Role of Palliative Care During COVID-19 Pandemic

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Outline

A. Three Core Applied Principles of Palliative Care in view of COVID-19 Pandemic
    1. Tips on communication
    2. Prognostication scales/tools
    3. High-yield resources on Primary Palliative Care especially on symptoms management
B. Additional tips on applying these principles virtually (when using telehealth)
C. Indications for additional help for Specialist Palliative Care

Three Core Applied Principles of Palliative Care

1. Discussion of Patient Wishes/Goals/Expectations, Articulation of Goals of Care, Sympathetic repeated-Stepwise Explanation of Facts and Align Treatment Plan-Communication
2. Minimize suffering via aggressive symptom control
3. Psychosocial support including for family/caregivers

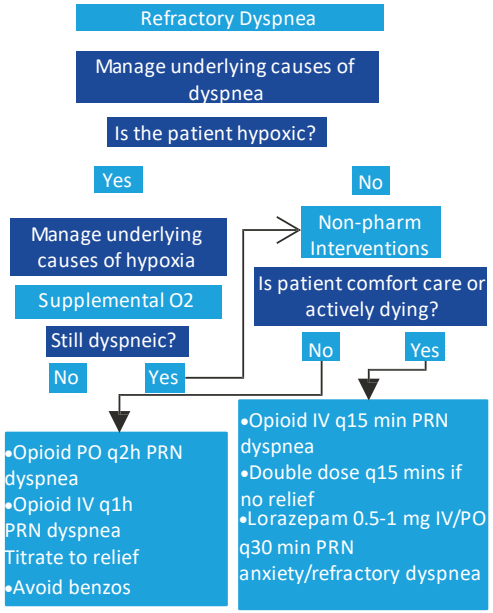
Role of Palliative Care in COVID-19 Pandemic

- **Communication:** Engage all patients to plan treatment decisions in advance (starting with the highest-risk patients); Provide step-wise guidance at each stage/visit, and summarize/document using standard format (MOLST)
- **Aggressive Symptoms Management:** For three groups of patients:
  - People with symptomatic COVID-19
  - People dying without ventilator support
  - People requiring hospitalization and ventilatory support

  Help manage patients at HOME who DO NOT WANT to go to hospital (and appropriately care for those who do not want to receive ventilator support).
- **Psycho-socio-spiritual Support:** For patients/families including the care of bereaved families including the care newly deceased bodies with dignity

A Pocket Care on Palliative Care for COVID-19

Relief of Dyspnea



Non-Pharmacologic Interventions:

- Bring patient upright or to sitting position
- Consider mindfulness, mindful breathing

Pharmacologic Interventions:

- Opioids are treatment of choice for refractory dyspnea
- For symptomatic patients, using PRN or bolus dosing titrated to relief is more effective and safe compared to starting an opioid infusion

Dosing Tips:

- For opioid naïve patients
  - PO Morphine 5-10 mg
  - PO Oxycodone 2.5-5 mg
  - IV/SC Morphine 2-4 mg
  - IV/SC Hydromorphone 0.4-0.6 mg
- Consider smaller doses for elderly/frail

Opioid Quick Tips

Pharmacodynamics of Opioids:

- **Time to peak effect / Duration of Action**
- **PO Opioids: 30-60 minutes / 3-4 hours**
- **IV Opioids: 5-15 minutes / 3-4 hours**
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

Other Opioid Principles:

- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

Relative Strengths & Conversion Table

Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	--
Hydromorphone	7.5	1.5

*Avoid fentanyl due to shortage

If Using Opioids, Start a Bowel Regimen:

- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs q HS, can increase to 4 tabs BID
- Add Miralax 17 gm daily, can increase to BID
- Bisacodyl 10 mg suppository if no BM in 72 hrs

Tips on Communication Skills

What They Say	*What You Say*
How bad is this?	From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day**, and we will update you.
Is my mother going to make it?	**I imagine you are scared.** Here's what I can say: because she is 70, and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.**
Shouldn't she be in an intensive care unit?	You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.**
What happens if she gets sicker?	If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her.
How can you just take her off a ventilator when her life depends on it?	Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different.
Resuscitation Status COVID-19	***Example Language***
Approach to when your clinical judgment is that a patient would not benefit from resuscitation	Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life**. My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear.
If in agreement:	These are really hard conversations. **I think this plan makes the most sense for you.**
If not in agreement:	These are really hard conversations. **We may need to talk about this again.**

When/How to Call for Help

[Insert Your PC Program Contact Info Here]

We are here to help. We've got your back.

