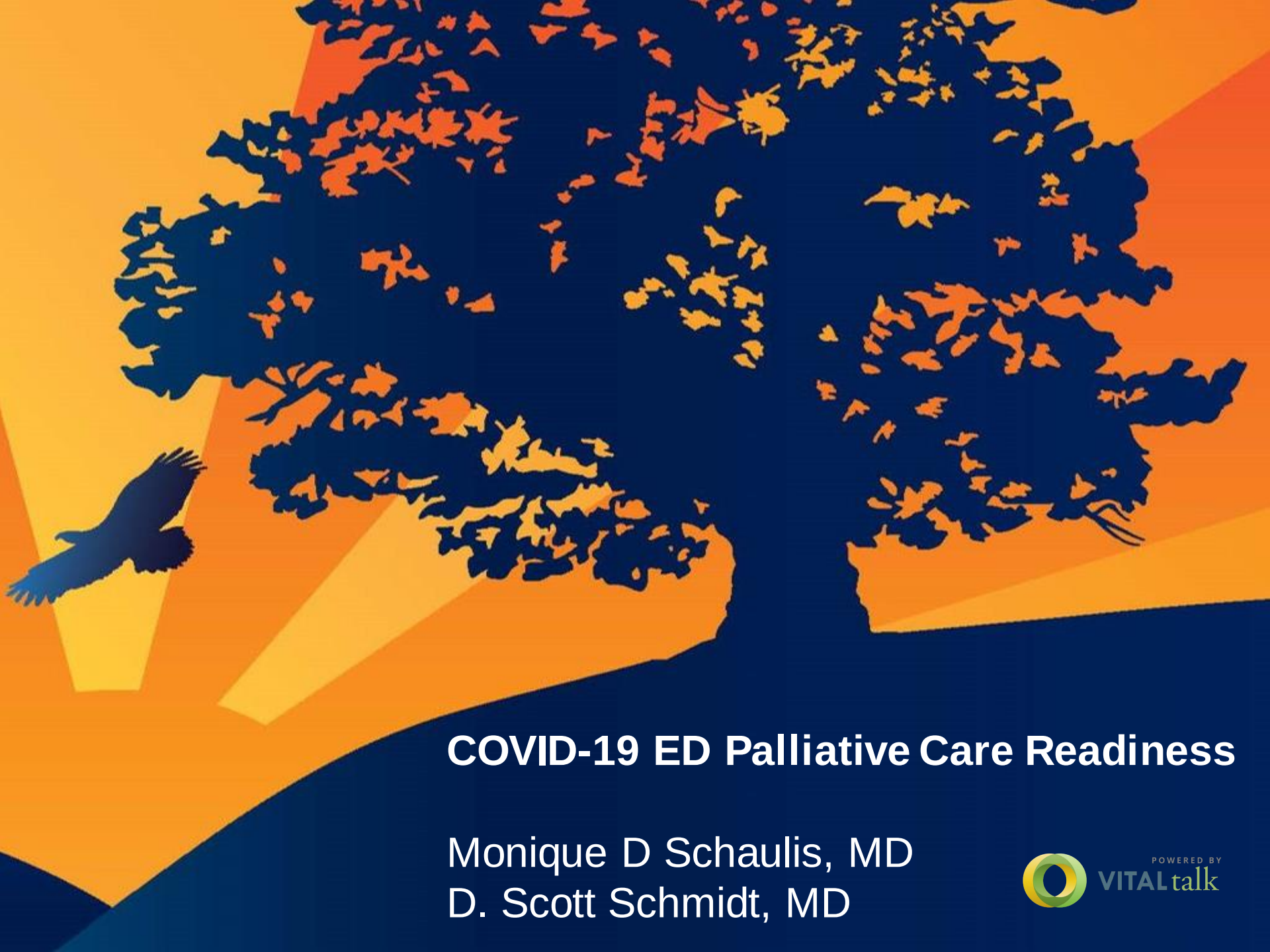

COVID-19 ED Palliative Care Readiness

Monique D Schaulis, MD
D. Scott Schmidt, MD

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Unanswered questions

Ventilator Shortages Loom As States Ponder Rules For Rationing

April 3, 2020 · 5:00 AM ET

MARTIN KASTE REBECCA HERSHER

The Covid-19 crisis too few are talking about: health care workers' mental health

Overwhelmed NYC Hospitals Reportedly Implementing 'Do Not Resuscitate' Policies For Coronavirus Patients

Health

Faced with a crush of patients, besieged NYC hospitals struggle with life-or-death decisions

Some have activated 'do-not-resuscitate' policies for coronavirus patients, canceled all but the most urgent surgeries and abandoned the use of isolation rooms.

