BIDMC Palliative Care COVID Response

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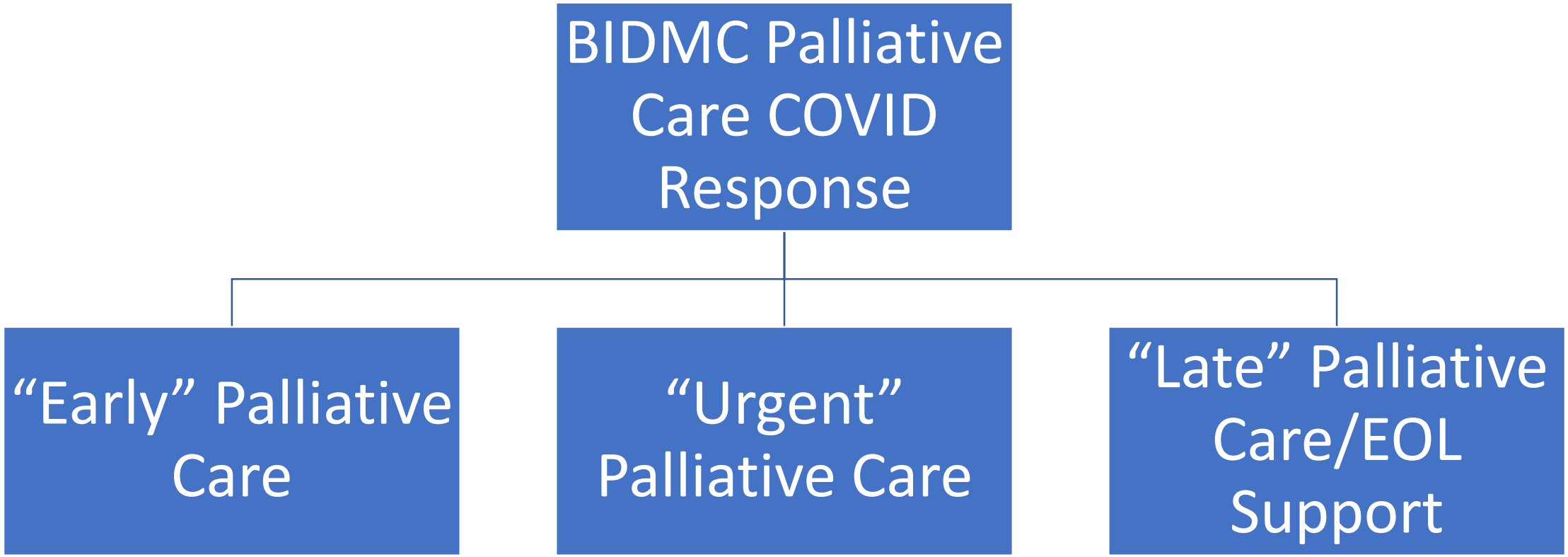
BIDMC Palliative Care COVID Response
“Early” Palliative Care
“Urgent” Palliative Care
“Late” Palliative Care/EOL Support

”Early” Palliative Care Response

GOAL: Define and document goals of care for high-risk patients.

Prompt/Support Primary Care

1. Identify high-risk patients with undefined goals of care
2. Prompt primary physicians to address advance care planning (ACP)
3. Provide educational tool to guide ACP and documentation of it.

