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THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

EXPERT PANEL WEBINAR
March 30, 2020

COVID-19 in Older Adults: Key Points for ED Providers

MODERATOR: **Don Melady, MD**

GEDC Faculty

"While patients of all ages are at risk for infection older adults continue to be the most vulnerable to consequences of COVID."

EXPERT PANEL

Michael Malone, MD
Geriatrician

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Emergency Physician & Geriatrician

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Critical Care Physician

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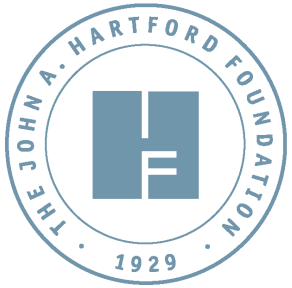

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1) All microphones have been muted

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

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Webinar RECORDING & SLIDES will be available in link you'll receive via email after the webinar

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COVID-19 in Older Adults: Key Points for ED Providers

Dr. Michael Malone

Dr. Teresita Hogan

Dr. Adam Perry

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Critically ill patients and COVID-19: What to know & how to help

https://gempodcast.com

Dr. Kusum Mathews
Icahn School of Medicine
Mount Sinai New York

Assessment, Critical Conversations, Advance Care Planning and Symptom Management with Older COVID-19 Patients

Dr. Martine Sanon
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COVID-19 in Older Adults: Key Points for Emergency Department Providers

Geriatric Emergency Department Collaborative
March 30, 2020

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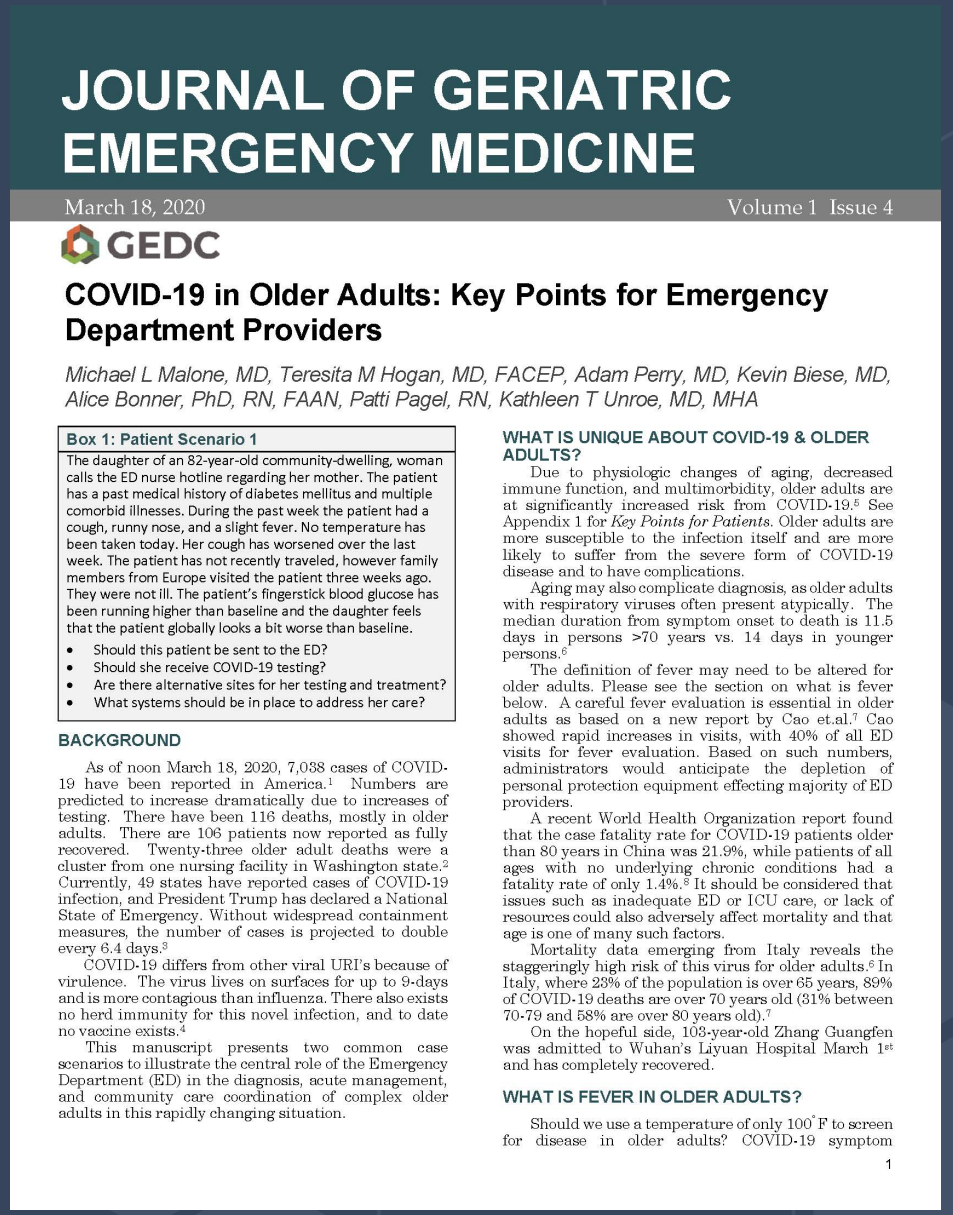
COVID 19 in Older Adults: Key Points for Emergency Department Providers