In addition to typical circumstances and consults, please consult us if:
•Patient in respiratory distress and not getting comfortable with initial efforts

Additional Resources

www.capc.org/toolkits/covid-19-response-resources/

Download these apps (Google Play or App Store) for more palliative care resources:

VitalTalk Tips (Communication)

Fast Facts (Symptom Management)

Current as of 3/27/2020. Stanford Health Care. Acknowledgements: MGH Continuum project, CAPC, VitalTalk, Gary Hsin, Karl Lorenz, Stephanie Harman, Ashley Bragg, Shireen Heidari, and Grant Smith, Modified by Diane E. Meier

A Bit More On Communication

- Explore, understand and document patient's goals of care

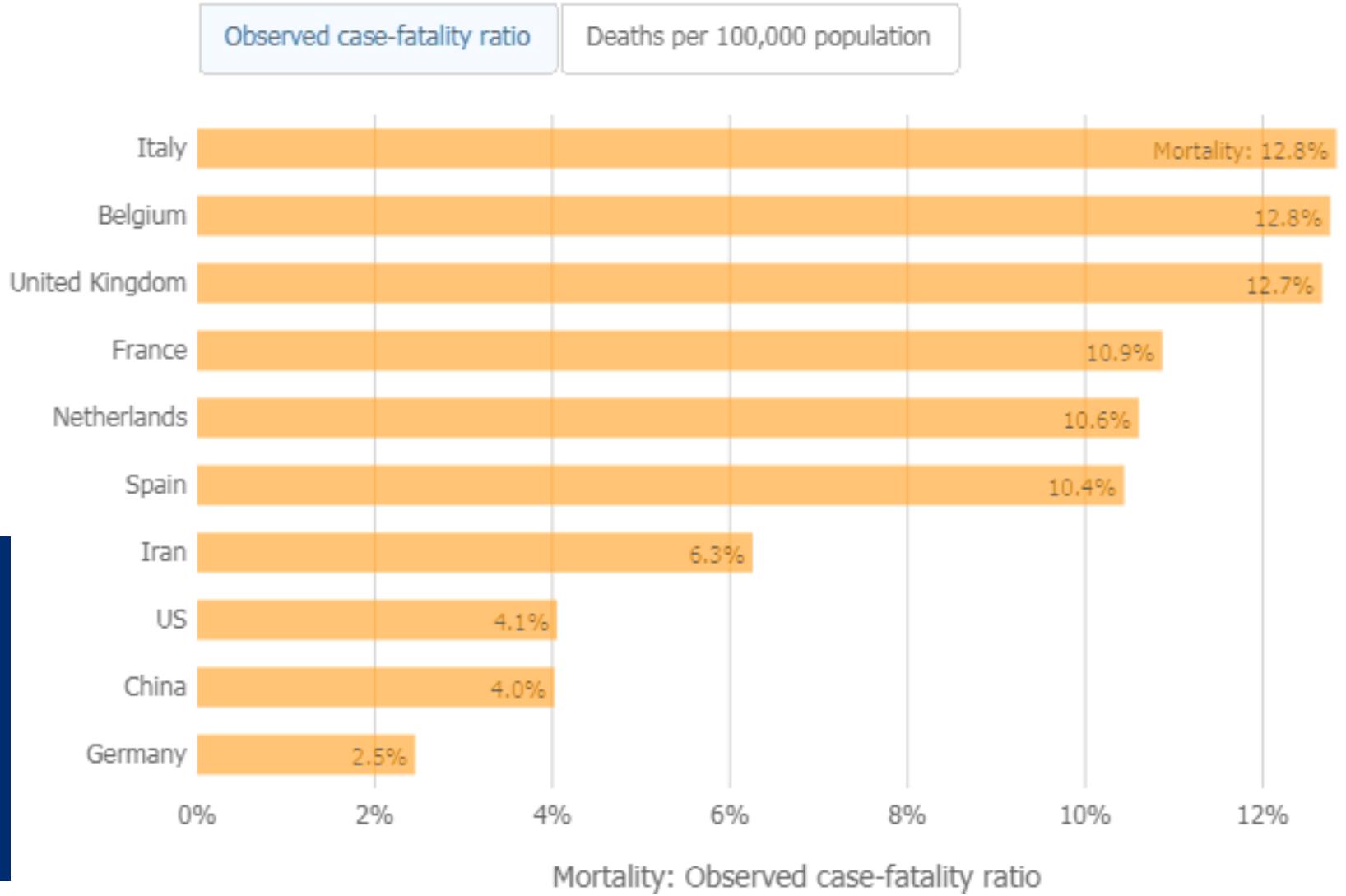
- Check, with patient permission, share the facts on COVID-19 and expected trajectories and its implications based on patient's goals of care