Palliative Care Outreach

1. Outreach to primary physicians
2. Virtual availability

Identifying High Risk Patients

AGE	DEATH RATE confirmed cases	DEATH RATE all cases
80+ years old	21.9%	14.8%
70-79 years old		8.0%
60-69 years old		3.6%
50-59 years old		1.3%
40-49 years old		0.4%
30-39 years old		0.2%
20-29 years old		0.2%
10-19 years old		0.2%
0-9 years old		no fatalities

PRE-EXISTING CONDITION	DEATH RATE confirmed cases	DEATH RATE all cases
Cardiovascular disease	13.2%	10.5%
Diabetes	9.2%	7.3%
Chronic respiratory disease	8.0%	6.3%
Hypertension	8.4%	6.0%
Cancer	7.6%	5.6%
no pre-existing conditions		0.9%

The *Report of the WHO-China Joint Mission* published on Feb. 28 by WHO, [2] which is based on **55,924 laboratory confirmed cases**. The report notes that "*The Joint Mission acknowledges the known* ***challenges and biases of reporting crude CFR early in an epidem***ic" A paper by the Chinese CCDC released on Feb. 17, which is based on **72,314 confirmed, suspected, and asymptomatic cases** of COVID-19 in China as of Feb. 11, and was published in the Chinese Journal of Epidemiology [1]

Advance Directives – 3 Easy Steps

1. **Identify a PROXY**
2. **Elicit PREFERENCES**
3. **Recommend a PLAN** – matched to preferences

1. Identify a Proxy

If no proxy:	• "Whom do you want to be your voice if you become unable to speak for yourself?"
If proxy in chart:	• Verify information is still accurate. • "Is NAME still your proxy?" • "Have you and your proxy discussed your thoughts and wishes, so s/he knows how approach medical choices?"
Document:	• In OMR, enter name and phone # under Advance Care Planning >> Health Care Proxy Edit

2. Elicit patient PREFERENCES

These are examples of samples phrases to stimulate a conversation. Choose 1 or 2.	
Opening line	*"If you are too sick to speak for yourself, what kind of medical care you would want?"*
Define "quality of life"	*"Everyone has different things that bring joy. What matters most to you? What 'defines' quality of life for you?"*
Explore hopes for future	*"As you think ahead, what are hoping for?" "If you undergo interventions/treatment, what are you hoping they accomplish?"*
Explore attitude toward risk	*"If doctors were unsure if a medical procedure would help you, would you consider trying it? . . . What if the odds were low that it would help? . . . What would make you want to try/not try it?"*
Normalize choices	*"Many patients tell me they do not want to be a vegetable/ be kept alive on a machine? Have you ever thought about that?"*

3: Recommend a PLAN.

Patients want and expect our guidance. Be honest about uncertainty. Give a recommendation that takes into account the individual patient's prognosis (specifically around survival of CPR/intubation.) Sadly, most patients with substantial co-morbidities will NOT survive/recover from prolonged intubation that is anticipated with COVID.	
Pt 1: clear about wishes	*"You seem clear in your desire to avoid being put on a machine. If you are certain, then we should complete some paperwork to document that."*
Pt 2: Everything now, but not later	*"It's important to you that you have as much time as you can. You want comfort at the end of your life. To honor that, we should continue current Rx. I would also recommend, in the event you get critically ill, we do not hook up to machines. When the time comes, we can focus on quality of life and time with family."*
Pt 3: ambivalent	*"We have a team skilled at these discussions. Shall I have them reach out to you?" - Consider referral to Pall Care*
Document:	**Enter note in OMR. Check □ Advance Care Planning on list of problems under note.** **Consider using MACRO: ACP Pall Care Template.** **Complete MOLST, if DNR/I is clear.**

Palliative Care Outreach

Dear Colleagues:

We recognize the stress that COVID has placed on all of us as providers and the questions and anxiety it has raised for many of our patients. We, the outpatient palliative care team, wants to support you and your outpatient population as much and as pro-actively as possible.

Completing advance care planning medically frail patient feels particularly. , it feels If you feel could benefit from having a goals of care discussion in response to the pandemic, please consider a Palliative Care consult. We are available for both telephonic visits and in-person visits. We are committed to collaborating with you during this time.

Sincerely,

BIDMC Outpatient Palliative Care Team

To place a palliative care consult in OMR:

Orders → New Order → Consults: Palliative Care Referral

OR e-mail Carrie Currier @ ccurrier@bidmc.harvard.edu