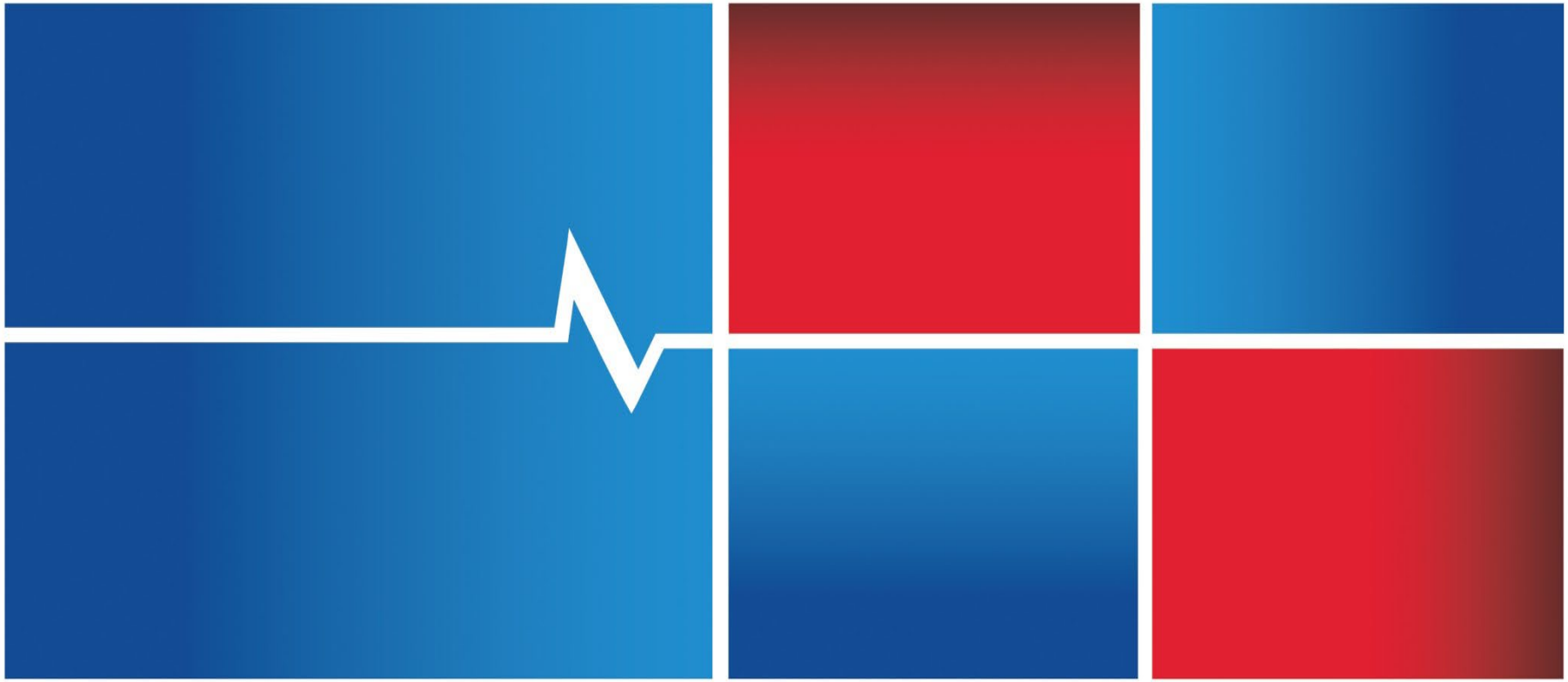

Palliative Care During COVID: Innovations in Care Delivery

Agenda

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

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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

