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Palliative Care Considerations for Older Adults in the Emergency Department During the COVID-19 Pandemic

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Box 1: Patient Scenario

ME is a 79 year old male with past medical history significant for hypertension, hyperlipidemia, Type 2 diabetes mellitus, heart failure, prior DVT (on lifelong anticoagulation), chronic kidney disease, and a history of cerebrovascular accident in 2002 and in 2019 with residual L sided weakness who presented with dyspnea, a dry cough, and fevers x 5 days.

On triage in the ED, vital signs included: BP 121/71, HR 86, RR 40, Temp 36.4, SpO2 100% on nasal cannula at 4 L/min. On initial exam, patient was wheezing and with increased work of breathing.

Basic labs and blood cultures were obtained. Imaging revealed bilateral infiltrates on chest X-ray. He was given Azithromycin x1, and a COVID-19 nasopharyngeal swab was sent. He was placed on a non-rebreather mask (12L) due to ongoing hypoxia and was admitted to a medicine team for further management.

In the ED, advance care planning (ACP) conversations were initiated with the patient and his daughter by the primary ED clinician after reviewing the patient's medical record.

During prior outpatient clinic visits, several ACP conversations were started in light of patient's functional decline, worsening pressure injuries, and underlying chronic medical co-morbidities. Initially, the patient's daughter (health care agent) expressed that they had conversations years ago that he would like to be fully resuscitated and try life support measures for 10 days. More recently, his daughter admits things have been different for some time, and the patient was often frustrated by recurrent admissions to the hospital and is fearful about COVID-19.

- Is there a framework to guide urgent medical decisions?
- How can ED providers elicit goals, values, and guide patient preferences during this COVID-19 pandemic?
- What are recommendations for symptom management for older adults with COVID-19 in older adults?

BACKGROUND

The Emergency Department (ED) has long been a particularly challenging environment for older adults, and particularly those with serious illness and palliative care needs.[1] Given that the ED is a crucial safety net to older adults in crisis, those presenting are at heightened risk of adverse outcomes such as functional decline and death.[2,3] While the ED is necessary for the delivery of acute medical care for older adults, the ED's physical environment is characterized by overcrowding and a need for rapid assessment and decision making. This makes geriatric assessments and nuanced discussions about goals and values challenging.

The coronavirus (COVID-19) pandemic has only increased the need for geriatric and palliative care expertise in the ED. While prognostic data is still preliminary, multiple studies have shown high rates of morbidity and mortality from severe acute respiratory distress syndrome among older adults with multiple chronic conditions.[4,5,6] Among individuals of all ages surviving a critical case of COVID-19, hospitalizations are long (median 17 days) as is the duration of mechanical ventilation (median 10 days)[7] and thus may be even lengthier for older adults.

The heightened risk COVID-19 presents to older adults makes integrating geriatric and palliative care principles into ED care even more critical. For high-risk older adults admitted to the ED with probable COVID-19, initiation of early goals of care (GOC) conversations are crucial to providing patient-centered care. Ideally, these discussions would happen in the outpatient setting over multiple encounters; however, the rapid onset, and often unexpected decline, of patients with COVID-19 is moving the GOC conversations into the ED. The window of time in the ED where a meaningful conversation with patients who still have capacity and are conversant can be extremely limited.

This article discusses the overwhelming need to expand geriatric and palliative care support to the most vulnerable patients seen in the ED during the COVID-19 pandemic. It is important to convey how this infection is different compared to other viruses or bacterial illnesses and what that means for clinical outcomes. To guide clinical decisions in older adults with multimorbidity and COVID-19, prognosis, trajectories of disease, patient preferences, and symptom management need to be considered.

