COVID-19 Challenges: Palliative Care, Communication, and End-of-Life in a Pandemic

SPEAKER:

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DISCUSSANTS:

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Emory University School of Medicine, Atlanta

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Pulmonary and Critical Care Medicine
Hospice and Palliative Care Medicine Fellow
Mt. Sinai Hospital, NYC

THE CORONAVIRUS CRISIS

Patients Dying Fast, And Far From Family, Challenge Practice Of Palliative Care

May 4, 2020 · 10:49 AM ET

What COVID-19 isolation means for patients' end-of-life experience

Mackenzie Bean - Tuesday, March 17th, 2020 Print I Email

IDEAS • COVID-19

It's Time to Get Serious About End-of-Life Care for High-Risk Coronavirus Patients

Objectives

- Case presentation
- Highlight challenges faced in providing palliative care and end-of-life care to critically ill patients with COVID-19
- Identify strategies to address these challenges
- Discuss available resources

Case

- 83yoM with history of HTN, diabetes, prolonged hospitalization 1 year ago for gallstone pancreatitis
- Presents to the hospital with 1 week of shortness of breath, fevers, and fatigue
- On exam, mild respiratory distress. Oxygen 82%, Placed on 5L NC
- COVID +

Case Continued…

- Shortly after arrival, becomes more altered with increasing oxygen requirements, on maximal HFNC
- Chart review: DNR/DNI after prolonged ICU stay last year
- Wife unable to come into the ED
- After conversation over the phone decides to reverse DNR/DNI, and wants the team to proceed with intubation

ICU Course

- Refractory hypoxemia requiring proning and paralytics
- Renal failure → CRRT
- Refractory shock
- Ventilator-associated pneumonia
- DVT

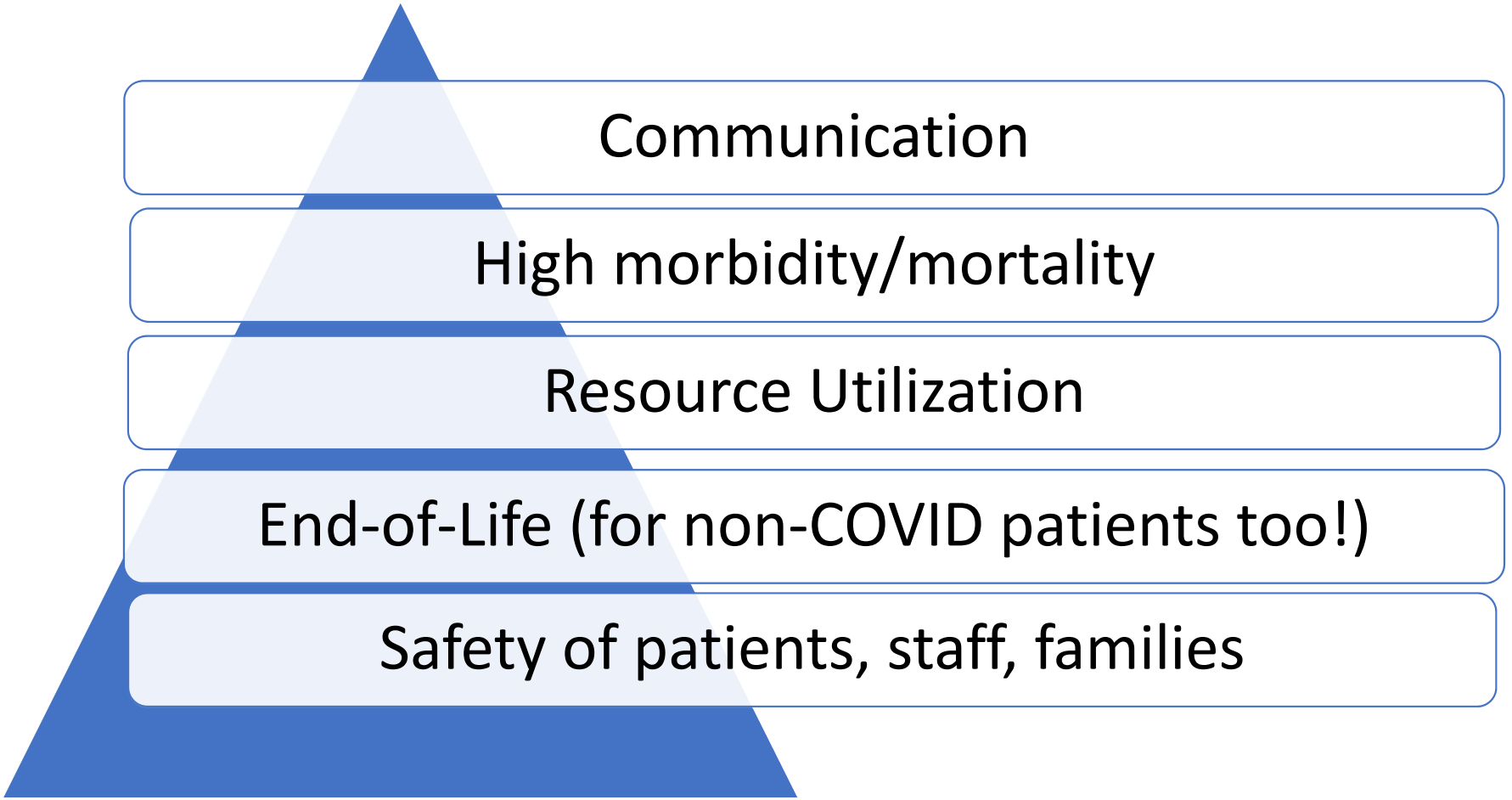
Communication Strategy

- Automatic palliative care team involvement for all ICU patients
- Daily phone updates to wife and sons by both ICU and palliative care teams
- Daily use of iPad by RN or chaplain for family to see/talk to patient
- High family anxiety about unknowns of COVID-19 and potential therapies