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Prognosis

High risk populations

- Constantly moving target
- Case fatality rate in ages 80-89 likely 15-20% (Lancet and JAMA)
- UK -Critical care age >70, so far 68% died in ICU (many pts still in ICU so may be higher) Geripal 4/6
- Evergreen Hosp, WA (SNF pts) ICU mortality 70-90%
- Ventilator mortality older adults likely well over 50% may be up to 90%

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What's the Same?

We are still trying to give the best care possible

ED visit often determines trajectory of care for hospital course, particularly in cases of severe illness

AND some patients still don't want and shouldn't get aggressive care near the end of their lives

Case Scenario

79 yo with ESRD from SNF, non ambulatory. COVID test positive from SNF.

Temp 100 RR 28, 02 85% on NRB BP 98/66, HR 108

Pt is confused and slightly agitated, unable to participate in decision making.

Approach:

1. Critically ill.
2. Mortality likely >80%.
3. You wisely determine that you must address goals of care.


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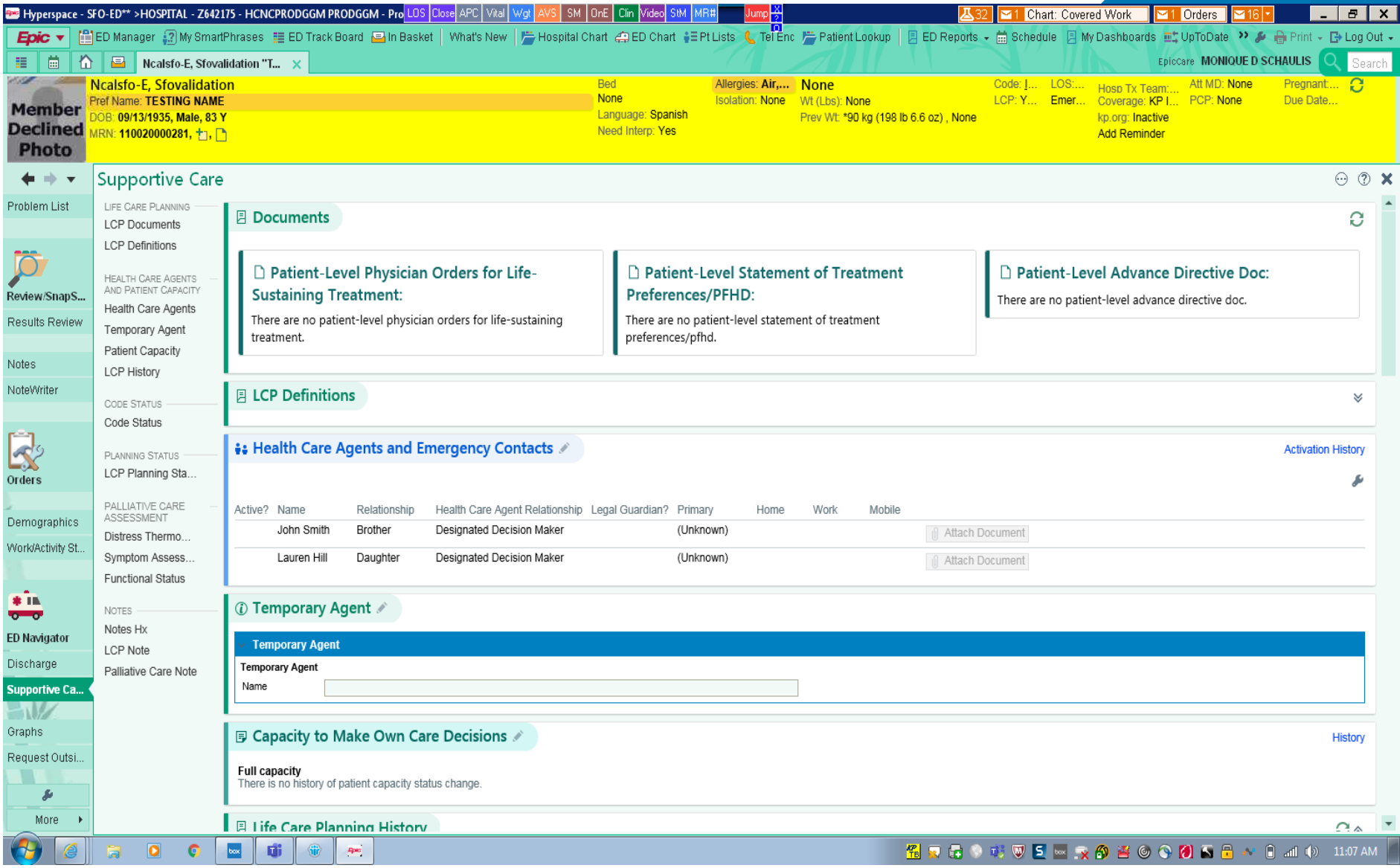