- Align, negotiate and develop a mutually agreed upon care plan with clear directives and directions (e.g., using if … then …)

COVID-19 Facts (as of April 8, 2020 at noon)

	Reference:			Mass DPH Data 25,475 (out of 116,730 tested, i.e. 22% test positive rate)		
	Risk of Hospitalization	ICU Stay/Ventilatory Support	Case-Fatality Rate	Risk of Hospitalization	ICU Stay/Ventilatory Support	Case-Fatality Rate
Overall	20%	3% (higher in some studies)	2%	2,235 (8.8% Hospitalization Rate among test positive)		756 deaths (~ 3% mortality among test positive)
Once Hospitalized	NA	20%	13%			
Once In ICU	NA	NA	Up to 65%			
Comments	LOS	LOS				

Mortality Rate varies by many factors including % Older adults,# of Tests, Healthcare response, Time to follow up



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https://coronavirus.jhu.edu/data/mortality

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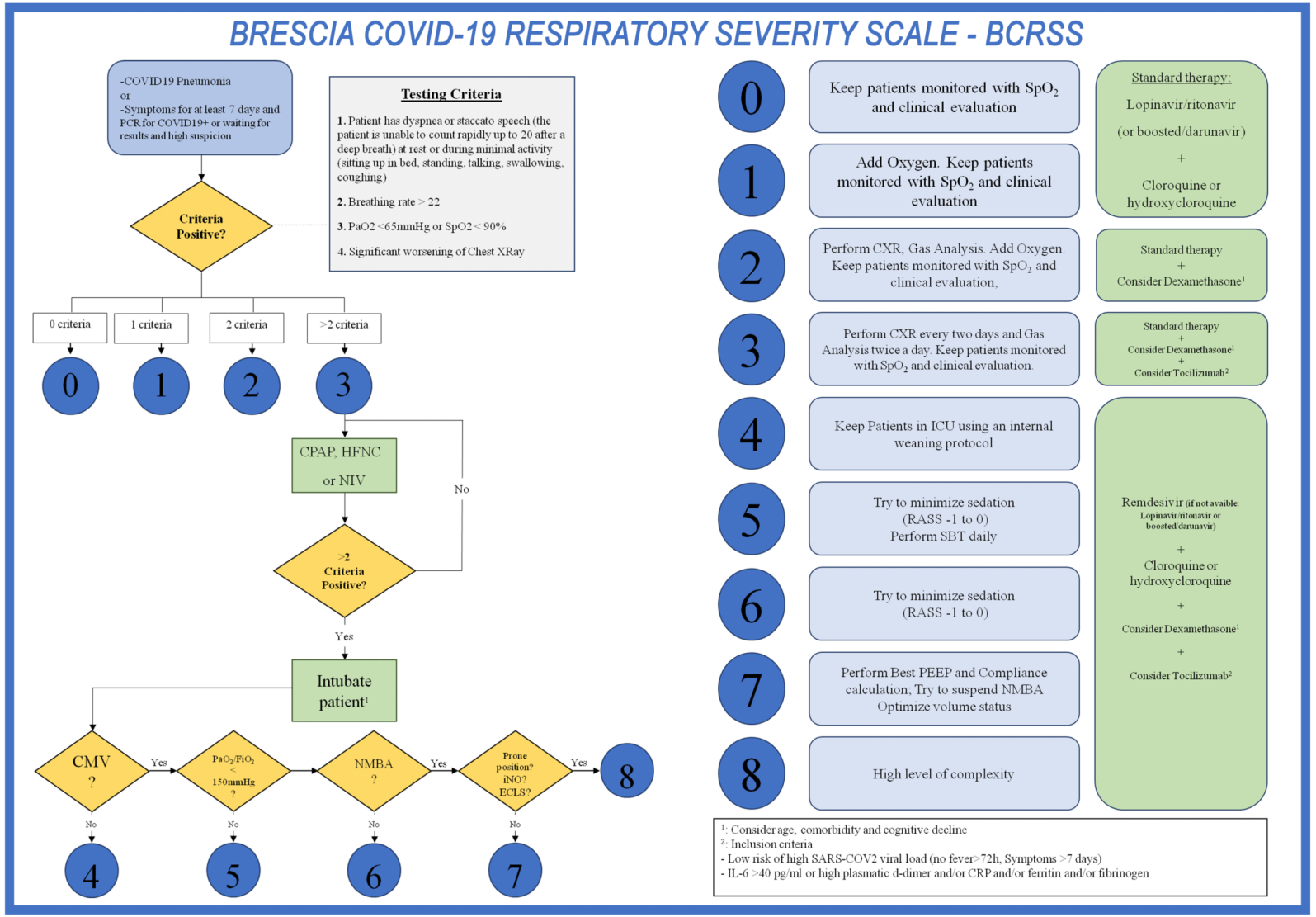
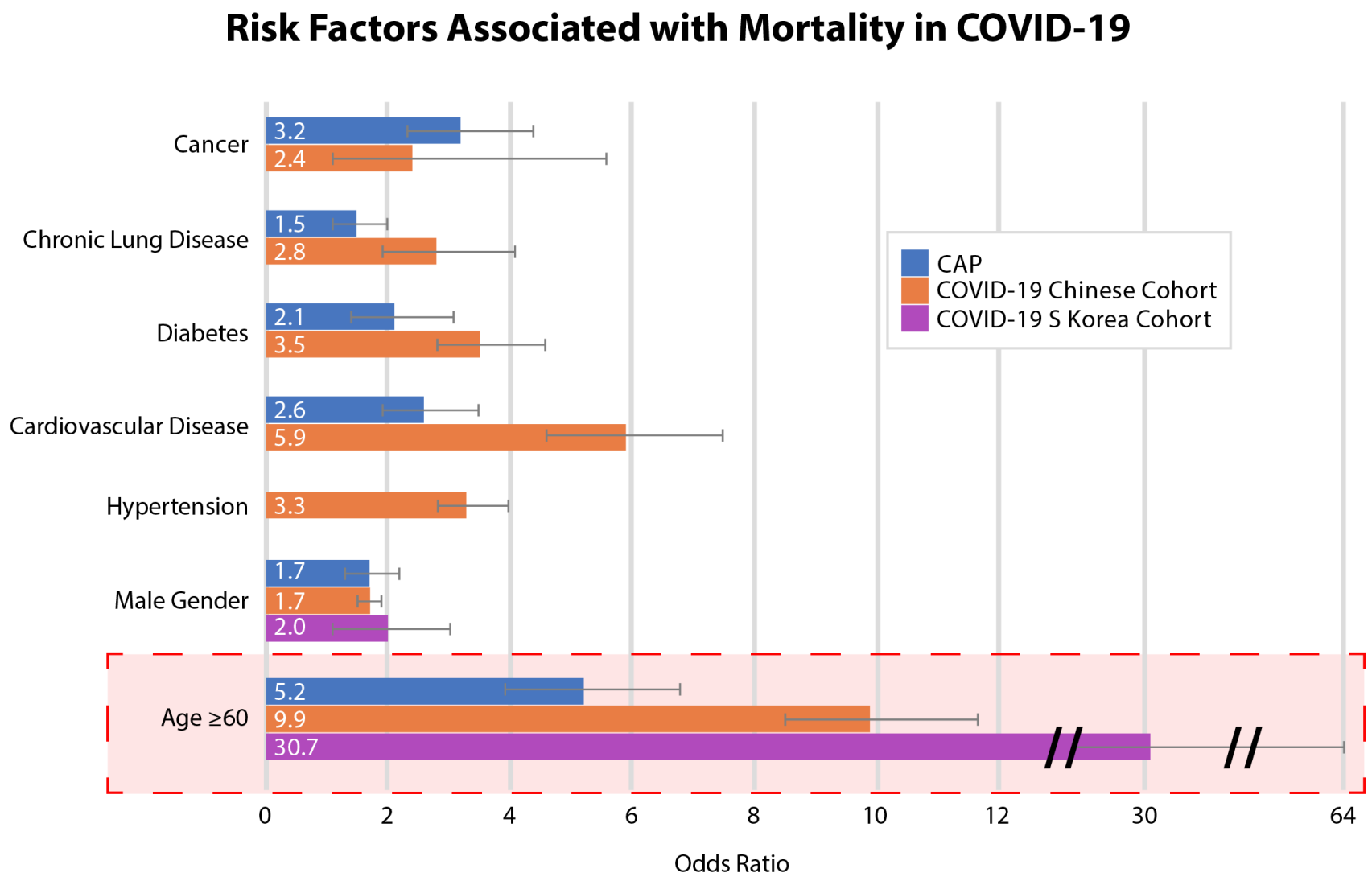
An Example of Severity Scale to Guide Treatment



