GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

EXPERT PANEL WEBINAR

Monday, June 1, 2020

Palliative Care Considerations for Older ED Patients in the age of COVID-19

MODERATOR: Don Melady, MD

Please visit gedcollaborative.com

COVID-19 Resources https://gedcollaborative.com/article/jgem-1-6/

EXPERT PANEL

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Vision

A world where all emergency departments provide the highest quality of care for older patients.

Mission

We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine.

We build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.

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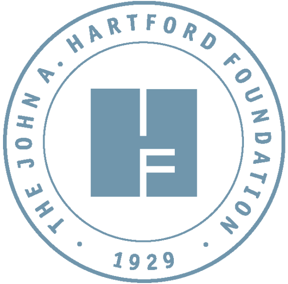

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Zoom Webinar Pointers

1. All microphones have been muted.

2. Hover your mouse over the Zoom window to bring up five icons in the bottom center

3. Q & A Function will NOT be used.

4. Click on **Chat** function, the icon on lower right.

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Geriatric Emergency Department Collaborative
June 1, 2020

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

Martine Sanon, MD, Ayla Pelleg, MD, Claire Ankuda, MD, and Emily Chai, MD

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.

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Expert Presenters

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Critical Conversations in Serious Illness

Without COVID

- Breaking bad news
  - You have serious illness…
- Prognostication
  - What are we expecting, what are we hoping for?
- Goals of Care Conversations
  - What's important to you?
- Life Sustaining Interventions
  - What we should try and what we shouldn't…

With COVID

- All the same + "severity factor"
- Older patients with COVID don't do as well as younger patients
  - Uncertain factor

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Breaking Bad News

- New Diagnosis of COVID, Asymptomatic:
  - COVID will be discovered to have COVID in the ED with rapid testing and patient sorting
- New Diagnosis of COVID, Symptomatic
  - COVID with clinically consistent symptoms
- Known COVID Exacerbated illness
  - Patients known to have COVID previous to ED visit and have new deterioration will
- Suspected COVID but NO Confirmed Test
  - "I am really worried that…"

Prognostication and Trajectories

- Gaps in knowledge and experience
- Only 4 months of data at “best”
- We have “age” as a predictor but we don’t know much more than this
- Symptomatic vs. Asymptomatic COVID in ED presentation
- When is COVID a real clinical factors in the illness trajectory vs. a carrier state?
- Due to testing delays (unable to obtain in the ED) you may not be able to confirm COVID

COVID as a Severity Factor
A New Way of Seeing the Equation

$$a^2 + b^2 = c^2$$

Non-COVID
Prognostication

$$x = \frac{-b \pm \sqrt{b^2 - 4ac}}{2a}$$

COVID Prognostication

"Standard" Goals of Care Conversation

1. **Confirm a shared understanding** of the patient's medical condition
2. Elicit personal goals for health care
3. Clarify whether primary goals of care are
4. **Recommend treatments** consistent with the patient's goals
5. Establish a plan and confirm it

Discussing Next Steps and Life Sustaining Treatments

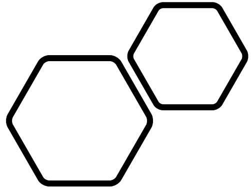
Try to Do….

- Approach goals of care conversations early and often
- Establish patients’ baseline function
- Identify advance care plans and legal surrogate decision makers
- Acknowledge prognostic uncertainty when appropriate
- Appreciate that we know relatively little about the predictive factors for poorest outcomes in COVID

Try to Avoid…

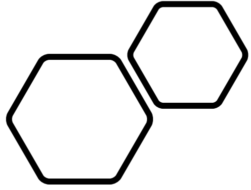
- Avoid therapeutic nihilism and cognitive bias
  - Don’t forget there could be other illnesses that could be reversible
- Avoid “rationing” when there is nothing to ration
- Making recommendations based on age alone

Dr. Erin O’Connor



General Principles for management of symptoms in the ED

- Establish goals of care established/identify SDM
- Review previous medications list
- Determine if imminently dying vs. symptomatic



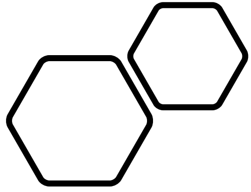
COVID-19 Considerations

Is the respiratory distress due to COVID-19 or another cause?

- You may not know this in the ED

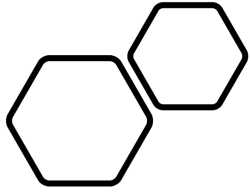
Staff/other patient safety

- Avoidance of BiPAP/high flow O2/nebulized medications/fans
- May change based on underlying community spread
- Consideration of number of visitors/PPE for visitors



Potential Symptoms to Anticipate

- Dyspnea
- Nausea
- Airway secretions
- Agitation



Dyspnea

Morphine 1-2.5 mg subcut/IV q30min prn OR

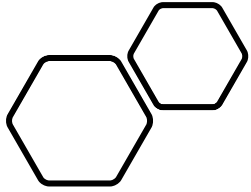
Hydromorphone 0.25-0.5 mg subcut/IV q30min PRN OR

Fentanyl 12.5-50 micrograms subcut/IV q15min prn

If severe,

Add Midazolam 0.5-1mg subcut/IV q30min prn

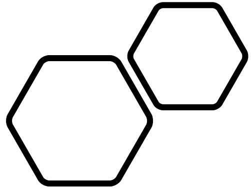
Ketamine in dissociative dosing (1-2 mg/kg IV or 4 mg/kg IM) as a temporizing measure until the above medications can be titrated to effect.



