UW Medicine Palliative Care COVID-19 Experience

March 30, 2020
<table>
<thead>
<tr>
<th>Time</th>
<th>Presenter(s)</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>1:32-1:40</td>
<td>James Fausto, MD, MHA</td>
<td>Disaster Planning &amp; COVID-19</td>
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<td>UW Medicine Medical Director of Palliative Care</td>
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<td>1:40-1:48</td>
<td>J. Randall Curtis, MD, MPH</td>
<td>COVID-19 ICU Experience</td>
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<td>Director of the Cambia Palliative Care Center of Excellence at UW Medicine</td>
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<td>1:48-1:56</td>
<td>Lianne Hirano, MD</td>
<td>Navigating Visitation Today</td>
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<td>Section Head, Palliative Care</td>
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<td>Harborview Medical Center</td>
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<td>1:56-2:04</td>
<td>Darrell Owens, ARNP, PhD</td>
<td>COVID-19 Case Review</td>
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<td>Section Head, Palliative Care</td>
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<td>UWMC, Northwest Campus</td>
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<td>2:04-2:30</td>
<td>Panel</td>
<td>Question &amp; Answer</td>
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Palliative Care Response Plan and COVID-19

James Fausto, MD, MHA
Medical Director of Palliative Care
UW Medicine
Outline:

• Review Disaster Plan Framework

• Review pieces of UW Medicine Palliative Care Response Plan
### Allocating Scarce Resources in Disasters Framework

(John Hick, et al)

**Incident demand / resource imbalance increases**

**Risk of morbidity / mortality to patient increases**

**Recovery**

<table>
<thead>
<tr>
<th>Conventional</th>
<th>Contingency</th>
<th>Crisis</th>
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<tbody>
<tr>
<td>Space</td>
<td>Usual patient care space fully utilized</td>
<td>Patient care areas re-purposed (PACU, monitored units for ICU - level care)</td>
</tr>
<tr>
<td>Staff</td>
<td>Usual staff called in and utilized</td>
<td>Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc)</td>
</tr>
<tr>
<td>Supplies</td>
<td>Cached and usual supplies used</td>
<td>Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies</td>
</tr>
<tr>
<td>Standard of care</td>
<td>Usual care</td>
<td>Functionally equivalent care</td>
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</table>

**Normal operating conditions**

**Extreme operating conditions**

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**Figure 1.** Continuum of incident care and implications for standards of care. Adapted from Institute of Medicine – Guidance for Establishing Crisis Standards of Care in Disaster Situations. 

Table 1: Strategy for Palliative Care Consult Service Interactions with the Emergency Department during Conventional, Contingency, and Crisis Capacity

<table>
<thead>
<tr>
<th>Strategy for Emergency Department</th>
<th>Conventional Capacity</th>
<th>Contingency Capacity</th>
<th>Crisis Capacity</th>
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</thead>
<tbody>
<tr>
<td>1) The emergency department can access onsite and in-person specialty palliative care most days from 9am to 6pm, by consult request. Additionally, palliative care telephonic coaching and support is available 24 hours a day, 7 days a week.</td>
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</table>
| 2) Additional planned daily huddles with the emergency department will occur to address increased need for palliative care.  
**Palliative Care Intervention:**  
- Consults for patients with poor prognosis and at risk of intubation or resuscitation will be prioritized.  
- Patients admitted to the hospital will be followed during a daily check-in with primary team.  
- Support for implementing DNR orders using informed assent or based on medical futility when appropriate  
- Chart review results and brief or full consults will be documented in the EHR |                       |                      |                 |
| 3) Palliative Care will embed a palliative care specialist in the ED to assist & address high volumes of patients and **screen patients based on the following criteria:**  
- COVID-19+/PUI or ARDS.  
- Multi-morbidity, severity of illness, & high oxygen requirement  
- Clinical status: symptom burden, frailty (using Clinical Frailty Scale[^10]), baseline functional status  
- Review code status: DNAR/DNI vs. DNAR-intubation ok vs. Full code/high intubation risk  
Based on screening the following will happen:  
1. meet or call with family/legal surrogate to address GOC and code status  
2. coach ED team on GOC and code status discussion  
3. assist with documentation of outcome and transitions of care |                       |                      |                 |