https://www.mdcalc.com/covid-19#nnt

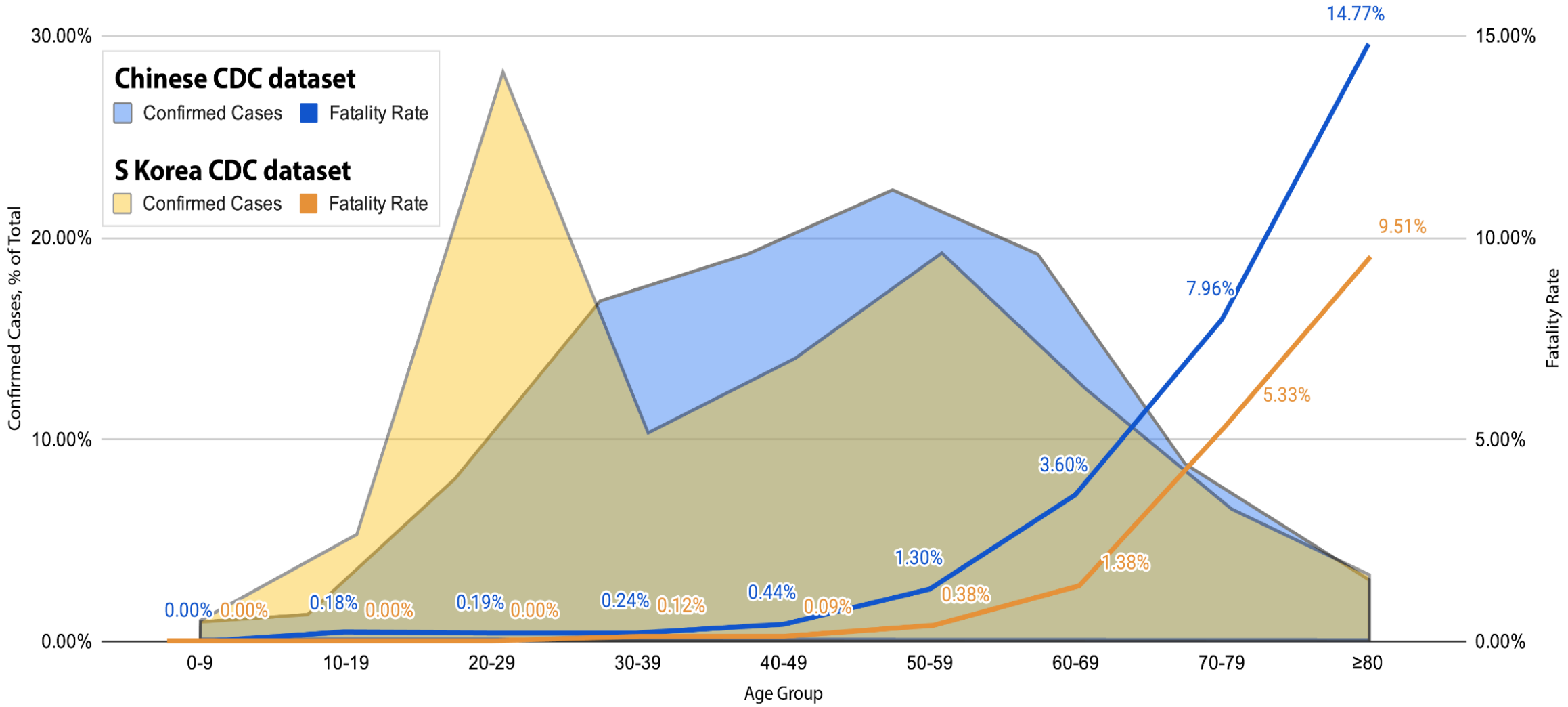
More User-Friendly Summary of Risk Factors



More User-Friendly Summary of Risk Factors

	Odds Ratio and 95%CI		
Factor	**CAP[1]**	**COVID-19[2,3] Chinese Cohort**	**COVID-19[6] S Korea CDC Cohort**
Age ≥60[†]	5.2 (3.9 - 6.8)	9.9 (8.5 - 11.7)	30.7 (14.7 - 64)
Male gender	1.7 (1.3 - 2.2)	1.7 (1.5 - 1.9)	2.0 (1.2 - 3.1)
Hypertension	-	3.3 (2.8 - 4.0)	
Cardiovascular disease	2.6 (1.9 - 3.5)	5.9 (4.6 - 7.5)	
Diabetes	2.1 (1.4 - 3.1)	3.5 (2.8 - 4.6)	
Chronic lung disease	1.5 (1.1 - 2.0)	2.8 (1.9 - 4.1)	
Cancer	3.2 (2.3 - 4.4)	2.4 (1.1 - 5.6)	