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Goals of Care Conversations

A high value intervention more important than ever because of the scale of the challenge we're facing

Ensure patients receive care consistent with their values and based in the reality of their prognosis

They can help to avoid unnecessary suffering for patients and to decrease moral distress for clinicians

Evidence shows that patients with advanced illness often choose less aggressive treatment and therefore will help with resource stewardship

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LIFEMAP: A GUIDE FOR VITAL CONVERSATIONS

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		Relationship to 4 Habits
		Invest in the beginning
L	**Lead the conversation**	"How have things been going for you?" "Given this situation, it is a good time to talk about the kind of care you would want if you were unable to speak for yourself". "Would it be ok to talk about what to do if your mom's breathing starts to fail?"
		Elicit the patient's perspective
I	**Invite the patient's perspective**	"What have you been thinking about COVID19 in your situation?" "What have you been told about how serious COVID19 can be for someone with your health conditions?"
F	**Focus on accurate understanding**	"Would it be okay if I added my perspective on what having COVID-19 might mean for you?" Consider a warning shot: "I wish things were different" or "I wish I had better news" "Unfortunately, most patients with your illnesses whose breathing fails due to COVID-19 and need a ventilator are unlikely to survive"
		Demonstrate empathy
E	**Expect emotion and demonstrate empathy**	"None of us were expecting we'd be facing something like this." "It sounds like you are frustrated or worried or scared or overwhelmed" (Naming) "I can see how committed you are to getting the best care possible for your..." (Respecting)
		Invest in the end
M	**Map important values & goals**	"Could we step back for a moment so I can understand more about you and what is most important given this situation?" "Given what COVID could mean for you, what worries you most?" "If we think you are dying of COVID, what would you/your dad want us to know?"
A	**Align yourself explicitly**	"Here's what I am hearing about your priorities." "I am hearing that your mom would want us to help her die as peacefully as possible" **Before you suggest a plan, show you heard them.**
P	**Plan & personally reflect**	"Given what you have told me, I recommend ...Do I have that right?" "What we will do is...What we won't do is…." **Don't assume the patient thinks you're on their side. Tell them.**

L I F E M A P

LEAD
the conversation

“How are you feeling about all this?”

“Given this situation, it is a good time to talk about the kind of care you would want if you were unable to speak for yourself”.

“Would it be ok to talk about what to do if your mom’s breathing starts to fail?”

L

I

F

E

M

A

P

INVITE
the patient's perspective

"What have you been thinking about COVID19 in your situation?“

"What have you been told about how serious COVID19 can be for someone with your health conditions?“

L I F E M A P

FOCUS
on accurate understanding

"Would it be okay if I added my perspective on what having COVID-19 might mean for you?"

Consider a warning shot: "I wish things were different" or "I wish I had better news"

"Unfortunately, most patients with your illnesses whose breathing fails due to COVID-19 and need a ventilator are unlikely to survive"

L
I
F
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EXPECT
emotion and demonstrate empathy

"None of us were expecting we'd be facing something like this."