Are there challenges you're encountering in real-time that the GEDC team might be able to help you with?

Are there learnings and innovations that your EDs are already implementing due to COVID that you want to pass on to other EDs elsewhere in the country?



JOURNAL OF GERIATRIC EMERGENCY MEDICINE

March 18, 2020 Volume 1 Issue 4

GEDC

COVID-19 in Older Adults: Key Points for Emergency Department Providers

Michael L Malone, MD, Teresita M Hogan, MD, FACEP, Adam Perry, MD, Kevin Biese, MD, Alice Bonner, PhD, RN, FAAN, Patti Pagel, RN, Kathleen T Unroe, MD, MHA

Box 1: Patient Scenario 1

The daughter of an 82-year-old community-dwelling, woman calls the ED nurse hotline regarding her mother. The patient has a past medical history of diabetes mellitus and multiple comorbid illnesses. During the past week the patient had a cough, runny nose, and a slight fever. No temperature has been taken today. Her cough has worsened over the last week. The patient has not recently traveled, however family members from Europe visited the patient three weeks ago. They were not ill. The patient's fingerstick blood glucose has been running higher than baseline and the daughter feels that the patient globally looks a bit worse than baseline.

- Should this patient be sent to the ED?
- Should she receive COVID-19 testing?
- Are there alternative sites for her testing and treatment?
- What systems should be in place to address her care?

BACKGROUND

As of noon March 18, 2020, 7,038 cases of COVID-19 have been reported in America.[1] Numbers are predicted to increase dramatically due to increases of testing. There have been 116 deaths, mostly in older adults. There are 106 patients now reported as fully recovered. Twenty-three older adult deaths were a cluster from one nursing facility in Washington state.[2] Currently, 49 states have reported cases of COVID-19 infection, and President Trump has declared a National State of Emergency. Without widespread containment measures, the number of cases is projected to double every 6.4 days.[3]

COVID-19 differs from other viral URI's because of virulence. The virus lives on surfaces for up to 9-days and is more contagious than influenza. There also exists no herd immunity for this novel infection, and to date no vaccine exists.[4]

This manuscript presents two common case scenarios to illustrate the central role of the Emergency Department (ED) in the diagnosis, acute management, and community care coordination of complex older adults in this rapidly changing situation.

WHAT IS UNIQUE ABOUT COVID-19 & OLDER ADULTS?

Due to physiologic changes of aging, decreased immune function, and multimorbidity, older adults are at significantly increased risk from COVID-19.[5] See Appendix 1 for *Key Points for Patients*. Older adults are more susceptible to the infection itself and are more likely to suffer from the severe form of COVID-19 disease and to have complications.

