Palliative Care During COVID: Innovations in Care Delivery
1. Overview of Palliative Care in the Emergency Department During COVID (10 min)

2. Case Studies (20 min)
   1. New York University
   2. University of North Carolina
   3. Yale New Haven
   4. Columbia

3. Panel Discussion (10 min)

4. Questions (10 min)
Overview of Palliative Care in the Emergency Department During COVID
The EM Landscape

• By 2030 1 out of every 5 Americans will be older than 65 years old
• These older adults are 7x more likely to use the ED, will make up almost half of our admissions, have 20% longer inpatient length of stay and use 400% more social services
• 75% visit the ED in the last 6 months of life
• Over half of them will visit the ED in the last month of life
• Treatment decisions that are made in the ED impact patients trajectories and subsequent care
We are the safety net for the acute and chronically seriously ill

~ Tammy Quest, MD
Gap around fidelity

• Significant attention spent on understanding unmet needs, patient identification, environment of care

• Many different pilots and programs have tried to address these gaps, with the most focused attention on primary palliative care

• However, variable descriptions, and little consensus, related to the ‘what’ and ‘how much’
A Model that Emerged During COVID

- Integrated PC providers into the ED starting in March 2020
- Initial goal: To provide support for coming “wave”
- Provider moral distress about providing care that may not be concordant with patients wishes or has a low likelihood to provide benefit – especially in the context of concerns related to resource shortages
- We aimed to achieve two specific outcomes
  1. Maximize goal-concordant care to avoid inappropriate use of medical interventions
  2. Provide assistance and support for (suspected) coming difficult conversations related to rationing of care
A Model that Emerged During COVID

• Starting March 23, Embedded a palliative care MD into the ED from 9 AM to 7 PM daily (including weekends)
  • Consultant name and pager written on a white board
  • Attended daily AM COVID rounds
  • Dedicated station in ED Bay
  • Back-up house MD also available overnight

• Started with “suggested consult criteria,” but quickly moved to proactively identifying casing by reviewing the census board
  • Completed 164 total consults between March 23 and May 14

<table>
<thead>
<tr>
<th>Core programmatic element</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Embedded PC in the ED</td>
<td>PC physician present 9a–7p, dedicated workspace near the ED team, presence at daily ED rounds</td>
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<tr>
<td>Rapid identification</td>
<td>In addition to ED-initiated consult requests, PC physician monitors the ED board and approaches the team if it appears that a serious illness conversation is indicated, based on chart review</td>
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<tr>
<td>Surge plan</td>
<td>Protocol created to engage inpatient PC team to support excess consults when needed</td>
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<tr>
<td>COVID-specific tools</td>
<td>Several COVID-specific conversation guides created and used as a teaching tool with ED staff</td>
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</table>

ED, emergency department; PC, palliative care.
100% identified a specific benefit:

- Freed them up for other tasks (89%)
- Helped them feel more supported during their shift (84%)
- Changed the patient's management or care trajectory (67%)
- Contributed to their personal education about goal concordant care (57%)
- Added to their own skill set/confidence in practicing primary palliative care within the emergency department (49%)

96% of providers felt that PC in the ED was valuable or very valuable

In their words

“Their expertise allowed us to provide care within the truest direction and compliance of patient’s GOC [goals of care], which sometimes I feel can be lost in the rush and uncertainties of an emergency room.”

“It was reassuring seeing the team physically present in the ED. This added a sense of support AND better care for the patient.”

“Love them, please never let them leave.”

### Table 2

**Summary of Innovations in PC-ED**

<table>
<thead>
<tr>
<th>Type of Innovation</th>
<th>Example of Innovation</th>
<th>Innovation Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model of care delivery</strong></td>
<td>Embedded PC clinician in the ED</td>
<td>PC clinician seated in the ED dedicated only to ED consults</td>
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<tr>
<td></td>
<td>Strengthened ED presence</td>
<td>Achieved through daily rounding and EMR chat function</td>
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<tr>
<td></td>
<td>Mobile PC consult service</td>
<td>Dedicated service focused on ED and ICU needs</td>
</tr>
<tr>
<td></td>
<td>PC attendings with extenders</td>
<td>Residents with focused GOC or ACP training</td>
</tr>
<tr>
<td></td>
<td>PC attending with PC fellows</td>
<td>Triage cases based on complexity to appropriate clinician</td>
</tr>
<tr>
<td></td>
<td>PC extender with psychosocial partner</td>
<td>Pair volunteer non-PC physician with social worker or child life specialist who perform all consults together</td>
</tr>
<tr>
<td></td>
<td>PC clinician seated in the ED dedicated only to ED</td>
<td>Achieved through daily rounding and EMR chat function</td>
</tr>
<tr>
<td></td>
<td>consults</td>
<td>Dedicated service focused on ED and ICU needs</td>
</tr>
<tr>
<td><strong>Technology-enhanced PC-ED</strong></td>
<td>Off-site tele PC</td>
<td>Centralized team of either RNs or PC physicians for all hospitals in a health system</td>
</tr>
<tr>
<td></td>
<td>Blended on-site tele PC</td>
<td>Triage patients based on their capacity to engage to either in person or tele PC</td>
</tr>
<tr>
<td><strong>Primary PC training and education</strong></td>
<td>Trainings and tools</td>
<td>COVID-specific conversation training; collated resources (with apps, Google Docs, and provided laminated cards)</td>
</tr>
<tr>
<td><strong>Case identification and task stratification</strong></td>
<td>Proactive case identification</td>
<td>Remotely screen ED track board, daily rounding</td>
</tr>
<tr>
<td></td>
<td>Formal triggers (for primary PC or specialty consult)</td>
<td>Automated or manual—encompassing age, marker of underlying illness, marker of acute illness</td>
</tr>
<tr>
<td></td>
<td>Focused abbreviated consults</td>
<td>Task-oriented consults focused on specific patient needs</td>
</tr>
<tr>
<td></td>
<td>Nursing-initiated consults</td>
<td>Consults to PC triggered by nursing staff using clear trigger criteria</td>
</tr>
</tbody>
</table>