Nausea

Haloperidol 0.5 mg-1mg subcut/IV q4h

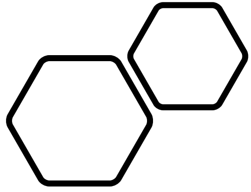
Ondansetron 4 mg subcut/IV q6h



Airway Secretions

Glycopyrrolate 0.4 mg subcut/IV q4h prn OR

Scopolamine 0.4 mg subcut/IV q4h prn



Agitation/Delirium

Haloperidol 0.5 mg- 1 mg subcut/IV q2h prn

If severe add Midazolam 0.5-1mg subcut/IV q30min prn

If severe add Methotrimeprazine 12.5- 25 mg subcut q4h prn

Resources

- EPEC-EM
  - www.epec.net
- LEAP-ED
  - Pallium.ca
- Hendin et al. *End-of-life Care in the Emergency Department for the Patient Imminently Dying of a Highly Transmissible Acute Respiratory Infection (Such as COVID-19).* CJEM. 2020 Mar 26;1-4.

Dr. Martine Sanon

Outline

- Enhancing Palliative Care Support in the ED
- Primary Palliative Care education for Frontline ED Providers
- Innovative Geriatric-palliative care models in ED during times of crisis

Palliative Care Considerations for Older adults in the ED

ED challenging environment for older adults

Not ideal for goals of care discussions when rapid, imminent decisions needed

Integrating geriatric and palliative care principles into ED care is critical during COVID-19 pandemic

Older Adults in ED….

Age is Not just a number

Helpful Strategies to Resolve Urgency of Decision Making for Older Adults in ED

1. Identify the correct decision maker. (Health Care Proxy (HCP) forms, POA, 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.

Primary Palliative Care Resources and Educational Tools

https://www.vitaltalk.org/

https://www.capc.org/

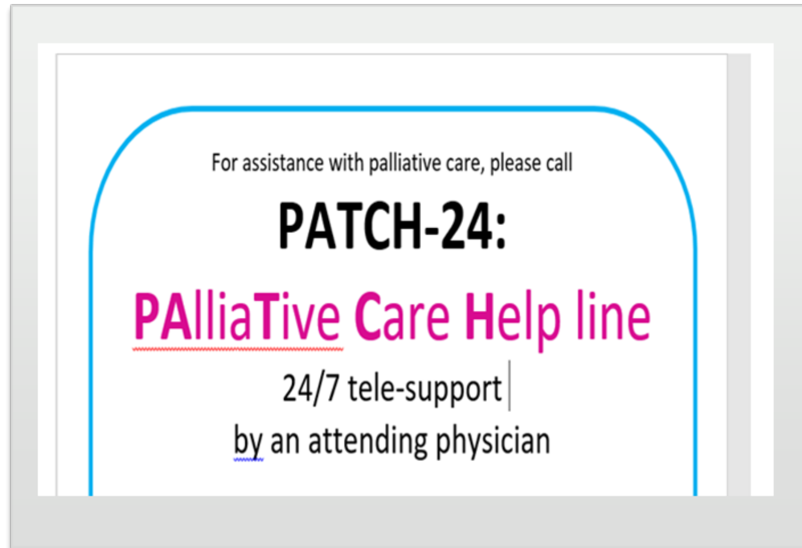
Education for Physicians in End-of-life Care (EPEC)

https://waportal.org/resources/education-palliative-and-end-life-care-epec

Virtual Training Sessions

Innovative Geriatrics and Palliative Care Models in the ED

Palliative Care Tele-consult and Tele-health Resources



Palliative Care Consultants Embedded in the ED

How To Engage Palliative Care Support

https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0204

Take Home Points

- Primary Palliative care skills are a necessity in the ED during these unprecedented times of COVID 19

- Utilizing the unique skills and strengths found in geriatrics and palliative care must be part of the response as we provide care for these patients.

- During times of crisis, collaborative efforts and innovation are needed to meet the growing palliative care needs of vulnerable patients in the ED

“Our ultimate goal, after all,

is not a good death,

but a good life to the very end.”

Atul Gawande

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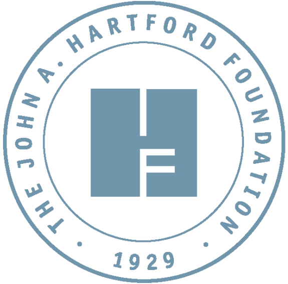

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