Aging may also complicate diagnosis, as older adults with respiratory viruses often present atypically. The median duration from symptom onset to death is 11.5 days in persons >70 years vs. 14 days in younger persons.[6]

The definition of fever may need to be altered for older adults. Please see the section on what is fever below. A careful fever evaluation is essential in older adults as based on a new report by Cao et.al.[7] Cao showed rapid increases in visits, with 40% of all ED visits for fever evaluation. Based on such numbers, administrators would anticipate the depletion of personal protection equipment effecting majority of ED providers.

A recent World Health Organization report found that the case fatality rate for COVID-19 patients older than 80 years in China was 21.9%, while patients of all ages with no underlying chronic conditions had a fatality rate of only 1.4%.[8] It should be considered that issues such as inadequate ED or ICU care, or lack of resources could also adversely affect mortality and that age is one of many such factors.

Mortality data emerging from Italy reveals the staggeringly high risk of this virus for older adults.[6] In Italy, where 23% of the population is over 65 years, 89% of COVID-19 deaths are over 70 years old (31% between 70-79 and 58% are over 80 years old).[7]

On the hopeful side, 103-year-old Zhang Guangfen was admitted to Wuhan's Liyuan Hospital March 1st and has completely recovered.

WHAT IS FEVER IN OLDER ADULTS?

Should we use a temperature of only 100°F to screen for disease in older adults? COVID-19 symptom

1

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GEDC

COVID-19 in Older Adults: Transfers Between Nursing Homes and Hospitals

Stacie Levine, MD, Alice Bonner PhD, RN, FAAN, Adam Perry, MD, Donald Melady, MSc Ed, MD, Kathleen T Unroe, MD, MHA

Box 1: Patient Scenario

An 80-year-old nursing home patient with moderate dementia, COPD, and HTN develops a new cough and low-grade fever on Friday evening. There has been an increase in COVID-19 cases in the region. The nurse notifies the on-call physician who orders placement of patient in isolation, respiratory viral panel (RVP), CBC, a stat portable CXR, and every 4-hour vital signs. At the time of the call, the patient has otherwise normal vital signs and appears clinically stable.

On Saturday afternoon the CXR is returned as "COPD changes, mild interstitial edema, clinical correlation advised." Labs are within normal limits, she remains afebrile, and RVP is negative. The patient's daughter is concerned the advanced practice nurse will not be in the building until Monday morning and insists EMS be called for transfer to the hospital. There are no documented advance directives regarding transfer, intubation, or CPR. The on-call physician instructs the nursing home staff to transfer to the hospital.

On ED presentation, she is alert and oriented to self only. Vital signs temperature 98.9, HR 92, RR 22, BP 130/87, pulse ox 91% RA. Lung exam reveals fair air movement, diffuse expiratory wheeze and rhonchi. The CXR and labs are consistent with Friday's findings. She is admitted to the hospitalist service and placed in isolation with the diagnosis of COPD exacerbation. The ED is holding admitted patients. No visitors are allowed. COVID-19 testing is sent, which is taking 2-4 days.

On Monday morning she develops significant respiratory distress and hypoxia with decreased alertness. Repeat CXR reveals bilateral reticular opacities. The hospitalist notifies the daughter of her worsening status who states, "We haven't really discussed her wishes if she were to become sicker. What do you think her chances are?" There are currently no ICU beds available and three remaining ventilators in the 350-bed hospital.

- What are the current recommendations for addressing COVID-19 in nursing homes?
- What are the important differences between nursing homes, skilled nursing facilities, sub-acute rehabilitation facilities, long-term acute care hospitals, and assisted living facilities regarding capacity to manage patients with potentially infectious respiratory illness?
- If the recommendations were to discharge after initial ED evaluation, would this patient be able to return to the nursing home without a negative COVID-19 test?
- How is information transferred between the nursing home and ED clinician regarding this patient's HPI, PMH, and goals of care? How should the conversation between nursing home and ED providers occur in the COVID-19 era?
- Should she have been transferred to the ED? Should she be intubated? How can the ED and nursing home providers collaborate in her care, and plan for similar cases?
- How would advance care planning (e.g. – Physician Orders for Life Sustaining Treatment POLST or similar tools) guide care in this case?