Chinese CDC and South Korea CDC Confirmed Cases and Fatality Rate by Age Group



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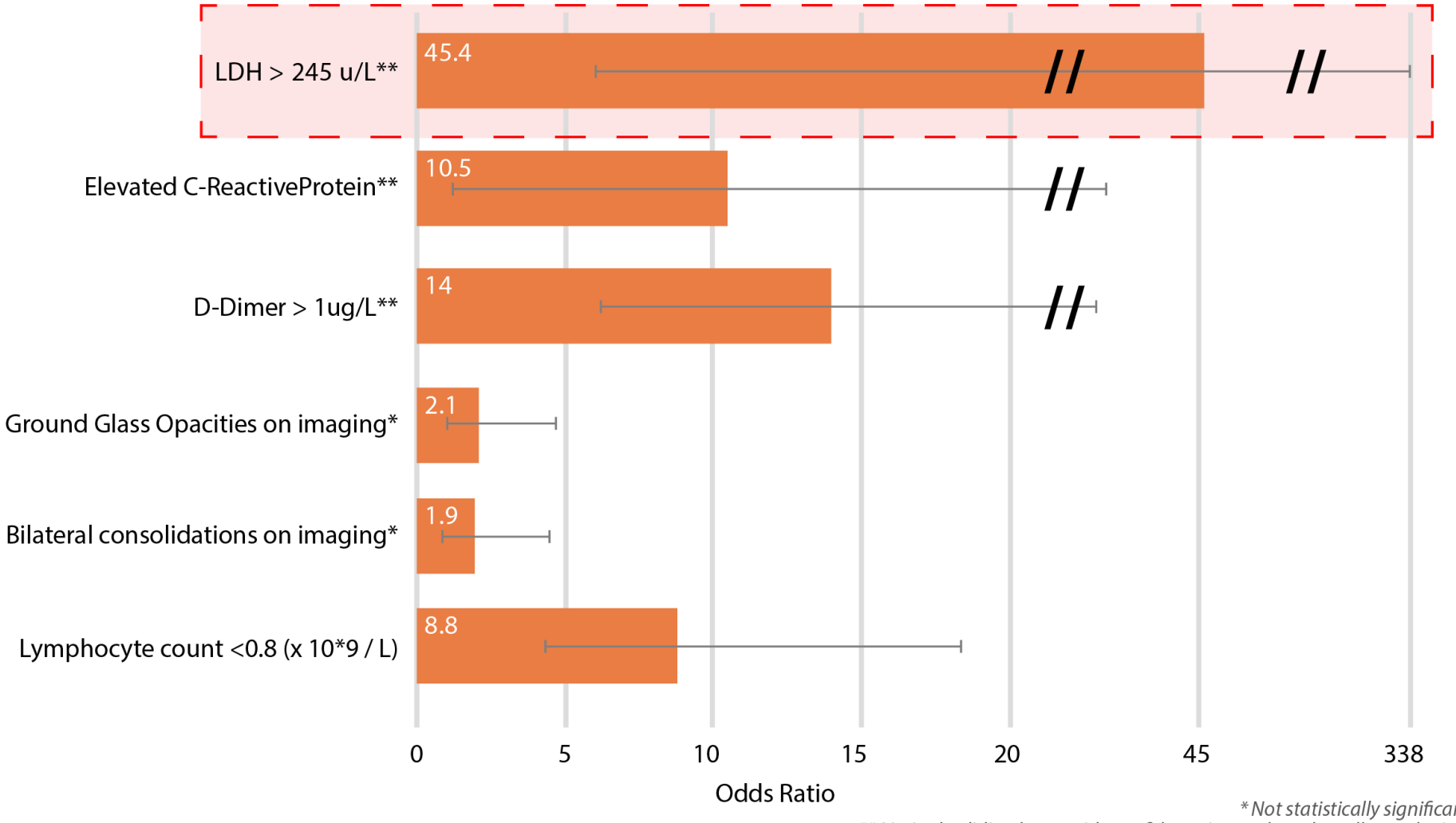
Laboratory values associated with mortality



** Not statistically significant*
*** Limited validity due to wide confidence intervals and small sample sizes*
***Note:** this is early data with a small N resulting in wide error margins*

Laboratory Values Associated With Mortality

Laboratory Value	Odds ratio and 95% CI
Lymphocyte count <0.8 (x 10*9 / L)	8.8 (4.3 - 18.4)[7]
Bilateral consolidations on imaging	1.98 (0.89 - 4.5)[8*]
Ground Glass Opacities on imaging	2.1 (0.99 - 4.7)[8*]
D-Dimer > 1ug/L**	14 (6.3 - 31)[3]
Elevated C-Reactive Protein**	10.5 (1.2 - 34.7)[7]
LDH > 245 u/L**	45.4 (6.0 - 338)[7]