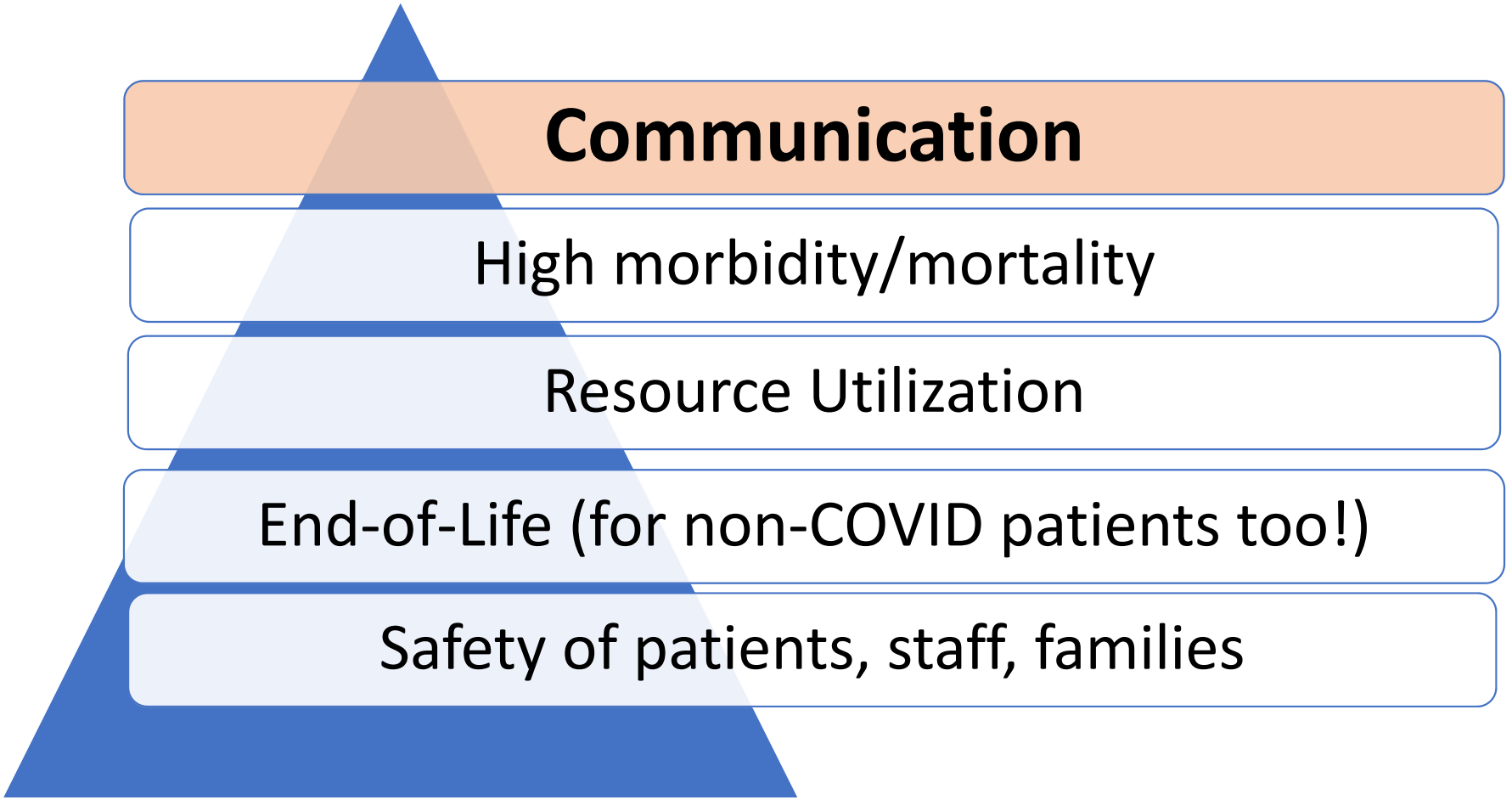
Case Continued…

- 2 weeks into ICU stay, develops fungemia and worsening shock
- After multiple discussions with family, decision is made to focus on comfort
- Per hospital policy, 2 family members are allowed in the room in appropriate PPE for patient's passing
- Remains on vent in SBT mode with alarms turned off to avoid disconnecting ventilator resulting in aerosolization

Challenges


Communication
High morbidity/mortality
Resource Utilization
End-of-Life (for non-COVID patients too!)
Safety of patients, staff, families

Challenges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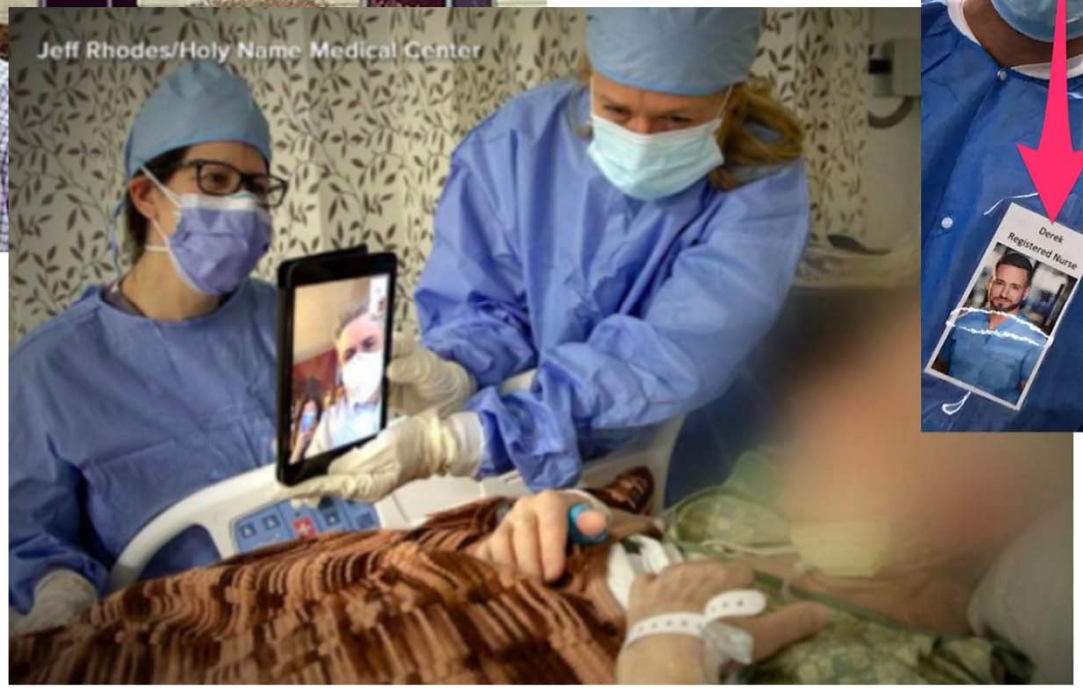
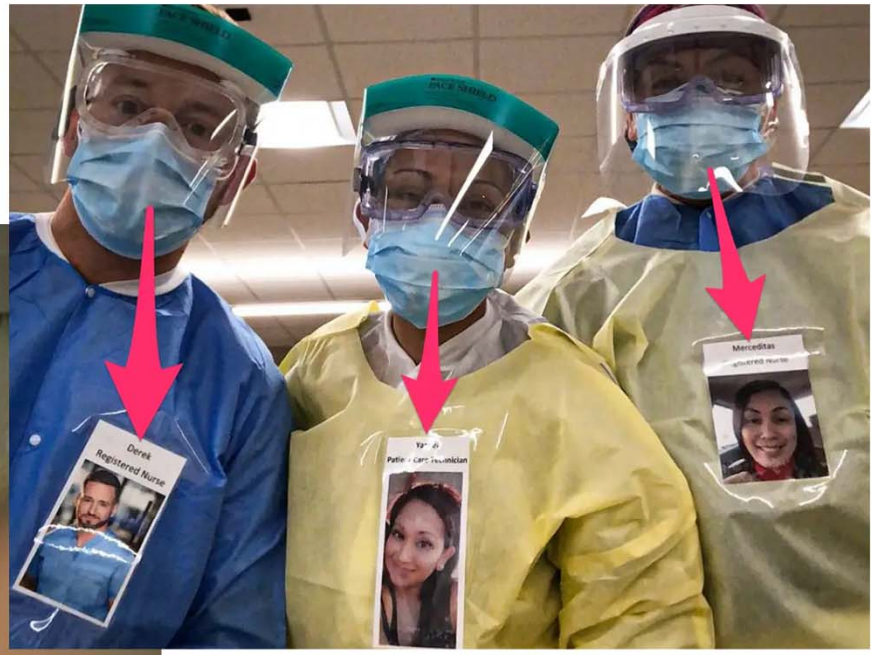




