Communication and Palliation in the Time of COVID-19 Infection

Rationale:

Prognosis in COVID-19 positive patients

Based on reports compiled by the CDC, mortality is negatively impacted by advancing age, with the population over 85 at highest risk. Patients ages 65-74 make up the largest population in need of critical care services. Over 80% of the deaths in China occurred in the population over 60 years of age.(1) Patients with underlying comorbidities are also now recognized to be at increased risk for adverse outcomes in the setting of COVID-19 infection.(2-4) With a rapid increase in infection rates and subsequent strain to care systems, there is a great need for frank conversations regarding prognosis and resource allocation.

Practitioners have been encouraged to embrace and practice primary palliative care, incorporating advance care planning across all care platforms. This movement has grown, particularly with the recognition that trained palliative care practitioners are few in relation to need.(5) The current COVID-19 pandemic truncates the timeline from diagnosis to advanced illness, placing further strain on resources and traditional modalities of advance care planning. Additional concerns have been raised regarding the ability for care providers to ensure adequate symptom management and to avoid patient suffering. (6)

Hospital admissions:

All hospital admissions should be accompanied by documentation regarding advance care planning (ACP) materials and goals of care communication. For all hospital admissions:

- Identify health care proxy
- Obtain contact information for health care proxy
- Identify existing advanced directives and obtain documentation

COVID-19 Persons Under Investigation (PUI) or COVID-19 positive patients:

- All patients who are identified as PUI, with COVID-19 lab pending
  - Confirm ACP documentation
  - Confirm Health Care proxy/surrogate decision maker
  - Distribute education pamphlet
- All COVID-19 + patients
  - Consult Palliative Care for patients <65 years of age
  - Consult Geriatrics for patients >65 years of age
  - Confirm ACP documentation
  - Confirm Health Care proxy/surrogate decision maker
  - Patients will be prioritized for consultation from highest acuity to lowest (ICU → PCU → MedSurg) as staffing and time permits
  - Distribute education pamphlet
- All PUI patients admitted to ICU

        - Consult Palliative Care for patients <65 years of age
        - Consult Geriatrics for patients >65 years of age
    - ALL PUI and COVID+ patients who require surgical intervention
        - Prior to operative intervention, document patient or surrogate telephone communication delineating prognosis, goals of care, recommendations regarding interventions, and code status.
        - Patients proceeding to OR should have consideration to code status and for those with anticipated poor prognosis, DNR status should be considered preoperatively to limit the possibility of CPR in the OR. The use of vasopressors as standard of care in anesthesia management, in general, should be permitted.
        - Trauma cases should be excluded from discussions regarding goals of care due to limited time from admission to surgery, unless the patient already carries advanced directives.
            - Following emergent intervention, advance care planning must be addressed and documented in the chart
            - Palliative Care consultation should be obtained

Resources through the Center to Advance Palliative Care and VitalTalk have been made publicly available to facilitate effective communication. An additional resource may be provided through Serious Illness Conversations©(7-9)

Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age. (3)
• **Blood disorders** (e.g., sickle cell disease or on blood thinners) • **Chronic kidney disease** as defined by your doctor. Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis • **Chronic liver disease** as defined by your doctor. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because of liver disease or is under treatment for liver disease. • Compromised immune system (immunosuppression) (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS) • **Current or recent pregnancy** in the last two weeks • **Endocrine disorders** (e.g., diabetes mellitus) • **Metabolic disorders** (such as inherited metabolic disorders and mitochondrial disorders) • **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease) • **Lung disease** including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen • **Neurological and neurologic and neurodevelopment conditions** [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].

RESOURCE ALLOCATION- Ventilators, CRRT, ICU care

Based on guidelines for RUHS Resource Allocation some patients may be ineligible for escalation of care that would otherwise be provided in non-mass casualty settings. Guidelines have been created clearly articulating the prioritization of ventilator, CRRT, and ICU resources. The priority to patients is based on comorbidities and physiologic findings, without consideration to demographics, social standing, financial standing, payor model, religion, or ethnicity.

Patients and their loved ones must be engaged in clear communication regarding the limitations of care and the expectations of clinical outcomes. These conversations should be summarized and documented in the EMR.

A resource allocation team has been created to monitor and facilitate processes of allocation. Practitioners may find that additional support from this team is necessary to relay difficult news to patients and families.