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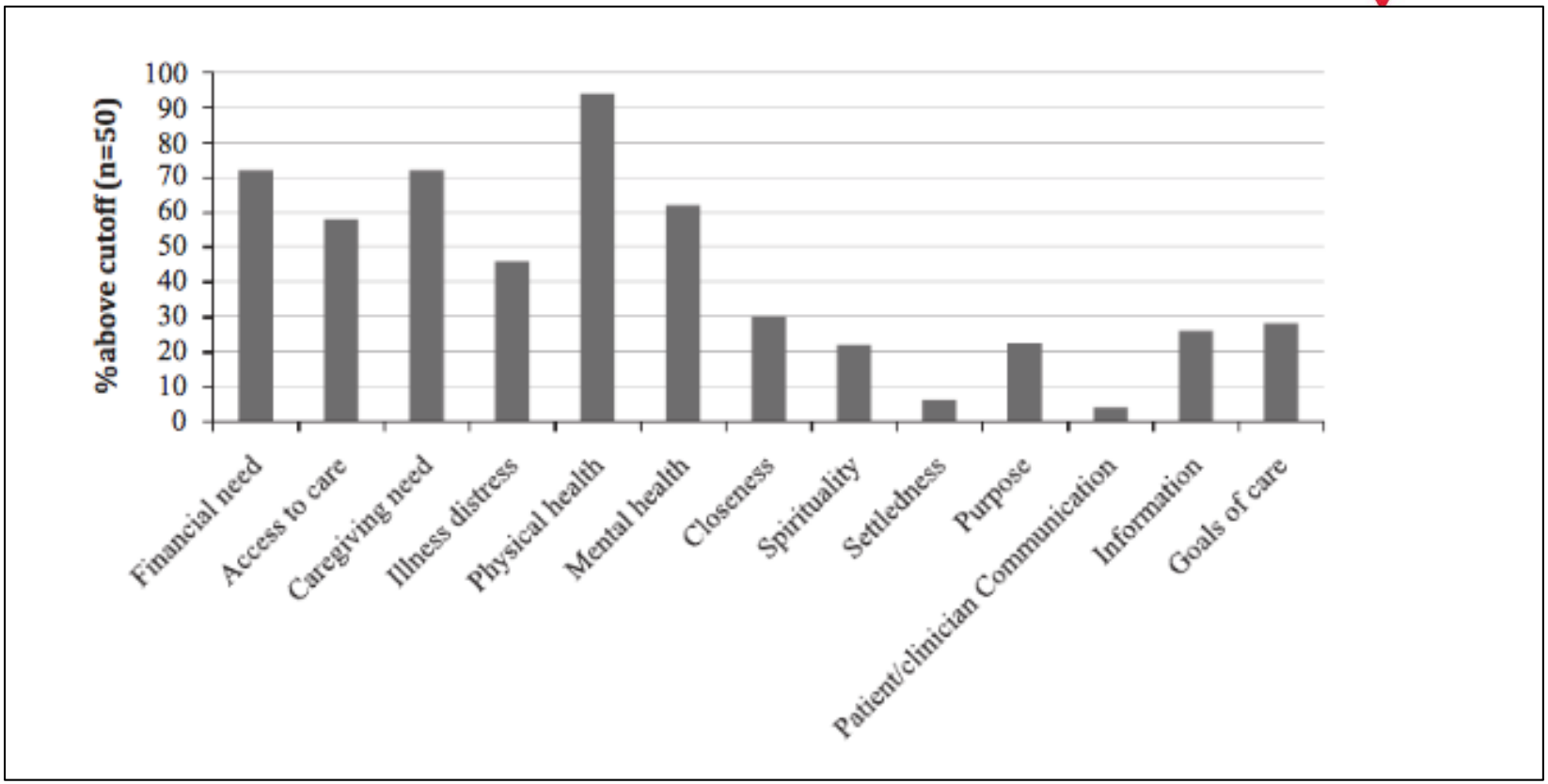
Unmet Needs



Grudzen CR, Richardson LD, Morrison M, Cho E, Morrison RS. Palliative care needs of seriously ill, older adults presenting to the emergency department. Acad Emerg Med. 2010 Nov;17(11):1253-7.

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 1. CORE PROGRAMMATIC ELEMENTS OF THE COVID EMERGENCY DEPARTMENT PALLIATIVE CARE PROGRAM

Core programmatic element	*Description*
Embedded PC in the ED	PC physician present 9a–7p, dedicated workspace near the ED team, presence at daily ED rounds
Rapid identification	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
Surge plan	Protocol created to engage inpatient PC team to support excess consults when needed
COVID-specific tools	Several COVID-specific conversation guides created and used as a teaching tool with ED staff

ED, emergency department; PC, palliative care.

Emergency Department-Based Palliative Care during COVID. Stoltenberg M, Jacobsen J, Wilson E, Daubman BR, Ritchie CS, Petrillo L, Jackson V, Aaronson EL. J Palliat Med. 2020 Jun 22.