Advance Care Planning

- To provide goal-concordant care, elicit goals **early**
- Providing care that does not align with values :
  - harms the patient
  - puts healthcare workers at risk
  - utilizes resources unnecessarily
- These discussions can start during outpatient telemedicine visits

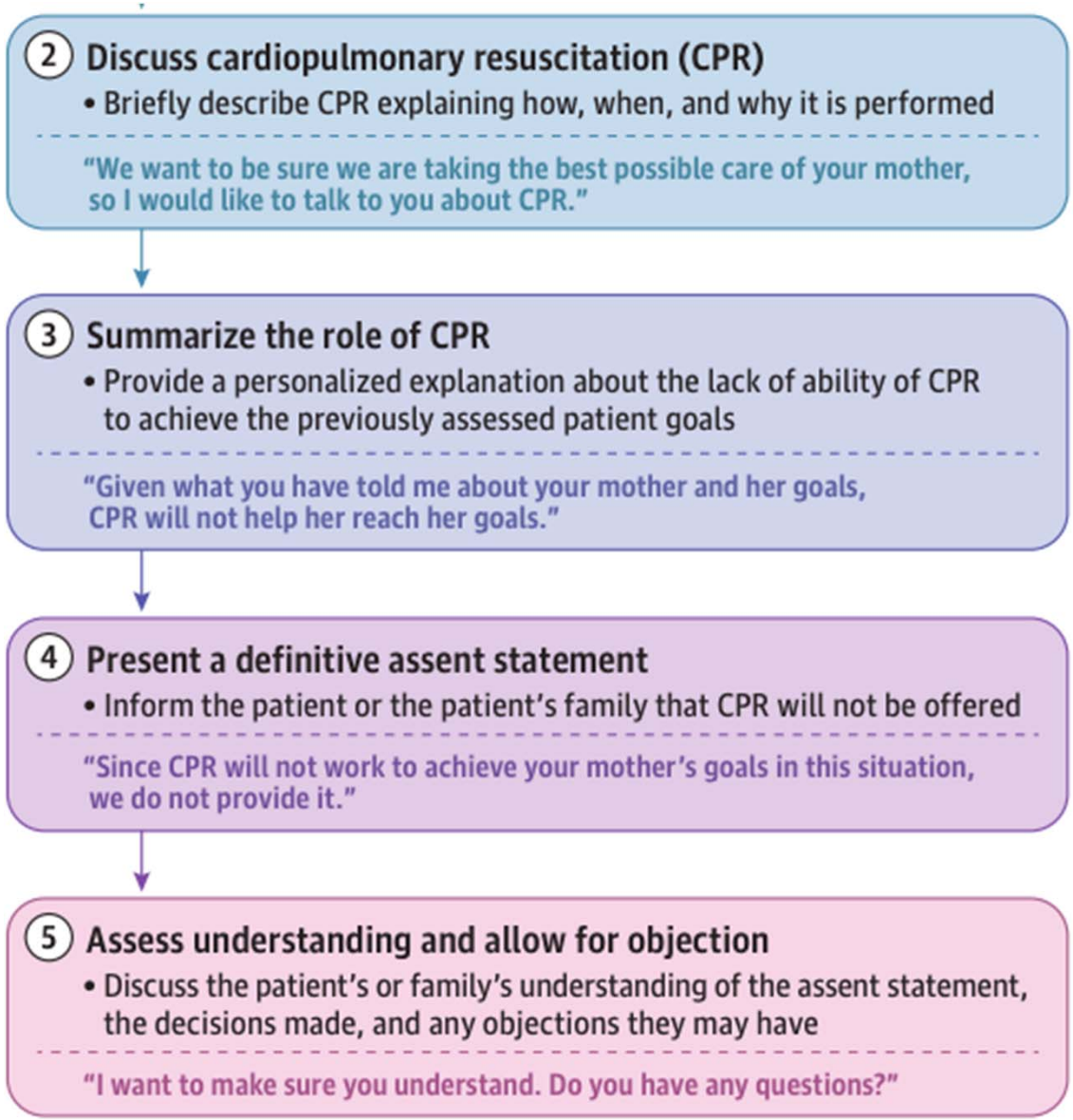
Advance Care Planning: Informed Assent

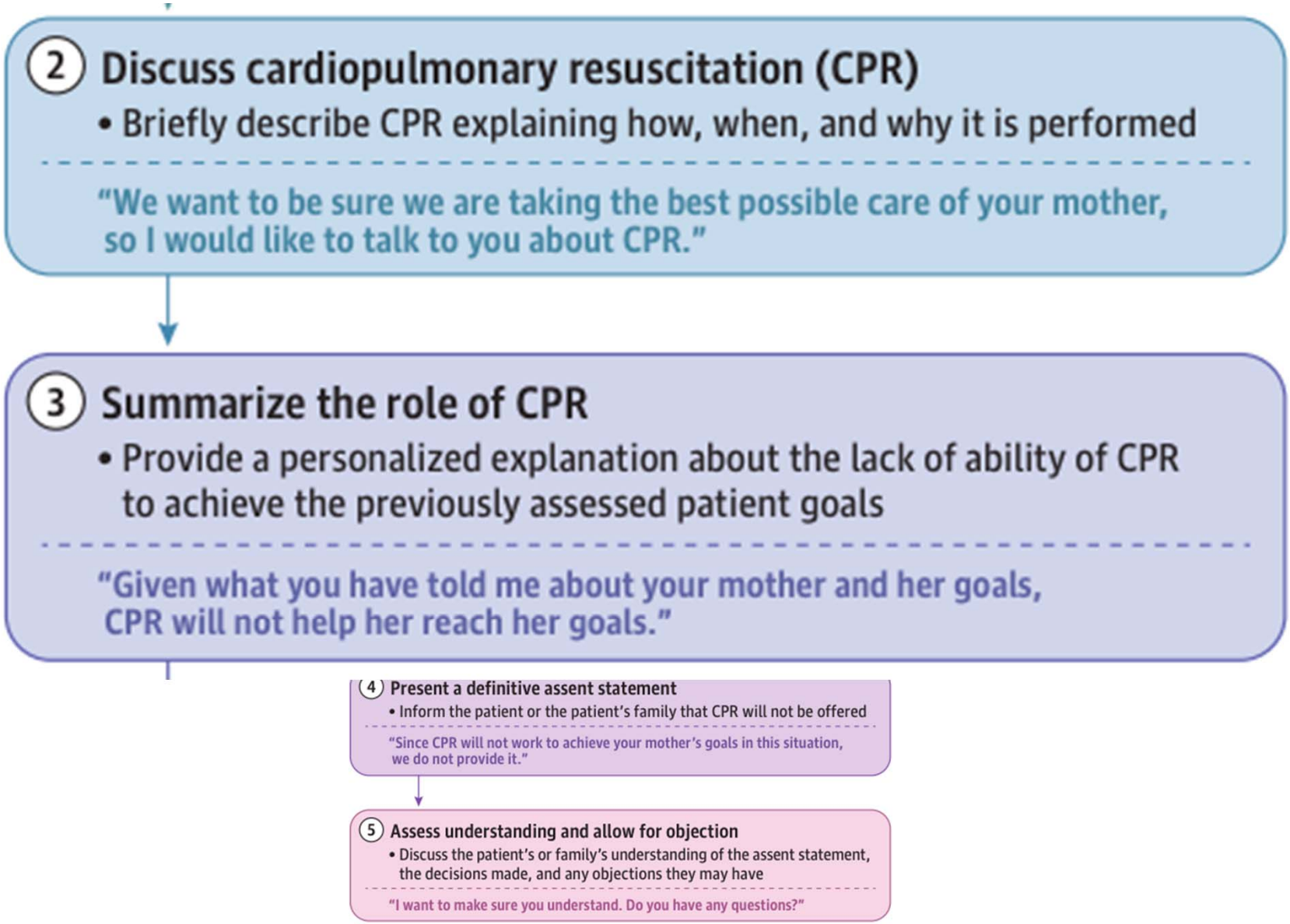
JAMA The Journal of the American Medical Association