EXCERPTS “COVID-Ready Communication Skills”, a VitalTalk publication (7):

New talking maps for contingency and crisis **Proactive planning, resource limits**

FOR PROACTIVE PLANNING IN CONTINGENCY

The COVID-as-a-starter preferences or goals talk for patients in a health care setting

“CALMER”

Check in

Take a deep breath (yourself!).
“How are you doing with all this?” (Take their emotional temperature.)

Ask about COVID

“What have you been thinking about COVID and your situation?”
(Just listen)

Lay out issues

“Here is something I want us to be prepared for.” / “You mentioned COVID. I agree.”
“Is there anything you want us to know if you got COVID / if your COVID gets really bad?

Motivate them to choose a proxy and talk about what matters

“If things took a turn for the worse, what you say now can help your family / loved ones”
“Who is your backup person--who helps us make decisions if you can’t speak? Who else? (having 2 backup people is best)
“We’re in an extraordinary situation. Given that, what matters to you? (About any part of your life? About your health care?)
Make a recommendation--if they would be able to hear it. “Based on what I’ve heard, I’d recommend [this]. What do you think?”

Expect emotion

Watch for this – acknowledge at any point
"This can be hard to think about."

Record the discussion
Any documentation – even brief -- will help your colleagues and your patient
"I'll write what you said in the chart. It's really helpful, thank you."

FOR CRISIS ONLY [C]

Talking about resource allocation (i.e. rationing).

"SHARE"
Show the guideline
"Here's what our institution / system / region is doing for patients with this condition."
(Start the part directly relevant to that person.)

Headline what it means for the patient's care
"So for you, what this means is that we care for you on the floor and do everything we can to help you feel better and fight this illness. What we won't do is to transfer you to the ICU, or do CPR if your heart stops.
(Note that you talk about what you *will* do first, then what you won't do)

Affirm the care you will provide
"We will be doing [the care plan], and we hope you will recover."

Respond to emotion
"I can see that you are concerned."

Emphasize that the same rules apply to everyone
"We are using the same rules with every other patient in this hospital / system /institution. We are not singling you out."

***This talking map is only used when an institution has declared use of crisis standards of care, or a surge state. When the crisis standards or surge are discontinued, this map should no longer be used.

When you need to talk a family member on phone or video through saying goodbye to a patient who is in their last hours or minutes
LOVE

Lead the way forward
"I am [Tony], one of the [professionals] on the team."
"For most people, this is a tough situation."
"I'm here to walk you through it if you'd like."

Offer the four things that matter to most people
"So we have the opportunity to make this time special."

"Here are five things you might want to say. Only use the ones that ring true for you."

"Please forgive me"

"I forgive you"

"Thank you"

"I love you"

"Goodbye"

"Do any of those sound good?"

Validate what they want to say

"I think that is a beautiful thing to say"

"If my [daughter] were saying that to me, I would feel so valued and so touched."

"I think he/she can hear you even if they can't say anything back"

"Go ahead, just say one thing at a time. Take your time."

Expect emotion

"I can see that he/she meant a lot to you."

"Can you stay on the line a minute? I just want to check on how you're doing"

(1) Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020. MMWR Morb Mortal Wkly Rep 2020;69:343-346. DOI: http://dx.doi.org/10.15585/mmwr.mm6912e2external icon.

(2) Onder G, Rezza G, Brusaferro S. Case-Fatality Rate and Characteristics of Patients Dying in Relation to COVID-19 in Italy. *JAMA.* Published online March 23, 2020. doi:10.1001/jama.2020.4683

(3) Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission. https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf

(4) Shi S, Qin M, Shen B, et al. Association of Cardiac Injury With Mortality in Hospitalized Patients With COVID-19 in Wuhan, China. *JAMA Cardiol.* Published online March 25, 2020. doi:10.1001/jamacardio.2020.0950

(5) Ballentine, JM. The Role of Palliative Care in a COVID-19 Pandemic. https://csupalliativecare.org/palliative-care-and-covid-19/

(6) Szabo, L. Shortfall Of Comfort Care Signals Undue Suffering For Coronavirus Patients. Kaiser Health News: March 26, 2020. https://khn.org/news/palliative-care-shortfall-coronavirus-patients-undue-suffering/

(7) COVID-Ready Communication Skills: a playbook of VitalTalk Tips. https://www.vitaltalk.org/guides/covid-19-communication-skills/

(8) CAPC COVID-19 Response Resources. https://www.capc.org/toolkits/covid-19-response-resources/

(9) Phrases and word choices that can be helpful when dealing with COVID19. Serious Illness Conversations© seriousillnessconversations.org