Fatality Rate by Age Groups Derived from Chinese CDC[2] and South Korea CDC[6] datasets

	Chinese CDC dataset[2]		South Korea CDC dataset[6]	
Age group	Deaths/confirmed cases	Fatality rate	Deaths/confirmed cases	Fatality rate
0-9	0/416	0%	0/83	0%
10-19	1/549	0.2%	0/427	0%
20-29	7/3619	0.2%	0/2301	0%
30-39	18/7600	0.2%	1/842	0.12%
40-49	38/8571	0.4%	1/1141	0.09%
50-59	130/10008	1.3%	6/1568	0.38%
60-69	309/8583	3.6%	14/1012	1.38%
70-79	312/3918	8%	28/525	5.33%
≥80	208/1408	14.8%	25/263	9.51%

Summary of Facts on Prognostication

- Older (esp those over 80): Men with co-morbidities are at the highest risk
- Selected group of younger adults also appears to be at risk (? Healthcare providers, Those with co-morbidities)
- Children seem to be lower risk

Goals of Care Discussion via Virtual Visit with a Family Member

Doctor	Family
Hello is this Ms. McNally? I'm Dr. Back from the COVID response team	Hi.
I understand your father has tested positive for COVID	Yes. I'm very worried. I feel guilty that he got it in a nursing home. I thought that place would be ok.
Anyone would be worried. And there is no way you could have known this would happen.	I suppose so.
Is it ok if we talk about what COVID means for your father?	Please.
May I first ask if you are the person who makes medical decisions for him.	Yes. I'm his surrogate whatever you call it. I have the papers.
Perfect. I like to make sure I'm talking to the right person.	That's me.
I need to give you some background. Most people who get COVID have a mild or moderate illness and don't need the hospital. The people who most often get a severe pneumonia with COVID are older and have existing medical problems, like your father.	You know, I've heard that on the news but have been afraid to think about it.
Well that's a very normal reaction. COVID has put all of us in a tough situation.	Yes. And I know that you are so busy.
We are doing our best under the circumstances. So I hope your father has a mild case and can stay where he is. We can make sure he gets all the treatments he needs. However, if his COVID becomes severe, it will almost certainly take his life.	I was afraid you would say that.
It's not what any family member wants to hear. Given that, if the worst case scenario happened and he was going to die, do you think he would rather be in the hospital or be at home—I mean at his nursing home.	Gosh. That's a big decision.
I can see that you want the best for him.	Absolutely.

Source: Vital Talk

Goals of Care Discussion via Virtual Visit with a Family Member (continued)

Doctor	Family
Let me put it another way. If he didn't have dementia and was as sharp as you or me. And he understood COVID and what would happen if he got a severe case. If he were sitting here with us, what would he say.?	Oh he would say, enough already. I'll stay here. But I don't know.
It sounds to me like If you put on his hat and become him, he'd say 'enough already. But if you put on your hat , you'd say, I don't know. Do I have that right?	Yes. I'm not ready to lose him.
Tell me more.	He's always been there for me and my kids. He's the backbone of the family. He always believed in me.
Would he believe in you now? To speak for him?	When you put it like that, I know the answer. I just don't like it.
It's not the kind of decision anyone wants to make. It does sound like you two may have talked about this?	He told me when he was first diagnosed with dementia, back then he was just a little forgetful, nothing big. We were driving to the park to walk the dog. He turned to me and said remember, when I can't do this anymore, it's time to let me go.
Wow, thank you for telling me that.	I had kind of forgotten about that. Its funny—I can see him saying it to me.
Hmm. That kind of memory is a gift. Would it be ok to honor that?	Now it's clear to me. Let's keep at him at his home.

A couple of links to useful videos: https://vimeo.com/401465080
https://www.youtube.com/watch?feature=youtu.be&v=KNHLaNAj08I

Source: Vital Talk

MOLST Order via Virtual Visits

- The **Emergency Update to the EMS Protocol 7.3** cites the following requirements for documenting verbal consent:

  Where it's not possible to follow usual MOLST standards requiring written signatures, clinicians are to document on the MOLST form:

  a) the patient's, patient's health care agent's or guardian's verbal consent;

  b) who witnessed this verbal consent (in accordance with the standards of the health care facility in which the patient is located); and in addition,

  c) document in the patient's medical record the details of how verbal consent was obtained.

- Upon reviewing such a MOLST form for a patient they encounter, EMS personnel are to accept a form that contains a) and b) in accordance with this procedure. As long as the witness portion is documented, EMS can accept it as meeting the standards of the health care facility.