Box 2: Helpful Strategies to Resolve Urgency of Decision Making

1. Identify the correct decision maker. (Health Care Proxy (HCP) forms, surrogate decision maker)
2. Elicit patient values and goals.
3. Determine prior stated wishes for intubation, resuscitation, and serious chronic illness.
4. Facilitate real time conversations by video or phone with a decision maker about COVID-19 and its disease course and how that aligns with a patient's values, goals, and wishes.
5. Develop a treatment plan aligning a patient's goals and then documenting this care plan in the electronic medical record.

COMMON ED CHALLENGES & MITIGATION STRATEGIES

Times of crises, such as the COVID-19 pandemic, call for quick decisions to be made for patients with uncertain prognoses. ED providers are on the frontlines, managing and stabilizing multiple acutely ill patients whose clinical statuses are rapidly changing. Due to the highly infectious nature of COVID-19, some hospitals have implemented limited visitor policies, including the ED. This means older adults are often arriving to the ED alone, separated from family, and without their trusted advocates. As many patients are unaccompanied, medical providers are unable to obtain collaborative history from family or caregivers while providing emergent medical care. For older adults that live in long-term care (LTC) settings, this is even more challenging as coordinating with the LTC facilities and trying to find advance care planning (ACP) documents requires additional time.

COVID-19 and its sheer volume and acuity of patient cases have overwhelmed many EDs in the epicenters of the pandemic. While ED clinicians are triaging and treating a high volume of critically ill patients, it is extremely challenging for them to make the time to assess for decisional capacity or have effective GOC conversations necessary to providing quality care to all patients. Skilled communicators versed or trained in geriatric and palliative care skills can and should play a significant role in the ED to help align clinical treatments with patients' goals and values. An effective collaboration between ED and these skilled communicators (geriatricians, palliative care clinicians, psychiatrists, and social workers) can greatly improve the quality of care delivered in these difficult circumstances.

Although many hospitals have these skilled communicators, there are only a few programs that embed them in the ED. While ED providers are assessing patients, these skilled communicators can gather psychosocial information about patients, identifying health care agents, clarifying wishes, values and preferences. Geriatricians and palliative care clinicians can take this one step further. By understanding their multiple complex comorbidities, they can often provide an overall prognosis, vital in decision-making. Early communication in the decision-making process ensures that patients and their loved ones are making complex medical decisions with the best available information.

KEY GERIATRIC & PALLIATIVE CARE PRINCIPLES

• **Determine who will assist in addressing the issues created by the need for social isolation:** Older adults with multiple chronic conditions are considered the highest risk for COVID-19 and its subsequent morbidity and mortality. Older adults living with chronic serious illness can have varying opinions about how they want to be cared for at the end of life, ranging from pursuing life prolonging interventions and a trial of critical care to focusing on comfort and quality of life. It is extremely important to clarify what is driving these medical decisions and honor patient's end of life wishes.

1. **Identification of appropriate decision maker**: Identifying a decision maker is key, including assessing if the patient has capacity to make complex medical decisions. For older adults with baseline cognitive impairment and an increased risk for delirium, it is important to review prior health care decision maker documents and/or verify surrogate decision makers. The clinical course of COVID-19 is unpredictable, and older adults may lose capacity unexpectedly, so reviewing and/or verifying the decision maker quickly is important while patients still have capacity.

   Assessing decisional capacity in a patient with cognitive impairment and/or delirium poses an additional challenge in the ED. A proper capacity assessment often takes time, and requires clinicians to verify the patient's cognitive baseline, assess for delirium with a validated tool and clarify a specific question in which the patient can participate in discussions. For example, a patient with cognitive impairment may be able to name a surrogate decision maker, but he/she is unable to participate in complex decisions regarding resuscitation and intubation. These additional assessments and complex conversations may require the collaborative skillsets and support of the ED team and skilled communicators.