PC = palliative care; ED = emergency department; EMR = electronic medical record; ICU = intensive care unit; GOC = goals of care; ACP = advanced care planning; RNs = registered nurses.
Case: New York University
Using Technology to Facilitate EM and PC Integration during the COVID Pandemic

• Facilitating access to advance directives
  • Pink banner within the Epic storyboard notifying providers of the presence of AD within the EHR
  • Access directly from the patient’s EHR to the external eMOLST website

• Utilizing clinical alerts within the EDIS
  • A clinical alert within our EHR was generated for patients presenting to the ED with high acuity (e.g. ESI 1) and a MOLST within the EHR

Research reported in this presentation was supported within the National Institutes of Health (NIH) Health Care Systems Research Collaboratory by cooperative agreement UH3AT009844-04 from the National Center for Complementary and Integrative Health, and the National Institute on Aging. This work also received logistical and technical support from the NIH Collaboratory Coordinating Center through cooperative agreement U24AT009676. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
Using Technology to Facilitate EM and PC Integration during the COVID Pandemic

- Assisting with communication between emergency and palliative care teams

- Targeted interventions for patients with higher mortality and greater need
  - MSQ=48 hours $\rightarrow$ prioritization for the palliative care inpatient team
Case: University of North Carolina
Overview

• **Aim 1:** Develop a tool for prognosticating and risk-stratifying patients with COVID-19 as well as scripted language for ED-based discussion of prognosis

• **Aim 2:** Use the prognostic resources to have ACP conversations tailored to the patient’s risk and educate ED providers on appropriate documentation
## Clinical Characteristics

### Goals of Care Priorities Based on Anticipated Course/Risk of Death

(Risk Based on Clinician Judgment Considering these Factors)

<table>
<thead>
<tr>
<th>Clinical Characteristics</th>
<th>Critical</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care Intensity</td>
<td>Likely to Need ICU</td>
<td>Hospitalization</td>
<td>Discharged</td>
</tr>
<tr>
<td>O2 REQUIREMENTS and VITAL SIGNS</td>
<td>&lt;88% on 5 L NC; OR tachypnea and signs of respiratory fatigue</td>
<td>88-93% on &lt;5L NC, OR tachypnea</td>
<td>&gt;93% on RA and normal respiratory rate</td>
</tr>
<tr>
<td>AGE</td>
<td>≥80</td>
<td>60-79</td>
<td>18-59</td>
</tr>
<tr>
<td>COMORBIDITY</td>
<td>Advanced illness or multiple chronic conditions AND significant deterioration in clinical status</td>
<td>Advanced illness or multiple chronic conditions</td>
<td>No advanced illness and no more than one chronic condition</td>
</tr>
<tr>
<td>FRAILTY</td>
<td>Mildly frail* or worse, needs help with ADLs</td>
<td>Some functional impairment, “slow”</td>
<td>Minimal or no functional impairment</td>
</tr>
<tr>
<td>LAB VALUES</td>
<td>Worsening leukopenia, acute renal failure</td>
<td>Mild lab abnormalities</td>
<td>Normal laboratory values</td>
</tr>
<tr>
<td>qSOFA (GCS &lt;15, RR ≥22, SBP &lt;100)</td>
<td>&gt;1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

### Goals of Care Discussion

1. Document proxy
2. Document code status
3. Document ACP as scenario allows

1. Document proxy
2. Document code status
3. Initiate ACP conversation; may defer to admitting team

1. Document proxy
2. Initiate ACP conversation and consideration of code status
3. Review return criteria
Case: Yale New Haven
1. ED provider in ED 11a-8p,
2. Identifies patients using “surprise” question
   1. Would I be surprised if patient died during this admission?
3. Approach patient/family for Goals of Care (GOC) conversation
   1. I am concerned...
   2. If things do not go the way you/we are hoping for...
   3. Tell me about yourself/patient...
4. Followed the patient throughout hospital stay
   1. Source of information between primary medical team and patient/family
   2. Provided palliative care recommendations to primary team as needed
5. New Health System Resuscitation Protocol in Place
   1. Default DNR/DNI for covid+ patients in case of cardiac arrest
   2. Any patient in ED could be made DNR/DNI in ED if 2 attendings agreed
Challenges

1. Only 1 ED provider with palliative care skills
   - Covering ED and floor (prior pts)
   - Very high volumes
2. Prognostication with a novel disease

3. Visitor restrictions
   - Could not see how ill patient was
   - Communication between provider and family only by phone

4. New Resuscitation Policy approved and developed but not publicized by hospital system
Case: Columbia
ER-based COVID-19 Palliative Care Response team

<table>
<thead>
<tr>
<th>Time</th>
<th>ER</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am – 6pm</td>
<td>●</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>6pm – 8am</td>
<td>●</td>
<td></td>
</tr>
</tbody>
</table>

- **Palliative care**
- **Psychiatry**

Communication workshop (VitalTalk/COVID)
Supervision by palliative care team

Shalev D, et al. J Pain Symptom Manage 2020
Outcomes

• 3/27/2020-4/10/2020 (2 weeks)

Lee J, et al. JAMA Intern Med. 2020;180(9):1252-1254
Panel Discussion