Source: MHA link

Palliative Care Resources

- https://qxmd.com/calculate/calculator_731/covid-19-prognostic-tool
- https://www.capc.org/training/learning-pathways/covid-19-response-training/
- https://www.vitaltalk.org/guides/covid-19-communication-skills/
- https://theconversationproject.org/wp-content/uploads/2020/04/tcpcovid19guide.pdf
- https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm?s_cid=mm6912e2_w#F2_down
- https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response/key-documents-for-italy
- http://www.thewhpca.org/covid-19
- https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
- https://inkvessel.com/2020/03/18/palliative-care-in-the-time-of-covid/

Primary vs. Specialist Palliative Care

Box 2: Suggested triage tool for referral to specialist palliative care[19]

All clinicians providing palliative care should address physical, social, financial and spiritual concerns

Clinicians who are not palliative care specialists (hospitalists, family physicians, internists, ICU physicians, nurse practitioners, nurses and paramedics) support the following:

- Identification and management of pain, dyspnea, agitated delirium and respiratory congestion
- Management of caregiver grief
- Discussions about prognosis, goals of treatment, suffering and resuscitation status

Palliative care specialist clinicians support the following:

- Patients with complex or refractory symptoms
- Patients who are denied access to critical care owing to a triage protocol, despite wanting aggressive care
- Management of complex depression, anxiety, grief and existential distress
- Requirement for palliative sedation therapy
- Pre-existing opioid use disorder
- Patients with young children
- Patients belonging to marginalized populations, including the homeless, incarcerated persons and Indigenous Peoples, who are at risk of being underserved by the health care system

Source. Pandemic Palliative Care. *CMAJ* 2020. doi: 10.1503/cmaj.200465; early-released March 31, 2020 https://www.cmaj.ca/content/cmaj/early/2020/03/31/cmaj.200465.full.pdf

Box 3: Suggested language for physicians providing support to a patient or family member who is denied intensive care because of resource scarcity

Normally, when somebody develops critical illness, the medical team would offer them intensive care (a combination of medications and machines to support their vital organs), provided that the medical team felt that they had a reasonable chance of survival. However, because of the COVID-19 outbreak, we are currently unable to offer intensive care to everyone who is critically ill. As a result, our hospital is working under triage guidelines, which means that we are offering intensive care only to those who are most likely to be able to survive and recover from their critical illness. You probably have heard about this in the news — all hospitals in the region are working under these guidelines.

I regret to inform you that we are unable to offer you intensive care treatments at this time, as a result of the triage guidelines. Because of your medical condition, the likelihood that you would survive even with intensive care is considered to be too low for us to offer intensive care. The team has made this decision based on the following information:_____.

I am deeply sorry about this situation. This is not the way we ordinarily make these decisions, and I can only imagine how you must feel right now. I want you to know that even though we cannot offer intensive care, we will do everything else that could conceivably give you a chance of recovering, including: _____.

And I promise you that, no matter what, we will also use medication to treat any discomfort, such as pain or shortness of breath. We know that when we treat discomfort appropriately, this is not harmful and may actually help improve your condition.

clans to ensure that any proposed treatment is clinically indicat

Box 4: Suggested language for discussing a treatment plan with someone who is unlikely to survive a critical illness, but whose current care plan would include life-sustaining therapies if indicated

You (your loved one) is currently suffering from _____. We have given you treatments, including _____ , but it seems as though your body is not responding well to them. If this continues, we would need to consider the use of life-sustaining treatments to support your body.

I am very concerned about this scenario; although it is very easy to start life-sustaining treatments, there are many scenarios where we strongly prefer not to because the chances of recovery are poor. That is usually when someone has chronic or incurable medical conditions, or their body has become weaker than it used to be. The other concern is that these treatments can cause a lot of discomfort. Of course, many people are willing to experience discomfort if there is a reasonable chance of a good recovery. But if the treatments cause discomfort and the chances of recovery are poor, we are very hesitant to offer those treatments.

I would like to propose an alternative plan. I would like to suggest that we continue doing the things that we are currently doing, including _____, in the hope that you might still respond and recover. We do not want to take away that opportunity. But if your body does not respond and you get worse, I would suggest that we do not start life-sustaining treatments. Instead, if you get worse, I would suggest that we focus on keeping you comfortable, understanding that any further escalation of care would probably do more harm than good. What do you think about that?

NEQCA COVID-19 Website

- **Updated daily**
- Upcoming Programs
- Statistics and Expert Resources
- Clinical Guidelines and Tools
- Medical Practice Sustainability
- Telehealth Services
- Broad Strategies To Combat COVID-19
- Resources for Patients
- Wellbeing for All
- Recorded Webinars, Presentations

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Stay Safe … and THANK YOU!