2. **Eliciting the values and goals of the patient**: Geriatricians have been reframing the way care is provided for older adults living with multiple chronic illnesses using a communication framework known as the Geriatric 5 M's. Geriatricians focus on 5 key areas (Multi-complexity, Medications, Mentation, Mobility, Matters Most) to help align clinical decision making.[8,9] During the COVID-19 pandemic, reviewing what "matters most" should be at the forefront of these conversations to allow clinicians to understand what is important for older adults. This allows for better alignment of clinical care decisions and identifies medical treatments that would and would not be acceptable to patients.

3. **Determining prior stated wishes for intubation, resuscitation and serious chronic illness:** The Medical Orders for Life-Sustaining Treatment (MOLST) or Physician Orders for Life-

Sustaining treatment (POLST) are medical legal documents, typically completed after a conversation or a series of conversations between the patient, the patient's health care agent or surrogate, and a qualified, trained health care professional, that defines the patient's goals for medical care, reviews possible treatment options, and ensures shared, informed medical decision-making. Commonly used in home based and outpatient primary care practices and LTC facilities, the MOLST or POLST form is one way of documenting a patient's treatment preferences regarding life-sustaining treatment, including wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, such as intubation, artificial nutrition and fluids, and the use of antibiotics. The MOLST or POLST is intended for patients with serious health conditions who want to avoid or receive any or all life-sustaining treatment; reside in an LTC facility or require LTC services; and/or whose prognosis is less than a year.[10]

Ideally, prior to an ED visit, GOC conversations would have taken place and MOLST/POLST forms would be completed and brought to the hospital or already in the electronic medical record (EMR). Having established goals of care can be extremely useful when critical decisions need to be made. Equally important with identifying goals is easy accessibility to ACP documents; this can be a problem in the ED when time is limited, and ACP documentation inconsistencies within EMRs exist.

To meet the needs of this vulnerable population during the COVID-19 pandemic, other clinical staff such as social workers, mid-level providers, or residents can be trained to initiate this process often completed by geriatricians and palliative specialists by reviewing proper documents, assessing for the decision maker and value exploration. Advanced communicators can then assist with the more complex goals of care discussions.

4. **Having a real time conversation by video or phone with decision maker about COVID19, the likely disease course and how that aligns with patient's value, goals and wishes:** There are unique aspects of understanding patients' preferences and goals in the context of the COVID-19 pandemic. ED providers often only have a narrow window to explore GOC before a patient loses capacity given acute clinical decompensation secondary to COVID-19. With COVID-19, there is concern of increased morbidity and mortality for older adults where CPR may not provide a significant chance of survival and intubation can be prolonged and complicated by multi-organ failure and debility from prolonged immobilization. Even with helpful prognostic tools, there is an unpredictable course to COVID-19 with much uncertainty and variability of patients' responses to this illness.

   Since the start of the COVID-19 pandemic, several resources have been developed to help facilitate these difficult conversations such as training toolkits and communication scripts from the Center to Advance Palliative Care (CAPC)[11] and Vital Talk[12], which have been tailored for ED providers (Vitaltalk.org and CAPC.org). These offer standardized protocols to help frame difficult conversations about serious illness during a crisis. Vital Talk's REMAP framework in an example of a stepwise approach to difficult conversations and is a helpful tool to use when clinical decisions are imminent. This framework guides goals of care conversations by Reframing the situation and why things are different; prepares the provider to Expect emotion; Map values before talking about code status; Align patient values; Plan medical treatments that reflect patient values by making a recommendation. These toolkits and communication scripts provide a structure for clinicians to elicit goals and values, provide recommendations aligning with patients' wishes, and ultimately improve quality of life.[13]

5. **Develop a treatment plan that aligns all of these and then documenting this in the chart:** Once the correct decision maker(s) has been identified and a patient's goals and values about end of life wishes are determined, the clinician can readdress preferences and develop a treatment plan keeping in mind the unique aspects of COVID-19. Understanding patients' GOC, overall frailty and functional status, in addition to more objective prognostic tools such as the Sequential Organ Failure Assessment (SOFA)[14] scores or Eprognosis (Walter Index)[15] may help align treatment recommendations and decisions. The final step requires completing appropriate documentation in real time and updating the electronic medical record.