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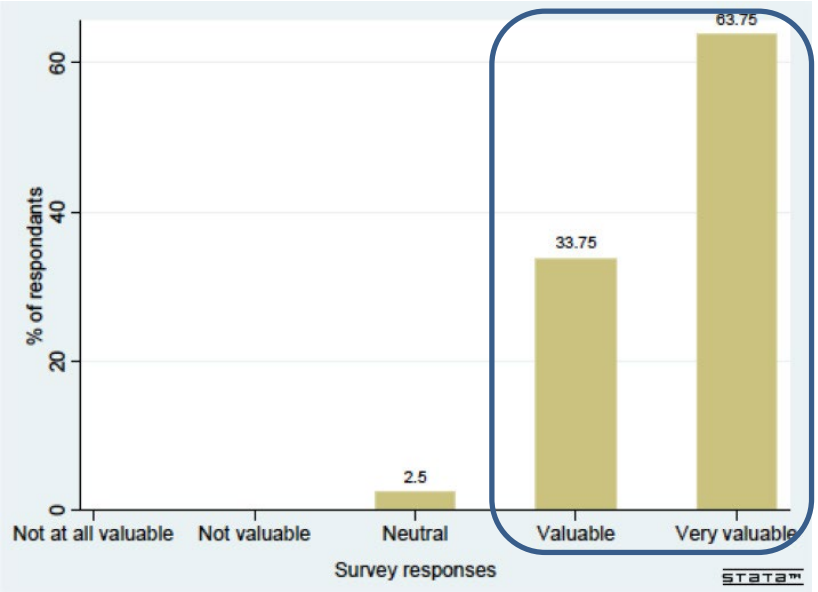
The Reception

- 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

Aaronson EL, Petrillo L, Stoltenberg M, et al. The Experience of Emergency Department Providers With Embedded Palliative Care During COVID. *J Pain Symptom Manage*. 2020;60(5):e35-e43.

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."

Aaronson EL, Petrillo L, Stoltenberg M, et al. The Experience of Emergency Department Providers With Embedded Palliative Care During COVID. *J Pain Symptom Manage*. 2020;60(5):e35-e43.

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What else was out there

Table 2
Summary of Innovations in PC-ED

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

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.

Aaronson EL, Daubman BR, Petrillo L, Bowman J, Ouchi K, Gips A, Traeger L, Jackson V, Grudzen C, Ritchie CS. Emerging Palliative Care Innovations in the ED: A Qualitative Analysis of Programmatic Elements During the COVID-19 Pandemic. J Pain Symptom Manage. 2020 Nov

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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

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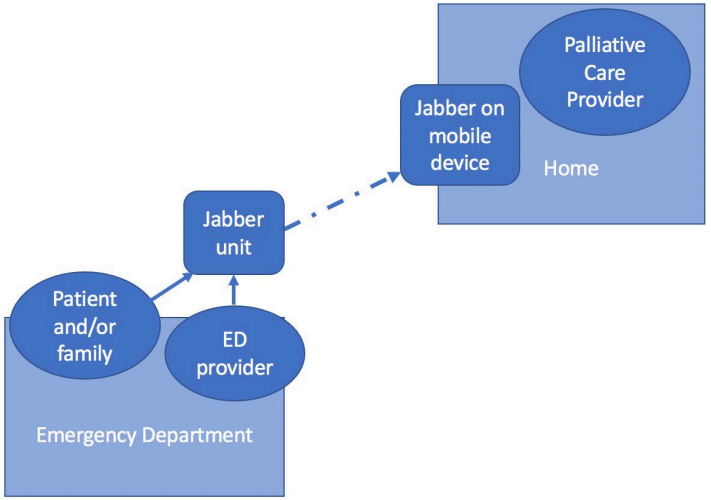
Using Technology to Facilitate EM and PC Integration during the COVID Pandemic

- Assisting with communication between emergency and palliative care teams



- Targeted interventions for patients with higher mortality and greater need
  - MSQ=48 hours → prioritization for the palliative care inpatient team

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

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Case: Yale New Haven

EM-Palliative Care Provider Embedded in ED

1. ED provider in ED 11a-8p,
2. Identifies patients using “surprise” question
    1. Would I be surprised if patient died during this admission?
    2. Covid-19, unknown, and non-Covid-19
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