VIEWPOINT

The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)

Curtis J, Kross E, Stapleton R


2 Discuss cardiopulmonary resuscitation (CPR)
• Briefly describe CPR explaining how, when, and why it is performed
"We want to be sure we are taking the best possible care of your mother, so I would like to talk to you about CPR."
3 Summarize the role of CPR
• Provide a personalized explanation about the lack of ability of CPR to achieve the previously assessed patient goals
"Given what you have told me about your mother and her goals, CPR will not help her reach her goals."
4 Present a definitive assent statement
• Inform the patient or the patient's family that CPR will not be offered
"Since CPR will not work to achieve your mother's goals in this situation, we do not provide it."
5 Assess understanding and allow for objection
• Discuss the patient's or family's understanding of the assent statement, the decisions made, and any objections they may have
"I want to make sure you understand. Do you have any questions?"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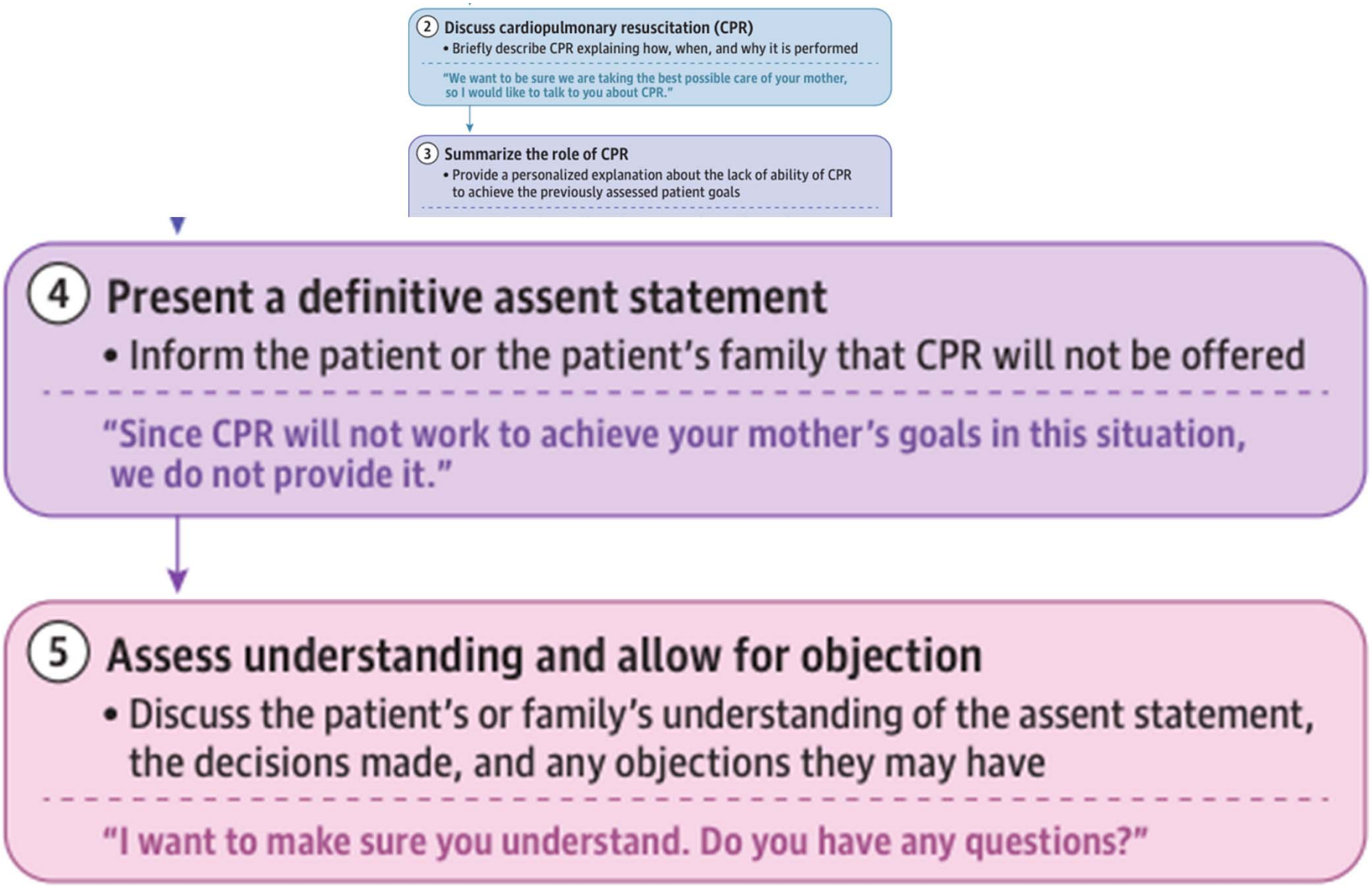
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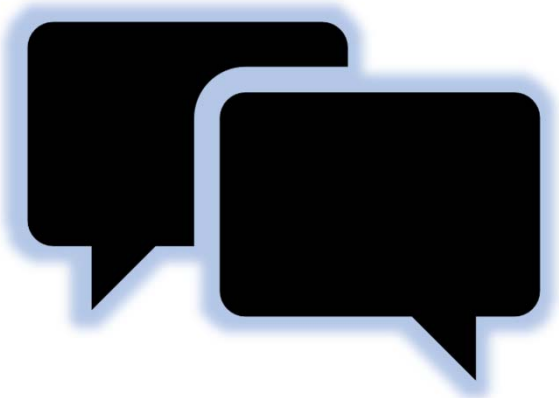
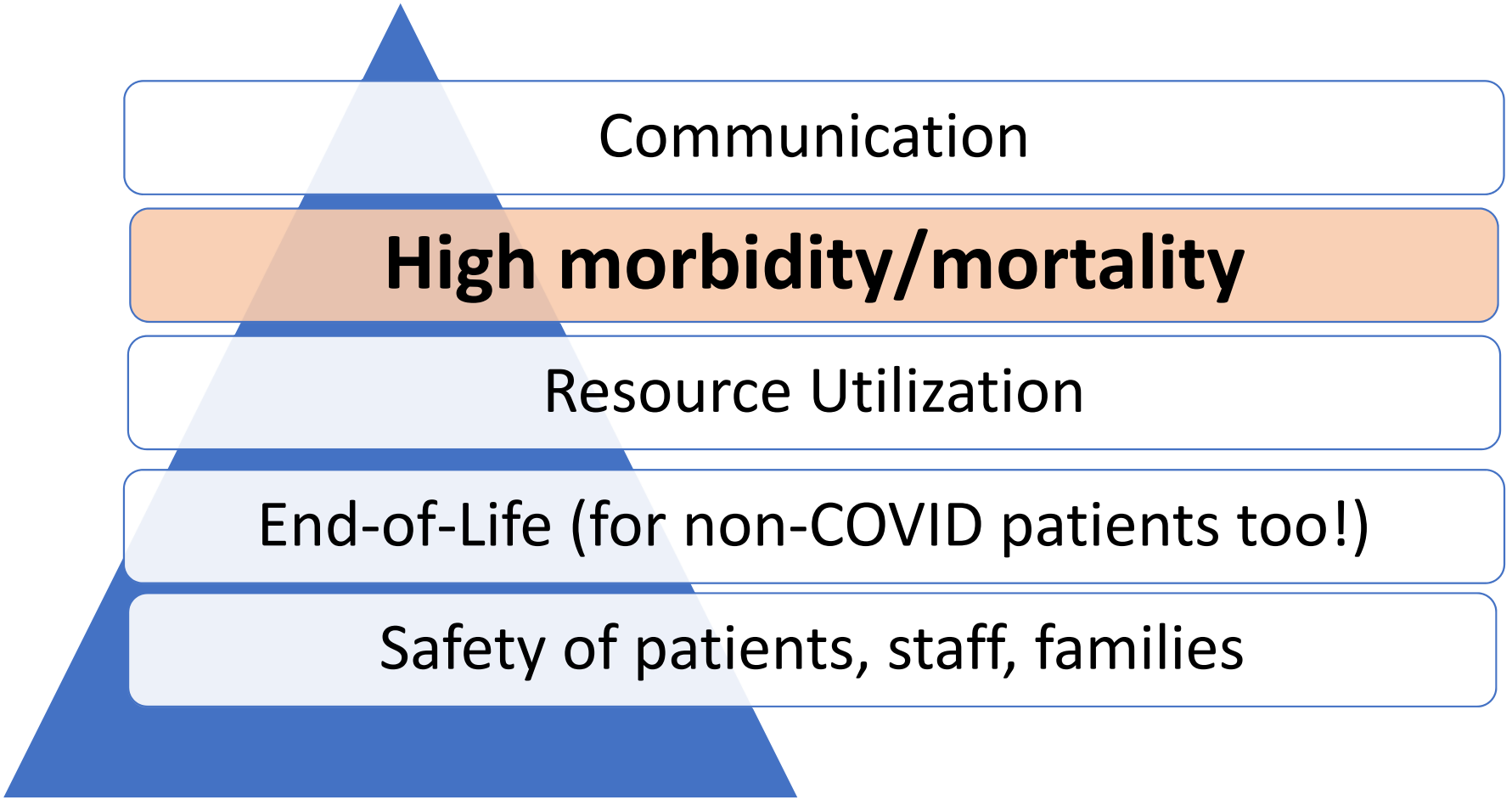