Table 2: Strategy for Palliative Care Consult Service Interactions with the Intensive Care Units during Conventional, Contingency, and Crisis Capacity

<table>
<thead>
<tr>
<th>Intensive Care Unit – Non-COVID-19 Units</th>
<th>Conventional Capacity</th>
<th>Contingency Capacity</th>
<th>Crisis Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) An ICU can access to onsite specialty palliative care most days from 9am to 6pm, by consult request. Additionally, palliative care telephonic coaching and support is available 24 hours a day, 7 days a week.</td>
<td>Green</td>
<td>Yellow</td>
<td>Red</td>
</tr>
<tr>
<td>2) Daily huddle with key ICUs to auto-assess all confirmed COVID-19 positive for unmet palliative care needs or needs exceeding ICU team’s capacity, prioritizing:</td>
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<tr>
<td>i. Lack clear GOC or full code by default</td>
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<tr>
<td>ii. GOC or code status not aligned with likely prognosis</td>
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<tr>
<td>iii. End of life or moderate/severe symptom needs</td>
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<tr>
<td>iv. Family needing high levels of support</td>
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<tr>
<td><strong>Palliative care intervention:</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Assist through brief or full consultation</td>
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<tr>
<td>3) Follow Contingency Capacity approach regarding interaction and reasons for intervention and modify as follows.</td>
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<tr>
<td><strong>Palliative care intervention:</strong></td>
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<tr>
<td>i. Invoke brief consultation, document critical/essential content</td>
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<tr>
<td>ii. Lead on symptom assessment and management including medication ordering and planning</td>
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<tr>
<td>iii. Assist with transitions of care (i.e. withdrawing life support, GIP hospice, discharge on hospice) when applicable &amp; possible</td>
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<tr>
<td>iv. Support for implementing DNR orders based on medical appropriateness or scarce resource allocation models in accordance with institutional, city, county and state protocols</td>
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Other Considerations

<table>
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<th>Considerations</th>
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<tbody>
<tr>
<td>1. Challenges based limited palliative care subspecialty staffing:</td>
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<tr>
<td>2. PPE Preservation Challenges: If PPE shortages exist, palliative care is a consulting service and should only utilize PPE when necessary for the delivery of care. Only 1 PC provider should enter COVID+ and PUI rooms.</td>
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<tr>
<td>3. After hours: On-call palliative care attending will provide coaching to primary team and telephonic support to patient/family.</td>
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<tr>
<td>4. Routine PC consultation during this time will be heavily triaged and postponed where able, if urgent consult is not needed</td>
</tr>
<tr>
<td>5. Goals of Care and Code Status guidance for primary teams – all teams should be supplied with clinician discussion tools to assist with complex communication.</td>
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</table>

| 1. Creation of an End of Life Unit to be staffed by PC specialists: based on the number of patients experiencing a need for symptomatic support at the end of life, it may be necessary to create an end of life unit staffed by Palliative Care Physicians &/or APPs. |
| 2. After hours coverage: in a Crisis Capacity state, telephonic support at all hours will need to be expanded to create greater capacity to provide coaching and symptom guidance to primary teams. |
| 3. Code Status guidance for primary teams – all teams should be supplied with clinician discussion tools to assist with complex communication. |
Palliative Care and COVID-19

J. Randall Curtis, MD, MPH
Director, Cambia Palliative Care Center of Excellence Harborview Medical Center, University of Washington

@JRandallCurtis1
• Discussing ACP and code status during COVID-19
• Triage process for scarce resources
• Supporting families through restricted visitation
• Optimizing use of PPE
COVID-19 heightens the importance of ACP and goals-of-care discussions

Key role for palliative care to teach, coach, and support

**Figure. Proposed Components of Informed Assent Framework**

1. Assess patient’s values and goals
   - Elicit values and preferences for therapies and outcomes from the patient or designated family member and formulate overall therapeutic goals

   "Is it important to your mother to live as long as possible, no matter what her quality of life, or are there circumstances in which she would not want to receive life support, such as a prolonged nursing home stay?"