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Challenges

- 1. Only 1 ED provider with palliative care skills
  - Covering ED and floor (prior pts)
  - Very high volumes
- 3. Prognostication with a novel disease
- 4. Visitor restrictions
  - Could not see how ill patient was
  - Communication between provider and family only by phone
- 5. New Resuscitation Policy approved and developed but not publicized by hospital system

Case: Columbia

ER-based COVID-19 Palliative Care Response team

	ER	Remote
8am – 6pm		
6pm – 8am		

 Palliative care

 Psychiatry

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

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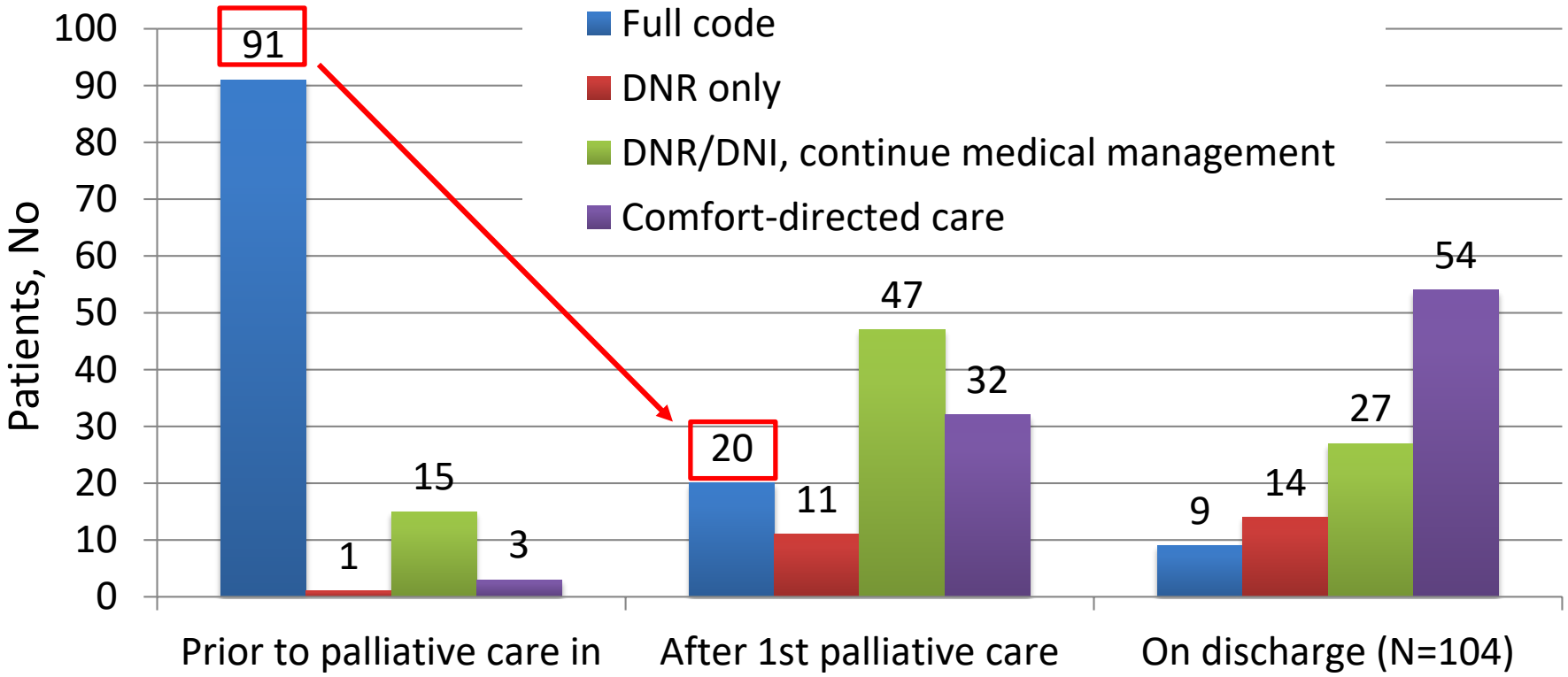
Shalev D, et al. J Pain Symptom Manage 2020

Outcomes

- 3/27/2020-4/10/2020 (2 weeks)



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

Panel Discussion