"It sounds like you are frustrated or worried or scared or overwhelmed" (Naming)

"I can see how committed you are to getting the best care possible for your..." (Respecting)

L I F E **M** A P

MAP
important values and goals

“Could we step back for a moment so I can understand more about you and what is most important given this situation?”

"Given what COVID could mean for you, what worries you most?“

“If we think you are dying of COVID, what would you/your dad want us to know?”

L
I
F
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M
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P

MAP
important values and goals

"If your loved one heard and understood how serious this could be for her, what would she want us to know?"

Build your understanding of this patient as a person to make a recommendation that will stick.

L I F E M A P

ALIGN
yourself explicitly

“Here’s what I am hearing about your priorities.”

"I am hearing that your mom would want us to help her die as peacefully as possible”

Before you suggest a plan, show you heard them.

L I F E M A P

PLAN
and personally reflect

"Given what you have told me, I recommend ...Do I have that right?“

“What we will do is...What we won’t do is….”

Don’t assume the patient thinks you’re on their side. Tell them.

Documenting your Goals of Care Conversation

.goalsofcare

GOALS OF CARE DISCUSSION

- **GOC Discussed With:** Multi-select
  - Patient/Family/Agent/ Other
- **Does the patient have capacity?** Single select
  - Patient has decision-making capacity/Patient does not have decision-making capacity/Other: ***
- **Does patient have DDM or DPOAHC named in AHCD?** Single Select
  - Yes/No/Other
- **Patient/Family Understanding of Illness:** Single Select
  - Informed/Limited Understanding/***
- **Quality of life defined by:** Multi-select
  - Physical Independence/Mental Clarity/Ability to Communicate/***
- **Values Expressed Relevant to Treatment Preferences:** Multi-select
  - Longevity/Maintain Quality of Life/Comfort-focused treatment/***
- **PLAN: ****
- **POLST:** Single Select:
  - Yes (POLST drop down)/No/ Patient has a POLST form on file dated *** that was reviewed with patient or surrogate and validated as current/Other: ***
- **Inpatient Code Status:** Single Select:
  - Full Code/Partial/DNR
  - Discussed with: ***
- **Next Steps:** Multiselect
  - Refer to Palliative Care/Refer to Life Care Planning/Refer to Hospice/Continue current treatment plan/
  - Other: ***

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SUPPORTIVE CARE SERVICES

Who Else Should Have a Conversation?

COVID with risk factors being discharged

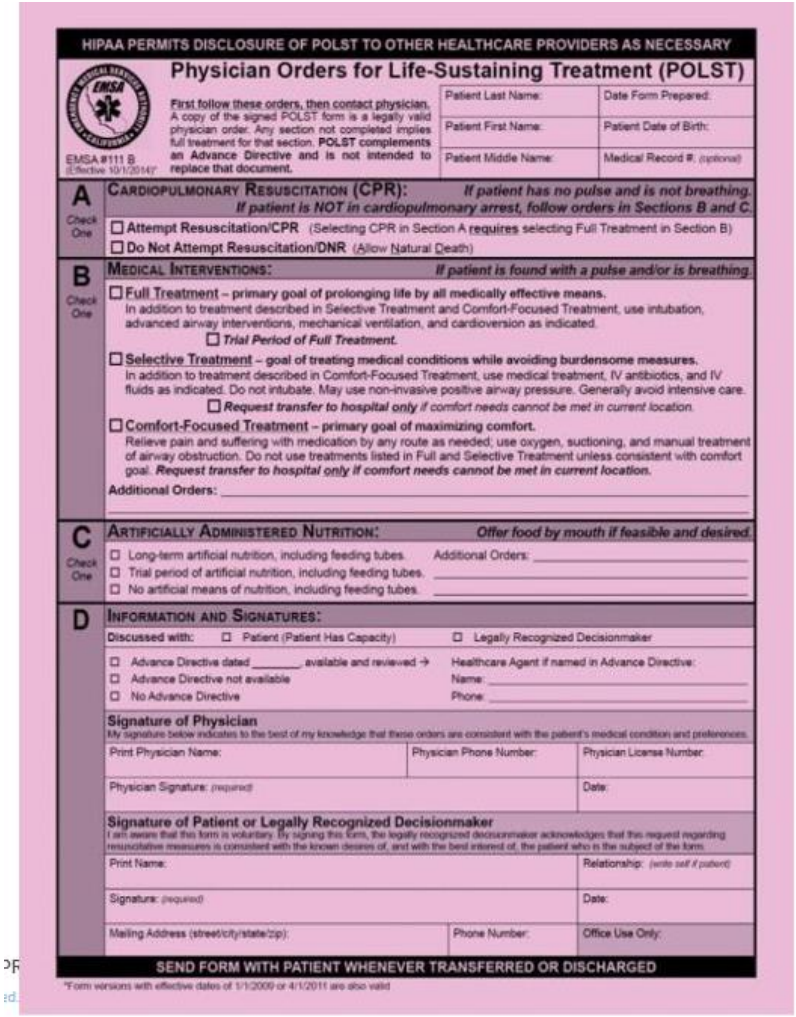
- 75 yo HTN, COPD, PUI/ COVID but well enough to discharge