INTRODUCTION

The COVID-19 pandemic is uniquely devastating for frail older adults who live in communal settings, such as nursing homes. Fatality rates are highest in persons > 85 years, ranging from 10-27%[1]. From a March 21st reference, approximately 25% of American deaths from COVID-19 have been among nursing home patients[2].

The COVID-19 era demands close and ongoing collaboration between acute care and communal facilities. The virus is spreading through nursing homes nationwide; creating simultaneously decreased staffing and decreased ability to accept admissions. Many nursing homes are not admitting new patients, and are not accepting patients back from the ED or hospital without negative testing[3]. Other nursing homes are choosing to stop taking admissions citing the need to reduce exposure during the physical care transition; or out of a fear that they will struggle to maintain sufficient staff to care for patients already in-house[4].

This article describes the impact of COVID-19 on this diverse, vulnerable population living in communal facilities. We outline key issues that will predictably arise between nursing homes and EDs in the COVID-19 era. Recommendations including reengineering nursing home-ED communication, coordinating hospital and non-hospital-based emergency care, and considerations in acute resource limitation, are discussed. Though these issues are universal, evolving solutions are necessarily local. This manuscript may guide conversations and planning now between nursing homes, health care systems, EDs, and state agencies.

BACKGROUND

The initial American nursing home COVID-19 outbreak was noted on February 19th, 2020. As of March 20th, 80% of patients in the home tested positive and 30% of those have died[5]. Since then, outbreaks have occurred in facilities in other states[6] and are expected to rise. In a recent JAMA article detailing ICU outcomes in a largely nursing home cohort, the authors reported that survival is unlikely

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EDUCATE IMPLEMENT EVALUATE

ACEP Geriatric Emergency Department Accreditation

HELP Hospital Elder Life Program

Preventing and Managing Delirium in Older Emergency Department (ED) Patients During the COVID-19 Pandemic

Ula Hwang MD MPH, Aaron J Malsch RN MSN GCNS-BC, Kevin J Biese MD, Sharon K Inouye MD MPH

1. **Delirium is an emergency!** The mortality for persistent delirium is higher than 1-year mortality rates for acute conditions like heart disease.[1] See the ADEPT tool for tips on delirium care: https://acep.org/patient-care/adept/
2. In older adults, **systemic illness (viral infection like COVID-19), fever, and hypoxemia may trigger delirium**. Acute confusion may be a sign of COVID-19 in older adults (even before fever and cough).
3. Although visitors in hospitals and EDs are now becoming restricted and use of personal protective equipment (PPE) during the COVID-19 pandemic will protect and limit spread, it will be important to **maintain calm, clear, and comforting communication** whenever possible with our older patients.
4. Confusion is **NOT** normal… it can be baseline, but it is not normal. Do not treat it as such.
   - "*Mom's not usually like this*" should be an alarm!
   - Assess baseline: Is the patient typically like this? Is this a change from their normal behavior? When did the change occur? Is there someone to provide information of what they are normally like?
5. **Delirium is an acute change from baseline**, highlighted by altered level of awareness and inability to maintain attention. In older adults, **hypoactive delirium** (sleepy, withdrawn, "pleasantly confused") **is more common** than hyperactive delirium (agitation and anxiety).
6. Risk factors for delirium are:[2]
   - **Sensory impairment (vision and hearing)**
   - **65+ years in age**
   - **History of dementia**
   - **Nursing home patients**
   - **SERIOUS INFECTION**
7. Other exacerbating factors in the context of COVID-19:
   a. Decreased availability of caregivers to orient and provide meaningful interactions.
   b. Trouble hearing (sensory impairment) worsened by use of PPE. Older adults with sensory or cognitive limitations (dementia), will no longer be able to read lips or hear communication obscured by masks, and may become disoriented, frightened, and agitated by gowned and masked caregivers.
   c. Being placed into isolation. Closing of the exam room door, curtailing ambulation and mobility in the ED, and how the patient sees people in protective gear doing invasive tests (nasopharyngeal swabs, blood draws) is stressful for all. For confused patients, it can only be worse.
   d. Polypharmacy and use of new anticholinergic or psychoactive medications.
8. Identify and treat **reversible causes of delirium – immobility, dehydration, fever, pain, hypoxia, nausea, constipation, psychoactive medications**.
9. **Prevention** is the best management for delirium. **Stop it before it happens**. Here are things that work: mobilize the patient, personal contact with orientation, ensure physiological needs are met (food, drink, warmth, bowel and bladder emptying). These may be hard with isolated older COVID-19 patients, but will be easier than managing agitated delirium once it develops.
10. Use of antipsychotics for management of delirium is **NOT** supported as best practice.[3] These medications may worsen delirium. If severe agitation develops, then use reduced doses of antipsychotics: Risperidone ≤1mg PO, Olanzapine 2.5-5mg PO, Quetiapine 25-50mg PO, Olanzapine 2.5-5mg IM, Haloperidol 1-2.5mg IM/0.25-1mg IV