2. Is longevity the patient’s primary value above all else, including quality of life?
   - No: Proceed with informed assent
   - Yes: Informed assent not appropriate

Curtis/Kross/Stapleton; JAMA 2020; Epub 3-27-20
Increased Importance of Addressing CPR During COVID-19

• Non-beneficial or unwanted CPR has always had risks for patients and family
  – Prolong patient suffering
  – Increase family distress

• Now CPR has increased risks for clinicians
  – Increased potential for exposure
  – Increased clinician distress
  – Increased use of limited PPE resources

• CPR will be even less effective in isolation
We need not discuss therapies that are not indicated.

CPR is an exception because of patient & family expectations.

Informed assent is an ethical option.  
- Can help some patients or families who can’t make a decision for DNR but will let doctors decide.
Steps of Informed Assent When CPR is Judged Not to be Indicted

Assess Patient Values: Identify the vitalists – life is worth living regardless of quality

- NO – Proceed with Informed Assent
  - Describe CPR
  - Explain CPR won’t achieve patient’s goals
  - Assent Statement: “In this situation, we don’t use CPR”
  - Assess Understanding and Allow for Objection

- YES – Informed Assent Not Appropriate
  - Consider unilateral DNR: Rare cases of true medical futility

Curtis/Kross/Stapleton; JAMA 2020; Epub 3-27-20
Things Would Change if We Hit Crisis Standards of Care

- Three levels of care
  - Conventional – usual care with adequate resources
  - Contingency – strive for usual care under stress
  - Crisis – scarce resources limit care
- We are not in crisis standards
  - Hope to avoid through public health measures
- If we hit crisis standards of care
  - Hospital triage teams make allocation decisions
  - Use of CPR may be included in those decisions
Triage of Scarce Resources: Ventilators or ICU beds

- Crisis standards would be applied at a state or regional level
- UW Medicine has a system-wide triage program with hospital-level teams
- Protocols and FAQ coming soon at UW Medicine COVID-19 Resources
- Role of PCS: Provide support and palliative care for patients and families
Supporting Families Given Visitation Restrictions

• Don’t under-estimate the stress
  – Patients, families, clinicians

• Identify alternative communication
  – Phone, video-conference

• Identify opportunities to allow family to see patients
  – Through the window into room
  – 1-2 family members in PPE for dying patients
Role of Palliative Care in Conserving PPE

- Limit in-person visits
  - Coaching for primary palliative care
  - Phone/video contacts with patients and family
- If in-person visits needed
  - One palliative care provider per visit
  - Complete training in donning/doffing
Resources for Communication

- Clinician communication:  www.vitaltalk.org

- Patients and families; Friends and relatives
  www.theconversationproject.org  www.prepareforyourcare.org
Maintaining Connections in the Midst of COVID

Lianne Hirano, MD
Associate Medical Director of Palliative Care
Harborview Medical Center
‘A Heart-Wrenching Thing’: Hospital Bans on Visits Devastate Families

To curb the risk of spreading the coronavirus, hospitals nationwide are banning visits from family and friends.


I’m on the Front Lines. I Have No Plan for This.

We’re not allowing visitors in the I.C.U. My patients will suffer in solitary confinement.

By Daniela J. Lamas
Dr. Lamas is a critical care doctor.


March 24, 2020
UW Medicine Guidelines:

- No visitors will be allowed in rooms of Persons Under Investigation (PUIs) or COVID-19 positive patients (unless at end of life). How do we define EOL? Pts on comfort-focused care?