• **Symptom management for serious illness during COVID 19:** The most common symptoms associated with COVID-19 in older adults include: delirium, dyspnea, and pain. In general, both non-pharmacologic and pharmacologic approaches should be considered in managing symptoms. Non-pharmacologic management strategies should be considered first line and should be implemented starting in the ED.

Often, hypoactive or hyperactive delirium is the only presentation of an acute medical illness in older adults. Many patients already have predisposing risk factors for delirium, including dementia, sensory impairments, and polypharmacy. With the COVID-19 pandemic, social isolation augmented by separation from families, staff limitations to provide personalized 1:1 or volunteers, and restricted contact with providers who are donned in Protective Personal Equipment (PPE), increases the risk for delirium. Delirium prevention strategies should be implemented including providing redirection and clear reorientation to older adults, spending more time to address their questions, ensuring safety while alone, and helping facilitate communication with loved ones (via telephone or video chat). It is also important to address common reversible causes of delirium, such as pain, dehydration, constipation, or urinary retention.

While there is little evidence to support the use of antipsychotics for the management of hyperactive delirium, agents such has haloperidol, quetiapine,

risperidone are used in the ED when agitated, delirious patients are a danger to themselves or staff. While benzodiazepines (e.g. Lorazepam) are avoided in older adults due to paradoxical agitation, low starting doses (start with half of the dose you would use in younger adult patient and titrate up) can effectively be used to treat anxiety and agitation at the end of life. [16,17]

Dyspnea and the sense of breathlessness is another common symptom seen in patients presenting with COVID-19 illness. Effective non-pharmacologic strategies used for symptoms at the end of life include repositioning patient to an upright position, providing supplemental oxygen, and encouraging mindful breathing exercises to ease anxiety and work of breathing. Fans which are often suggested as a non-pharmacological treatment for dyspnea is not encouraged in COVID as it can further disseminate the virus.

Given that delirious older adults may not be able to communicate if they are in pain, assessing for non-verbal symptoms (e.g.: increased respiration, tachycardia, facial grimacing, moaning, and inconsolability) is vital. The Pain Assessment in Advanced Dementia (PAIN-AD) score is commonly used to help assess for the severity of pain in non-verbal or altered patients.[18] For patients with refractory dyspnea and pain, opioids are often used. For older adults, the general recommendation is to start with the lowest dose and titrate slowly to an effective dose[11].

Morphine, which is available as liquid, oral, intravenous, or rectal formulation is typically the preferred agent, though oxycodone, hydromorphone, and fentanyl are commonly used alternatives, especially in patients with renal impairment. For those who are not opioid naïve, given there may be renal or hepatic impairment, it is best to also use lower doses of opioids.

Patients should be reassessed frequently to ensure analgesic response. Once an effective dose is identified to control symptoms, providers can consider transitioning to an equivalent intravenous drip to decreases COVID-19 exposure to healthcare workers. Given how common opioid induced constipation is, a bowel regimen should be started on all patients receiving opioids. The CAPC COVID-19 resource guide provides specific recommendations for symptom management protocols[11].

• **Encourage advance care planning with patients in your health system pre-hospital care:** In order to address the overwhelming needs of our older adults during the COVID-19 pandemic, advance care planning discussions should start before patients arrive to ED. Upstream and unbiased conversations about patients' goals, values, and preferences should begin within ambulatory care practices (e.g. primary care, geriatrics, family medicine), Sub-acute Nursing Facilities (SNFs), and Assisted Living Facilities (ALFs). Providers with long-term relationships with patient are better positioned to have meaningful discussions and can better guide clinical decisions and recommendations prior to a crisis.