Comments

Challenges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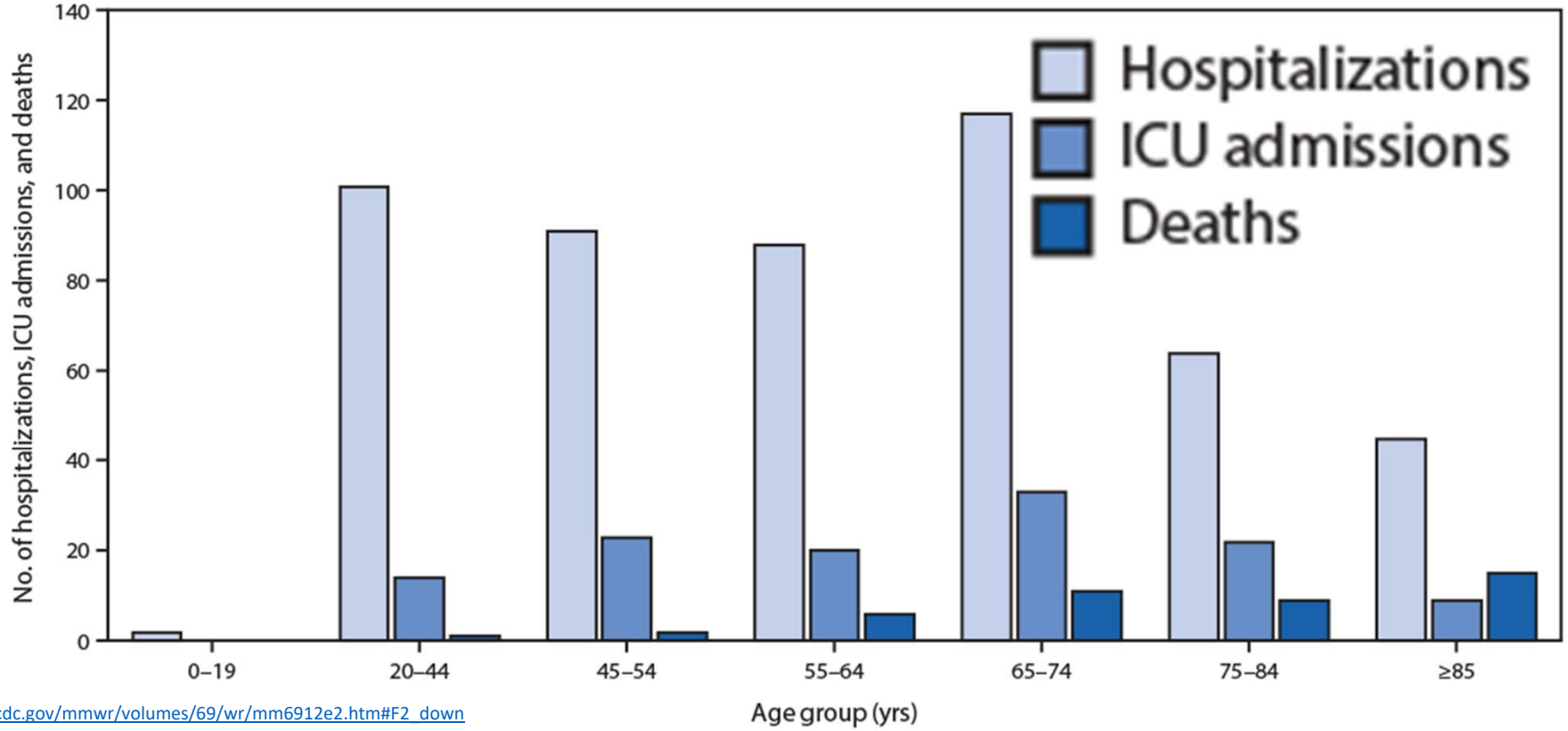
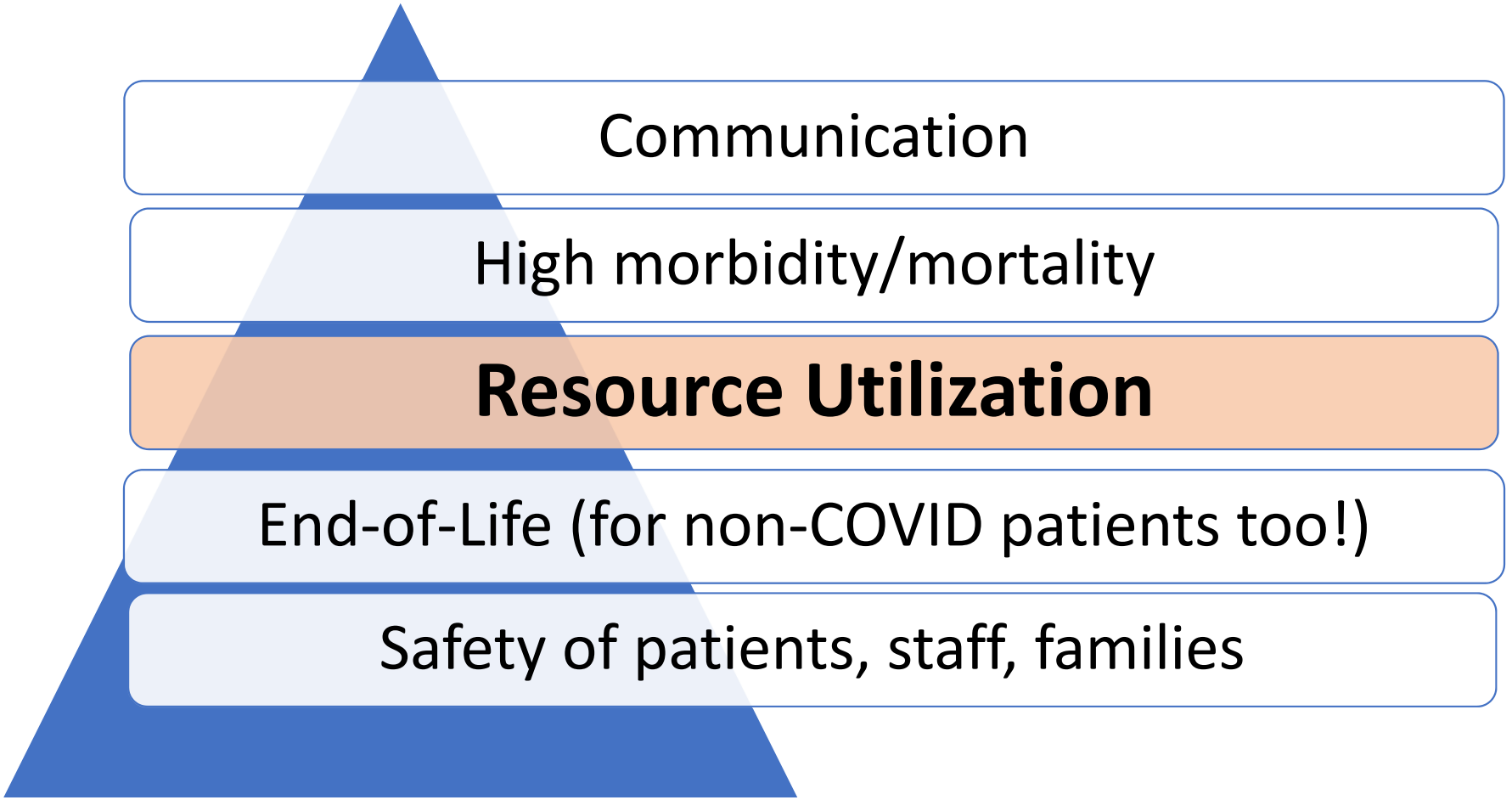
High Morbidity + Mortality

FIGURE 2. Coronavirus disease 2019 (COVID-19) hospitalizations,* intensive care unit (ICU) admissions,† and deaths,§ by age group — United States, February 12– March 16, 2020



https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm#F2_down

Challenges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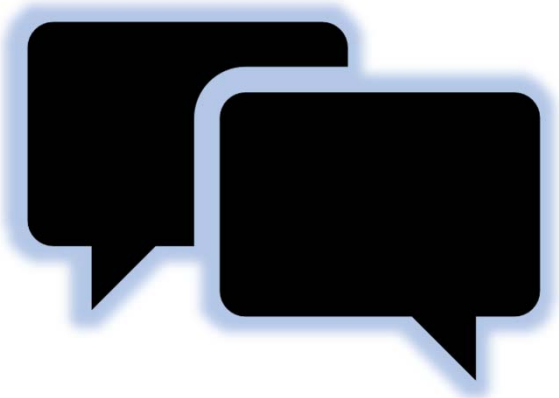
Resource Utilization

- PPE
- Healthcare workers
  - Palliative care teams
  - Chaplains
  - Social workers
- Prolonged recovery and rehabilitation
- Technology aids for communication
  - iPads
  - Baby monitors