- No other visitors will be allowed in the medical center at this time.
  - Any exceptions to this policy must be cleared by the clinical area administrator. Who approves visitors? Nurse Manager? Nursing Supervisor? Medicine Attending?

- Entrance will be limited at each organization to ensure appropriate screening can occur for the visitors in the exception list. What is appropriate screening? What if the visitor was exposed to the pt prior to coming to the hospital? What is the risk to the visitor in coming on to a COVID unit? Risk to staff?
How Palliative Care Can Help

- Draft a “Visitation Guide” for COVID EOL situations
- Use what has worked, feedback from nursing, find ways around challenges
- Have Infection Control and Risk Management review it (BE PATIENT)
- Be creative and start filling in the holes (ask for forgiveness later)
HMC COVID-19 End of Life Visitation Guide

- No visitors will be allowed in rooms of Persons Under Investigation (PUIs) or COVID-19 positive patients (unless at end of life, EOL) is defined as either transitioning to comfort care, or expected to transition to comfort care.

Any exceptions to this policy must be cleared by the clinical area administrator.

Entrance will be limited at HMC to ensure appropriate screening can occur for the visitors in the exception list.

- Prioritize video conferencing and phone calls using PC’s and family’s own devices. If PC does not have smartphone or tablet, can family provide one to be kept in the room w/ PC? If not, can HMC provide a tablet to be kept in that PC’s room?

If family requests visitation, inform family that they can designate 2 people to be designated visitors. (Will be up to the discretion of nursing and based on availability of staff)

Counsel family that designated visitors must meet the following criteria and should be screened by phone prior to visit:

- Asymptomatic (no fever, cough, throat pain, shortness of breath, myalgias, cold or flu symptoms)
- Not exposed???. We need to clarify what to do if designated visitors have been exposed to PC who is COVID+.
  - Should they be allowed to visit?
  - Do they need to quarantine prior to visit?
  - Do they need to don PPE at hospital entrance prior to visit?
- Able and willing to follow instructions (cognitively intact)
- Visitors should be screened for risk factors including older age, respiratory/cardiovascular disease, pregnancy, immunocompromised state (do we need to counsel them on risks? Risk worksheet), to standardize questions and have a counseling line that all visitors hear?

Once visitors are identified:

- Discuss with nursing and primary team a date and time for visit to occur, identify an escort that will be able to accompany PC from entrance to exit (consider Palliative Care for escort)
- Call designated visitor to give them instructions about the visit and assess needs (parking, spiritual care, palliative care, social work?)
- See checklist of needs and have these available prior to visit.

Comment [JRC]: I wonder if we need to try to define this a bit more precisely? Maybe patients going on comfort care? Does that capture all patients for whom this is relevant? We might hear some who die without going to comfort care, but I suspect that will be unusual.

Comment [INT]: No visitors were allowed in the COVID ICU rooms last week... From the Monday call, it sounds like this is being handled differently at different UW Medicine sites. Is there consensus at HMC at least on this point for now? Speaking to Randy’s point - it seems like we could say “unless in comfort care, or likely to be transitioned to comfort care” - last week we had people visit prior to comfort care transition since the COVID patients in this situation are on a lot of support and die quite rapidly after transition to CC.

Comment [BCS]: We have allowed ONE family member into patients room before, on a case by case basis and in appropriate PPE. I’ve added a section about this at the bottom.

Comment [INT]: ??
Hi Lianne/Cosmo,

This iPad belonged to my mother before I upgraded her. I know if my parents were in the hospital I’d like them to have an iPad. Thank you for doing this!

I upgraded the iPad to iOS 13.3.1, removed it from my mother’s iCloud account, and factory reset it.

Thank you for everything you’re doing on the frontlines.

Stay safe Lianne!

Bill
UW Medicine Palliative Care COVID-19 Experience

Darrell Owens, ARNP, PhD
Section Head, Palliative Care, UWMC, Northwest Campus, Clinical Assistant Professor, Division of Geriatrics.
Question & Answer
Thank you!