These upstream, documented GOC conversations can result in avoidable ED visits; opportunities to provide appropriate community support; address symptom management; and transition patients to programs such as Hospice. With community partnerships, patients may be able to transition to hospital at home programs, home-based palliative care program, and hospice programs, offloading EDs and hospitals while aligning patient care preferences.

GERIATRICS & PALLIATIVE CARE SKILLS IN THE ED

In time of a pandemic, innovation and collaboration is imperative. While it may not be feasible in most hospitals to have Geriatricians and Palliative Care providers embedded within ED, partnering with Geriatricians and Palliative Care providers to create virtual communication training workshops; educating ED social workers and ED providers how to quickly help identify surrogate decision makers or health care proxies, and creating medication order sets within an electronic medical record for COVID-19 patients in the ED can be helpful.

Table 1: Top Ten Palliative Care Principles in the ED During the COVID-19 Pandemic

1. Identify the correct medical decision maker for patients if they lack capacity or could in the near future - either from a new or previous HCP or a surrogate decision maker by state law.
2. Explore goals, values, and preferences in order to learn what is important to patients.
3. Determine medical treatments that would and would not be acceptable to patients.
4. Educate patients and families about how COVID-19 is different from other illnesses given the increased morbidity and mortality.
5. Facilitate conversations via phone or video between patients and their loved ones during an acute crisis or end of life.
6. Monitor for verbal and non-verbal signs and symptoms of dyspnea, pain, and delirium.
7. Manage uncontrolled symptoms, ensuring comfort in dying, and supporting families.
8. Ensure effective communication between all health care professionals involved in patient care.
9. Provide rapid reassessment of patients' goal and treatment plans as prognoses change.
10. Offer reassurance and skilled communication to patients and families in time of great uncertainty and support for medical providers and colleagues in ED.

For those with existing Geriatrics and Palliative programs, developing collaboration with them is a clear necessity, not only for the patients, but also the ED providers. For those without such programs, consider training clinicians to fill that role or partnering with nearby existing geriatrics and palliative care programs to meet clinical and educational geriatrics and palliative care needs. The creation of 24/7 tele-consults lines can help to provide remote telephonic counseling and assistance with GOC conversations as well as guidance on end of life symptom management.

All of these innovative models have been effective in improving patient care within the ED's in our health system and has had a downstream, positive impact on inpatient hospital units. Additionally, there has been significant appreciation expressed by patients, families, and colleagues.

SUMMARY

Our medical community is facing unprecedented times with the COVID-19 pandemic. Older, frail adults and/or those with underlying chronic or serious illness are most at risk from morbidity and mortality from the novel coronavirus. Our patients, colleagues, health system, and communities need collaborative expertise to overcome this pandemic. Emergency care providers can employ principles of geriatrics and palliative care in caring for these vulnerable patients.

Box 3: Patient Scenario Follow-Up

The geriatric-palliative care team followed up with ME's daughter by phone and provided a medical update detailing his quick clinical decompensation. His breathing was more labored, and he was less alert. Even though COVID-19 test was still pending, his chest X-Ray showed a similar pattern, and his clinical picture was consistent with the virus. The fact that coronavirus is different; causing severe illness especially in older adults was explained. The team explained that in the event that ME did not respond to these therapies, aggressive treatments like CPR and intubation/mechanical ventilation have not shown to be beneficial and would cause harm.

Review of values, and goals, and care preferences:

ME's daughter understood his functional status had changed over the past years and shared concerns in the setting of the COVID-19 infection. After further discussion with the ED clinicians, SW, and Geriatrics-Palliative Care team, and reframing values the daughter who understood her father's overall prognosis, agreed with DNR/DNI and wanted to try all possible medical treatments including antibiotics, intravenous fluids, and noninvasive positive pressure ventilation up until the point of cardiac or respiratory arrest. ME was admitted to the Geriatric inpatient team and required aggressive symptom management for dyspnea and agitation. His symptoms were managed, and he died peacefully two days later.

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