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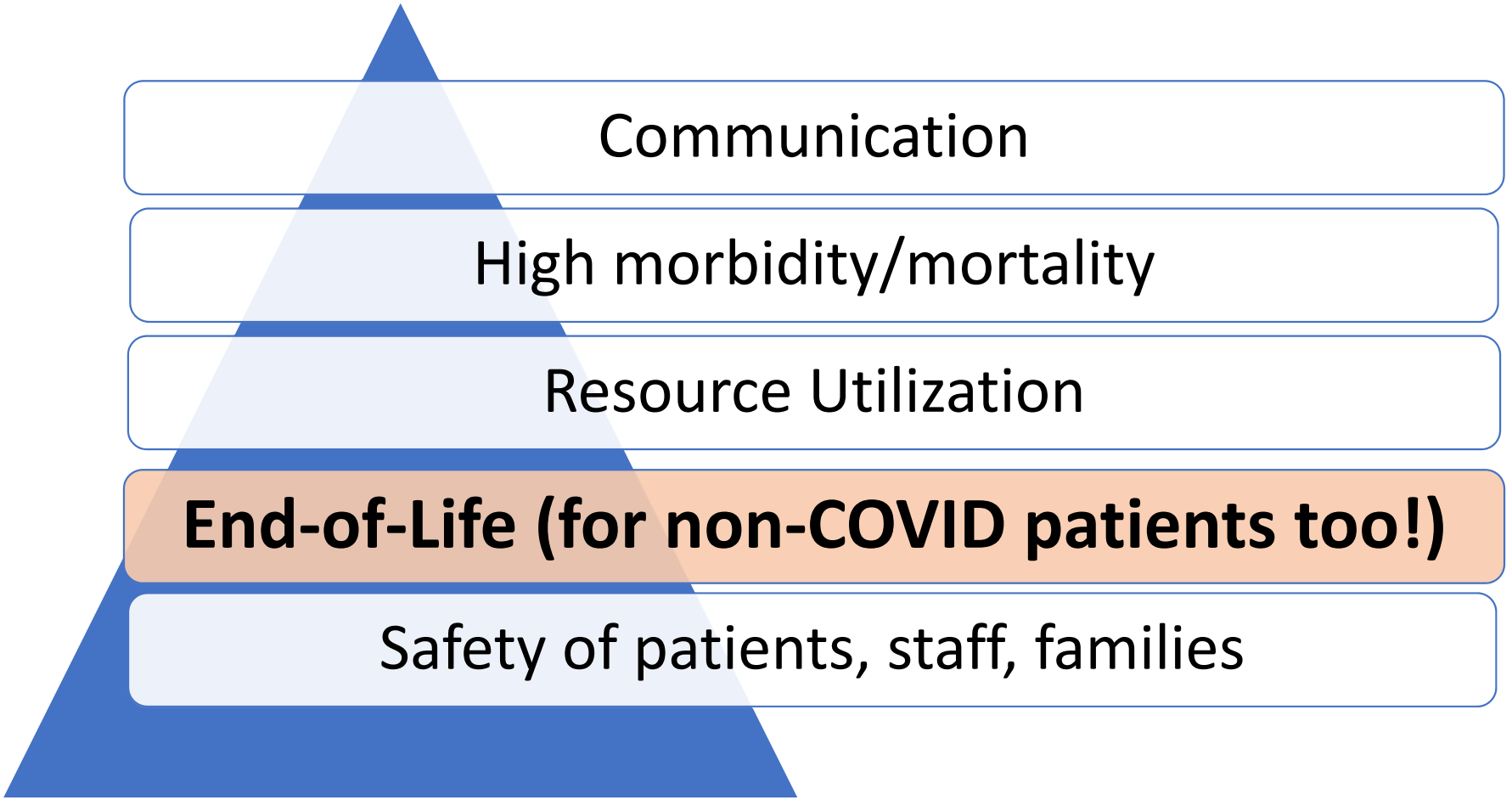
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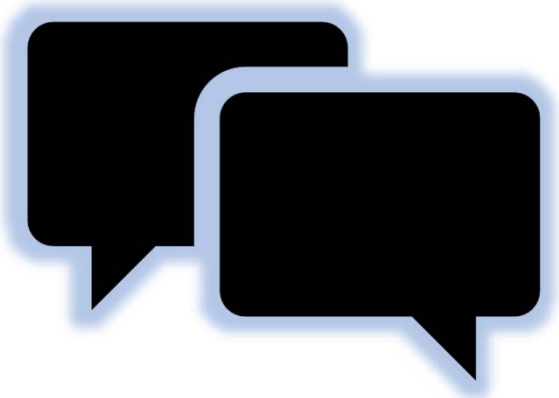
End-of-Life

- Visitation protocols (COVID and non-COVID)
- Discuss risk with family members, offer alternatives to being in person
- Extubating is an aerosolizing procedure
  - Keep vent connected to simulate spontaneous breathing while minimizing discomfort
- Symptom management– plan ahead



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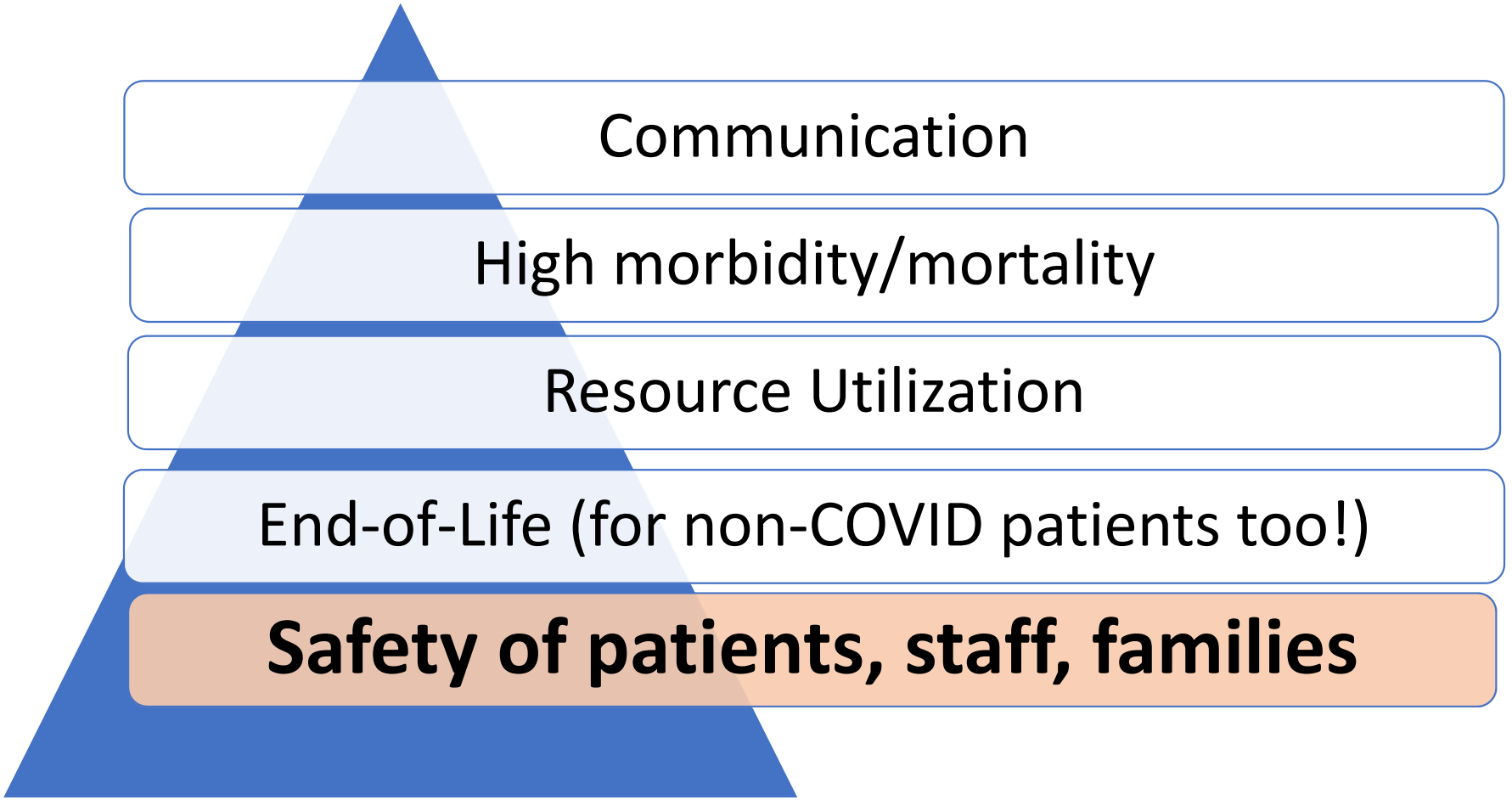
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Resources: Communication

