COVID19 Response: ED & Inpatient Palliative Care Delivery Pathways

Purpose:

The following plan is intended to guide the delivery of palliative care during the COVID-19 pandemic both for the current state and possible surge state. This plan will ensure that palliative care needs for critically ill COVID+ patients are systematically assessed and addressed given the high rates of morbidity and mortality within at-risk populations. We will seek to address in the areas of greatest need and capacity challenges in a surge state.

Emergency Department Setting:

<table>
<tr><th>Current State</th><th>Surge State* Modification</th></tr>
<tr><td rowspan="3">▪ Daily huddle with ED (unique at each site) to case find at risk patients in the ED or headed into the hospital with high morbidity presenting with possible COVID-19 or ARDS who:
a) Lack clear goals of care (GOC)
b) Possess GOC not aligned with likely prognosis
c) Possess end of life (EOL) symptom needs
▪ During routine work hours ED team to contact site specific PC team to assist with needs listed above
▪ After hours palliative care on-call attending can assist with telephone support and coaching.
Palliative care intervention:
▪ Consults for patients with poor prognosis and at risk of intubation will be prioritized.
▪ Patients likely to be admitted will be followed during daily huddles with primary team.
▪ Support for implementing DNAR orders based on medical futility when appropriate
▪ Chart review results will be documented in EMR.</td><td>▪ PC will aim to embed a PC specialist in the ED to assist & address high volumes of patients and <u>screen based on unique populations at each site</u>, unless populations become homogenous.
Based on screening the following will happen:
1. meet or call with family/legal surrogate to address GOC
2. coach ED team on GOC discussion
3. assist with documentation of outcome and transitions of care
▪ After hours palliative care on-call provider can assist with telephone support and coaching.</td></tr>
<tr><td><u>HMC Screen</u>
▪ COVID-19+/PUI or ARDS.
▪ Multi-morbidity & high oxygen requirement
▪ Clinical status symptom burden, frailty (use Clinical Frailty Scale), baseline functional status
▪ Review current code status:
DNAR/DNI or DNAR-intubation ok vs. Full code/high intubation risk</td></tr>
<tr><td><u>UWMC-M Screen</u>
▪ COVID-19+/PUI or ARDS.
▪ Multi-morbidity & high oxygen requirement
▪ Clinical status: symptom burden, frailty (using CFS), baseline functional status
▪ Current code status:
DNAR/DNI or DNAR-intubation ok vs. Full code/high intubation risk</td></tr>
</table>

*Surge state to be defined by multidisciplinary group in real time

	<u>UWMC-NWH Screen (Part of NWH Current State)</u> ▪ COVID-19+/PUI or ARDS. ▪ ≥60 y/o with multi-morbidity ▪ Current clinical status symptom burden, frailty (using CF), baseline functional status ▪ Current code status: DNAR/DNI or DNAR-intubation ok vs. Full code/high intubation risk

ICU Settings:

Current State:	**Surge State Modifications:**
1. Daily huddle with key ICUs to auto-assess all confirmed COVID+ for unmet palliative care needs or needs exceeding ICU team's capacity, prioritizing: a. Lack clear GOC b. GOC not aligned with likely prognosis c. End of life (EOL) symptom needs d. Family needing high levels of support **Palliative care intervention:** ▪ Assist through consultation	Follow current state model regarding interaction and reasons for intervention and modify as follows. **Palliative care intervention:** ▪ Invoke brief consultation, document critical/essential content ▪ Lead on symptom medication ordering and planning ▪ Assist with transitions of care when applicable & possible ▪ Support for implementing DNAR orders based on medical futility when appropriate

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Med/Surg Floor Setting:

Current State:	**Surge State Modifications:**
1. Teams to call for all confirmed COVID+, if unmet palliative care needs exist beyond primary team's capacity. . 2. After hours PC on-call provider can assist with telephone support and coaching. **Palliative care intervention:** ▪ Coach/guide teams on GOC discussion for patients with poor prognosis/at risk of intubation ▪ Consult if team needs assistance after first attempts on GOC ▪ Support for implementing DNAR orders based on medical futility when appropriate ▪ Assist with EOL symptom needs ▪ PC support team members (social work & spiritual care) assist primary teams after primary SW and SC engaged for families experiencing a high distress level	Follow current state model regarding interaction and reasons for intervention and modify as follows: **Palliative care intervention:** 1. Daily huddle in person or by phone with key units to assess changing needs for COVID+ patients including symptom management, EOL decisions and family distress. 2. Invoke brief consult for high needs cases 3. Advise on hospice opportunities were possible 4. After hours PC on-call provide can assist with telephone support and coaching.

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Considerations:

Current State:	**Surge State Modifications:**
1. Capacity: ▪ HMC has only 1 PC attending on service per week. Other specialty workforce exists & could be pulled from other services to increase the size and reach of palliative care team. ▪ NWH has only 1 PC provider with limited ability to pull in additional workforce. Clinicians may need to be redeployed across sites based on need. 2. PPE: Palliative care is a consulting service and should only utilize PPE when absolutely necessary for the delivery of care. Only the 1 PC provider should enter COVID+ and PUI rooms. 3. After hours: On-call palliative care attending will provide coaching to primary team and telephonic support to patient/family. 4. Routine PC consultation during this time will be heavily triaged and postponed where able, if urgent consult is not needed	Same as current state with following additions 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. Some or all sites may need to consider this intervention. 2. After hours coverage: in a surge 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 - See the Code Status and COVID19 Patients Guidance Document

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