1. Kiely DK, Marcantonio ER, Inouye SK, et al. Persistent delirium predicts greater mortality. *J Am Geriatr Soc.* 2009;57(1):55-61.
2. Lindroth H, Bratzke L, Purvis S, et al. Systematic Review of Prediction Models for Delirium in the Older Adult Inpatient. *BMJ Open.* 2018;8(4):e019223.
3. Neufeld KJ, Yue J, Robinson TN, Inouye SK, Needham DM. Antipsychotic Medication for Prevention and Treamtent of Delirium in Hospitalized Adults: A Systematic Review and Meta-Analysis. *J Am Geriatr Soc.* 2016;64(4):705-714.

What is unique about COVID-19 in older adults?

- The prevalence of cases and mortality rates in older adults
- Unique vulnerabilities: co-morbid illnesses, frailty; cognitive impairment; functional impairment; concurrent behavioral health needs; multiple medications
- Atypical presentations
- High rate of sensory troubles for older adults
- Care provided in multiple settings: home, home with home health, assisted living, skilled nursing facilities, acute care
- Strain on family caregivers and communication

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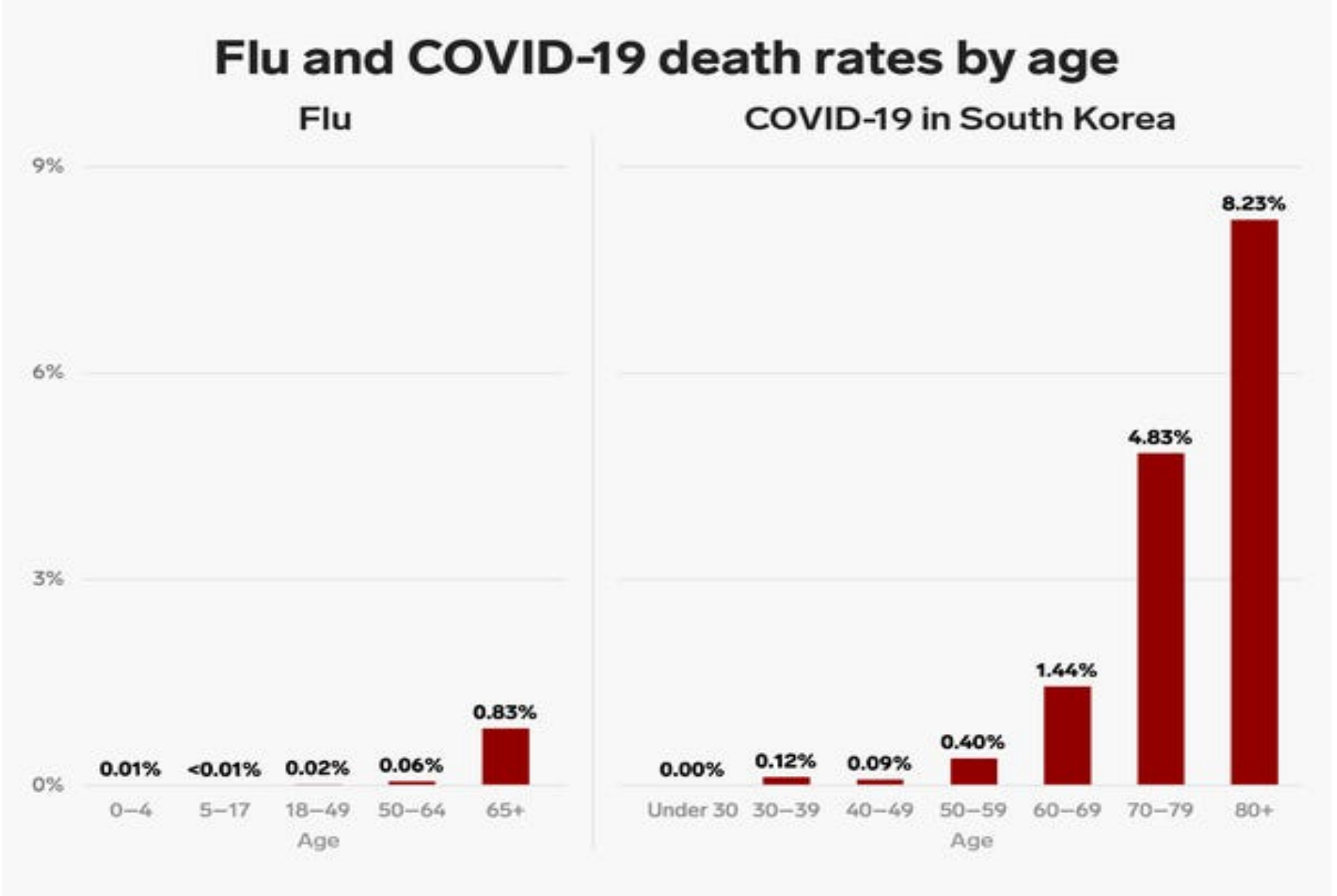
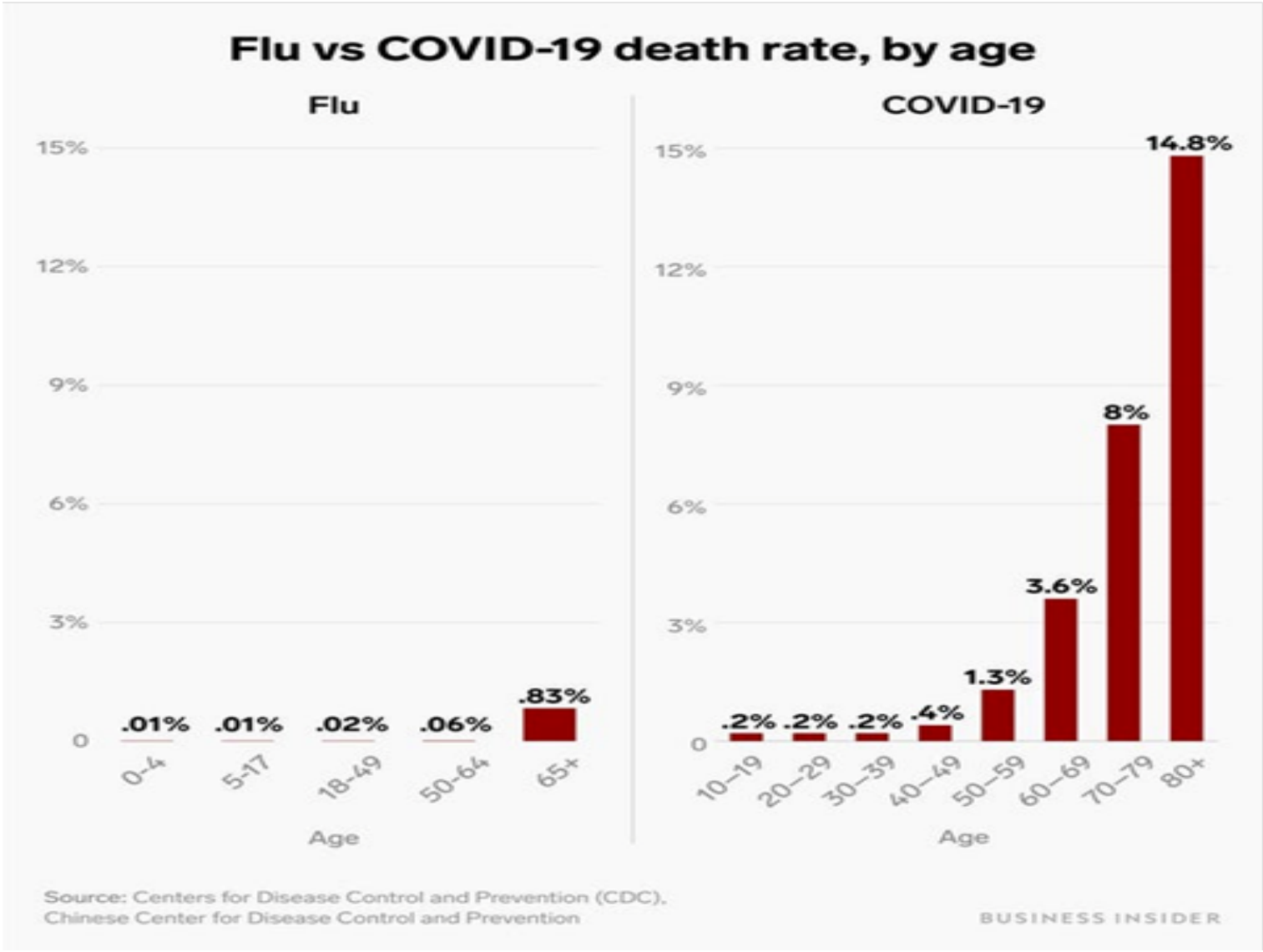
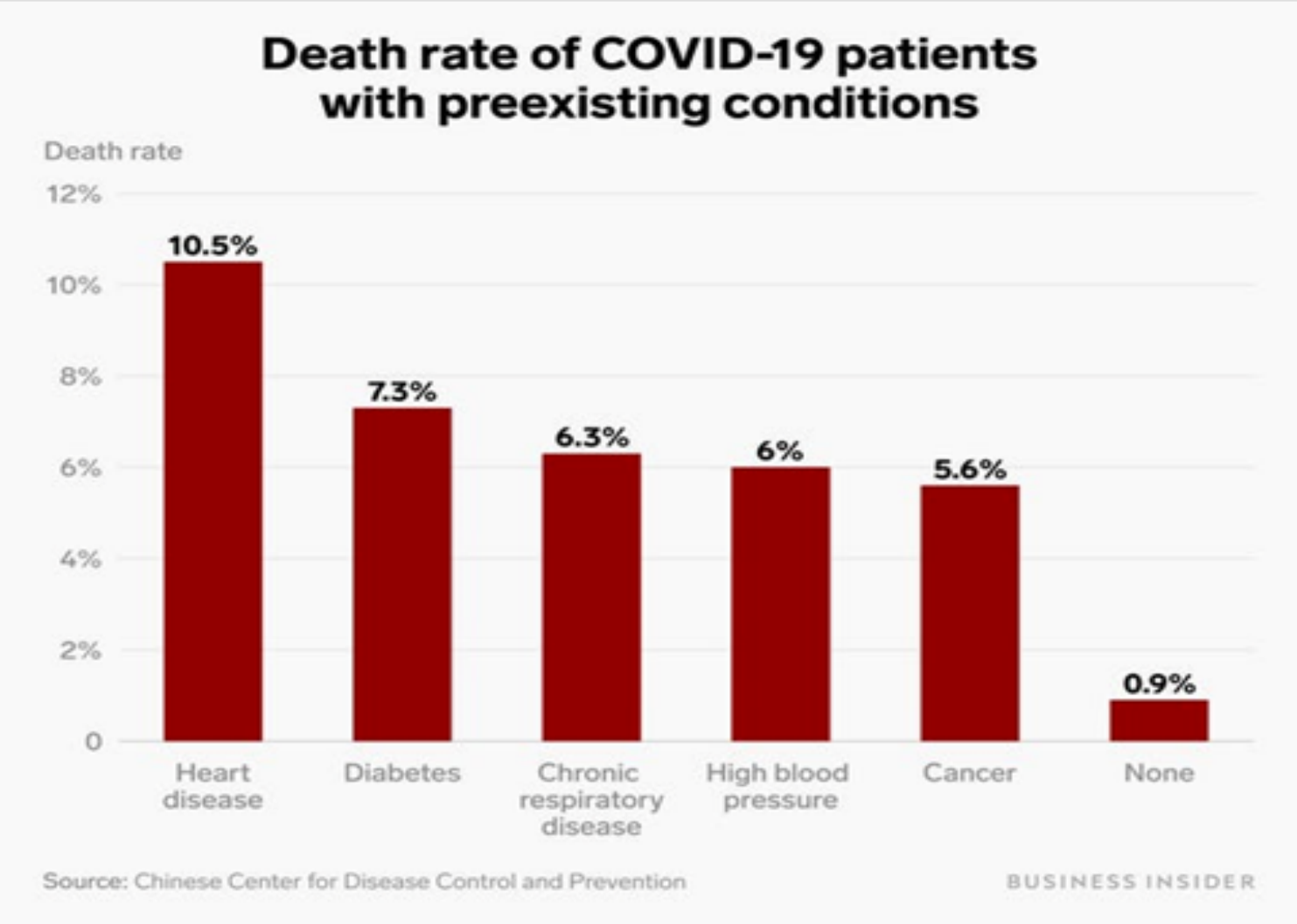
South Korea Data in perspective: Mortality comparison to flu