- *“Here's what we know about COVID-19: Most people don’t need the hospital."*
- *The people who get sickest from COVID are older or have existing medical problems **e.g.** diabetes, high blood pressure, lung disease or heart disease, like you do."*
- *"We hope that your disease won't be severe, but this is a good time to talk about it. Should you get worse and your breathing begins to fail, what would you want us to know about how best to treat you?"*

When to complete a POLST in the context of COVID-19?

Complete a POLST If a patient or decision maker makes it clear that the patient does not want:

- CPR
- intubation
- life prolonging measures ie wants comfort focused care only



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 10/1/2014)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name: | Date Form Prepared:
Patient First Name: | Patient Date of Birth:
Patient Middle Name: | Medical Record #: (optional)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ *Trial Period of Full Treatment.*

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
☐ Trial period of artificial nutrition, including feeding tubes. _____
☐ No artificial means of nutrition, including feeding tubes. _____

D **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name: | Physician Phone Number: | Physician License Number:
Physician Signature: (required) | Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name: | Relationship: (write self if patient)
Signature: (required) | Date:
Mailing Address (street/city/state/zip): | Phone Number: | Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

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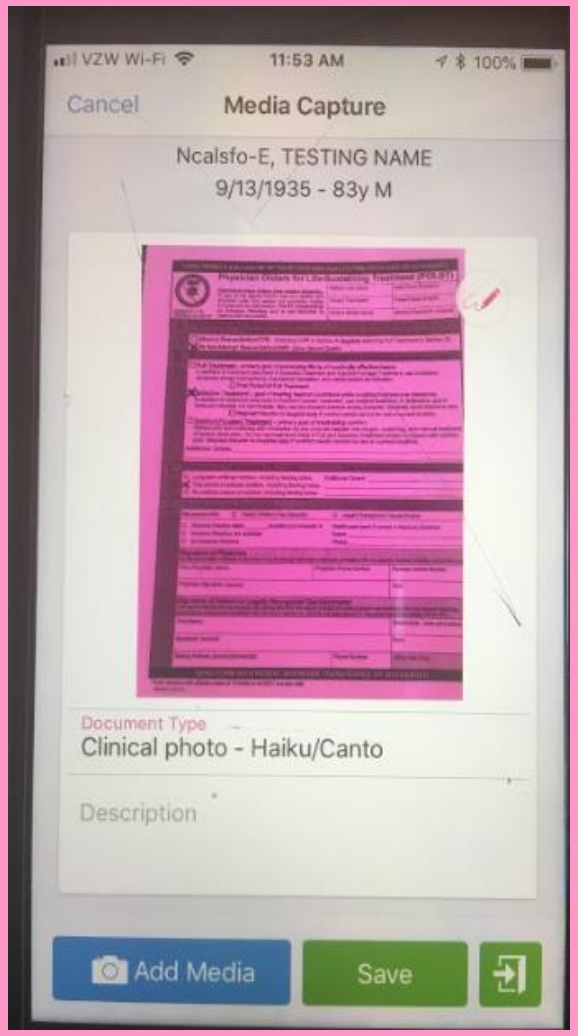
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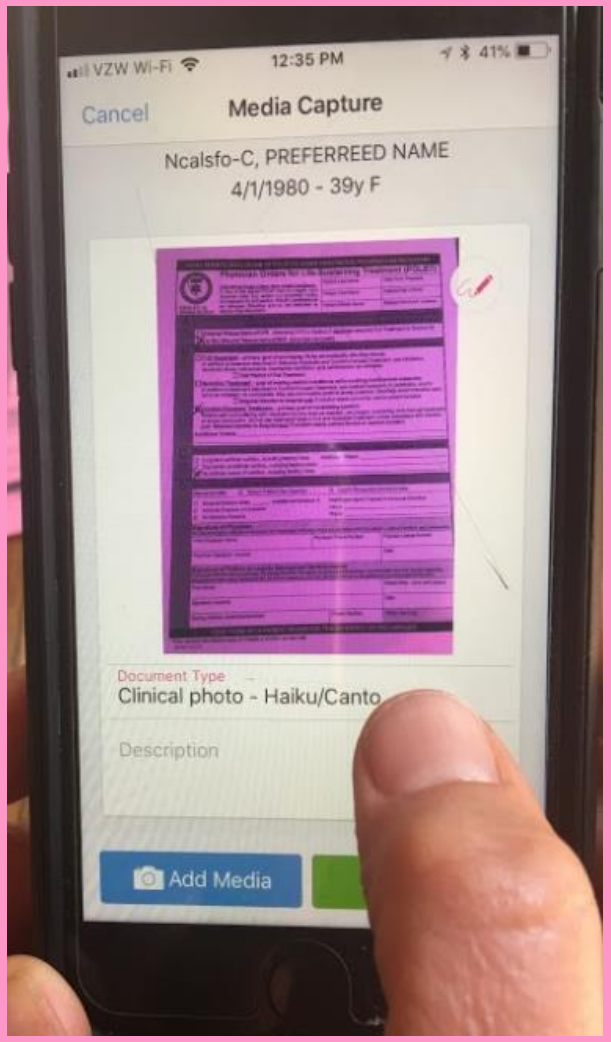
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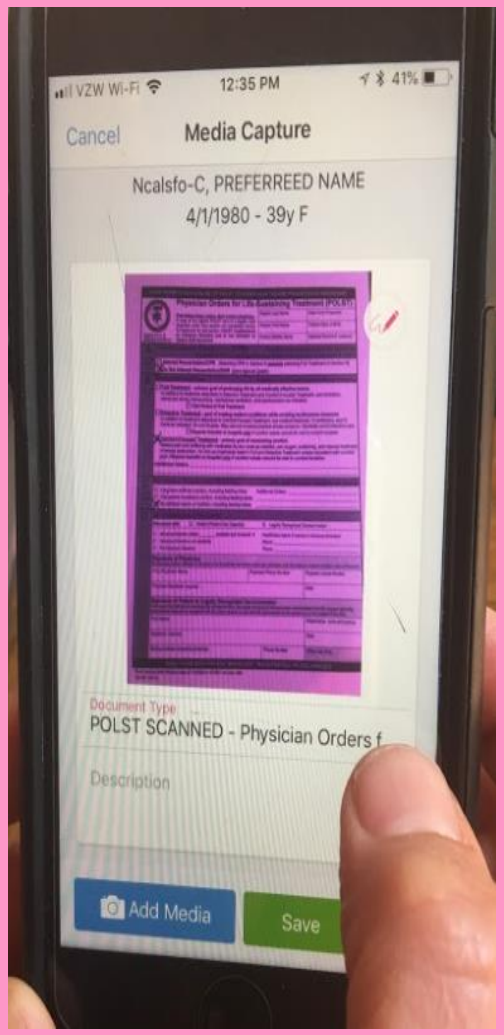
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COVID-19 Hospice Considerations

- No Medicare eligibility criteria exist yet
- Consider hospice referral for any high risk patient
  - Huge benefit is that patients could be with their families
- Hospice capacity may be limited by PPE, volume
- Hospice workflows are determined locally

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RESPECT: COVID-19 The Final Hours of Life

Critically ill or imminently dying patients that are DNR/Comfort are ours to help with

Comfort meds:

- Comfort Care Order set
- Morphine for dyspnea
  - 2-4 mg bolus and consider drip to ease RN/PPE burden
- Increased secretions reported
  - Glycopyrrolate; Atropine drops

Chaplain/SW support as available

Visitor restrictions appropriate but sad

- Official policy is that a dying patient may have one visitor
- Video visit on a workstation on wheels (WOW) with family at home
- Use patient's phone to set up facetime with loved ones

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SUPPORTIVE CARE SERVICES

COVID-19 ED Palliative Care Readiness: Conclusions

The COVID 19 pandemic is the greatest healthcare challenge of our time

- Goals of Care conversations are critical in all high risk COVID patients and especially those with respiratory failure

- Document your conversations.
    - .goalsofcare dot phrase
    - POLST

- Consider hospice referral for high risk patients that want to focus on comfort

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SUPPORTIVE CARE SERVICES

Thank you!

All the ED physicians and leadership

Supportive Care Services

Physician Education and Development

VitalTalk

Additional Trainings and Resources

Trainings/Resources	Details
CAPC Modules: **Pain:** https://www.capc.org/training/pain-management **Dyspnea:** https://www.capc.org/training/symptom-management/dyspnea/ **Anxiety:** https://www.capc.org/training/symptom-management/anxiety/ **Depression:** https://www.capc.org/training/symptom-management/depression/ **Nausea and Vomiting:**	All modules except pain are open to the public. You will need to create and account to access lecture on pain. Using your KP email and The Permanente Medical Group as your organization. Modules range between 30 mins-1 hr. CME provided upon completion of these courses.
SPC Guidelines for Covid-19	Guidelines to delivering care in the inpatient, outpatient and community setting. Includes recommendations for triaging, in person vs virtual care, and self care.
POLST FAQ: https://capolst.org/wp-content/uploads/2020/01/FAQ_Clinical.pdf	
Comfort Care Guidelines for Covid-19	Intended for hospitalized patients on comfort care. These guidelines will be included in the medical surgical and intensive care surge playbooks and posted on the regional command center sharepoint site.
SPC Documentation Job Aides (For initial and follow up consults and goals of care conversations updated for Covid-19)	Considerations for documentation during time of Covid-19 Surge
SCS Telehealth Tips for Clinicians	Messaging for discussions with patients and families specific to Covid-19.

References for Presentation

- https://www.youtube.com/watch?v=UdUci2Y9QB8U
- POLST FAQ: https://capolst.org/wp-content/uploads/2020/01/FAQ_Clinical.pdf
- **Center to Advance Palliative Care (CAPC)**
- Communication, ***Symptom management resources***, Palliative Care tools, TeleHealth, Patient and Family Support resources
- https://www.capc.org/toolkits/covid-19-response-resources/
- CDC: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#conditions
- Vital Talk
- https://www.vitaltalk.org/guides/covid-19-communication-skills/
- Documentation Resource Guide: https://sp-cloud.kp.org/sites/NCALSCS/SCS_Documents/Forms/AllItems.aspx?id=%2Fsites%2FNCALSCS%2FSCS%5FDocuments%2FLCP%20KPHC%20Job%20Aid%2Epdf&parent=%2Fsites%2FNCALSCS%2FSCS%5FDocuments

- ACEP COVID conversation framework 4/3/20 https://pod51096.outlook.com/mail/inbox/id/AAQkADM2MDJhNjQxLTM2YTQtNDFhZS1iZDk1LWMxMGRhZDg4M2FkMgAQAHpBngurqx9Lg7bwSWydx4c%3D
- https://www.geripal.org/2020/04/what-is-prognosis-of-covid-19.html

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Which patients need a GOC conversation in the setting of probable COVID 19?

1) Does this person have one or more advanced chronic conditions or a serious illness with a poor prognosis or advanced frailty?

2) Would you be surprised if the person dies in the next year?

3) Does the person express a desire to receive or avoid any or all life-sustaining treatment?

4) Does the person live in a nursing home or receive long term care services at home or in an assisted living facility?

5) Does this patient have decreased function, frailty, progressive weight loss, >= 2 unplanned admissions in last 12 months

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SUPPORTIVE CARE SERVICES