VITAL talk

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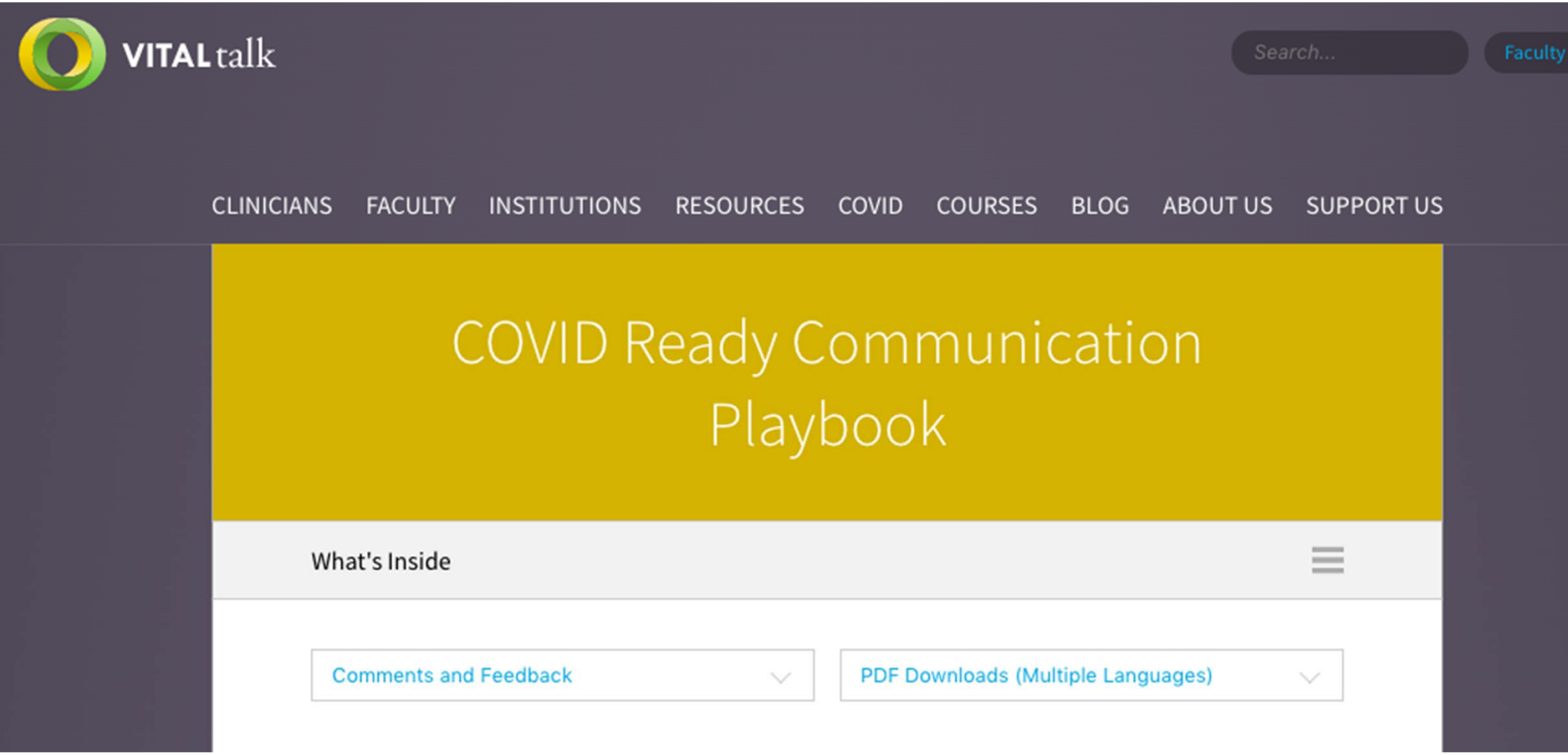
ARIADNE LABS

COVID-19 Response Toolkit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COVID Ready Communication Playbook
What's Inside
Comments and Feedback
PDF Downloads (Multiple Languages)

Deciding

WHEN THINGS AREN'T GOING WELL, GOALS OF CARE, CODE STATUS

I want everything possible. I want to live.	We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? **What do I need to know about you to do a better job taking care of you?**
I don't think my spouse would have wanted this.	Well, let's pause and talk about what they would have wanted. Can you tell me what they considered most important in their life? **What meant the most to them, gave their life meaning?**
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. **Can you say more about what you mean?**

Resources: Planning/Utilization

Creating a Palliative Care Inpatient Response Plan for COVID-19—The UW Medicine Experience

James Fausto, MD, MHA, Lianne Hirano, MD, Daniel Lam, MD, Amisha Mehta, MD, Blair Mills, MHA, Darrell Owens, DNP, MSN, MSHA, Elizabeth Perry, MSW, and J. Randall Curtis, MD, MPH

Resources: Planning/Utilization

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Specialty Palliative Care: COVID Crisis Service Design

Last Updated: April 1, 2020

Flowchart with service recommendations by setting and patien
palliative care teams to provide support to colleagues across th
clinicians should check with their institution's legal counsel to er
and state laws as well as institutional protocols.

DOWNLOAD

Palliative Care Referral Criteria: COVID-19 Context

Last Updated: April 15, 2020

When to refer patients with COVID-19 or pre-existing serious ill
care.

DOWNLOAD

Resources: Symptom Management

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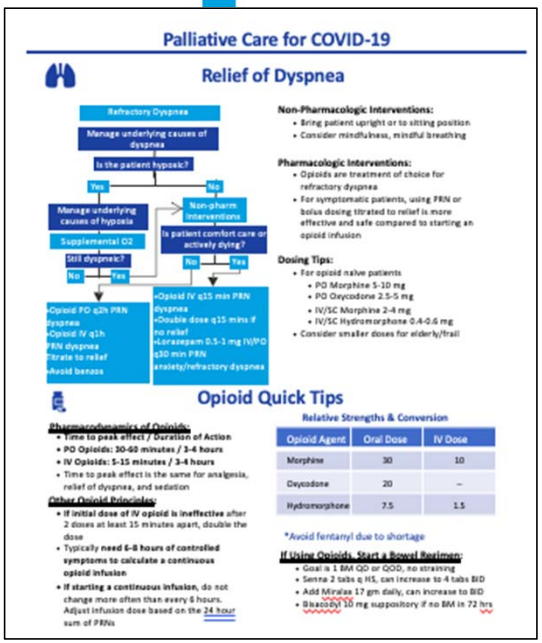

Palliative Care for COVID-19

Relief of Dyspnea

Refractory Dyspnea

Manage underlying causes of dyspnea

Is the patient hypoxic?

Yes

No

Manage underlying causes of hypoxia

Supplemental O2

Still dyspneic?

No

Yes

Non-pharm interventions

Is patient comfort care or actively dying?

No

Yes

•Opioid PO q2h PRN dyspnea
•Opioid IV q1h PRN dyspnea
Titrate to relief
•Avoid benzos

•Opioid IV q15 min PRN dyspnea
•Double dose q15 mins if no relief
•Lorazepam 0.5-1 mg IV/PO q30 min PRN anxiety/refractory 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 naive 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

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

Palliative Care COVID-19 Initiative

www.pallicovid.app

Questions/Comments?