[^2]: References:  
[^3]: References:  
[^4]: References:
# SOFA SCORE

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

## FRAILTY SCALE

<table>
<thead>
<tr>
<th>FRAIL</th>
<th>SCORE = 0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatigue</strong></td>
<td>“Are you fatigued throughout the day?” (yes=1pt)</td>
</tr>
<tr>
<td><strong>Resistance</strong></td>
<td>“Can you walk up a flight of stairs?” (no=1pt)</td>
</tr>
<tr>
<td><strong>Ambulation</strong></td>
<td>“Can you walk a block?” (no=1pt)</td>
</tr>
<tr>
<td><strong>Illness</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Loss of weight</strong></td>
<td>“Have you lost weight unexpectedly in the past 6 months?”</td>
</tr>
<tr>
<td></td>
<td>OR: If weights are in Epic, have they lost more than 5% body weight (yes=1pt)</td>
</tr>
</tbody>
</table>

**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
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 additional 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.