Chinese Data in perspective: Mortality also varies by nation



Data in perspective: varies by type of condition



Older Adult Workforce Needs

- Health care workers are among those who are at risk for COVID.
- Many providers are themselves older adults.
- Alternate staffing models.

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Older Adult Patient Safety

- Overcrowding disproportionally effects Older Adults.
- Delirium requires special attention.
- Medication reconciliation.
- Functional decline/immobility.
- Perceptions of risk and benefit may need to change.

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Optimizing ED Resources
Decreasing Risk for Older Adults

"Forward Triage"

- Community/NH Paramedics
- Telehealth – CMS changes
- EMS protocols
- Non-ED-based STAT imaging
- Advanced Care Planning

Communication in the Time of COVID

Two-Stage Warm Handoff

-On the way in: "ED Consult"

-On the way out: Shared Disposition Decision

NH and ED: On the Same Team

NH clinician knows family, is expert at goals of care

https://www.vitaltalk.org

https://www.capc.org

Dr. Kusum Mathews

Critically ill patients & COVID-19: What to know & how to help

Kusum S. Mathews, MD, MPH, MSCR

Assistant Professor

Division of Pulmonary, Critical Care, & Sleep Medicine, Dept. of Medicine

Dept. of Emergency Medicine

March 30, 2020

Icahn School of Medicine at Mount Sinai

Clinical presentation

Initial Symptoms

- Fever
- URI sx
- Hypoxemia
- Abdominal pain & diarrhea
- Atypical symptoms in the elderly

Initial Workup

SARS-CoV-2 PCR

Other ID: Cultures, Respiratory

DFA, legionella; Procalcitonin

Troponin

CK, LDH, CRP, D-dimer, fibrinogen

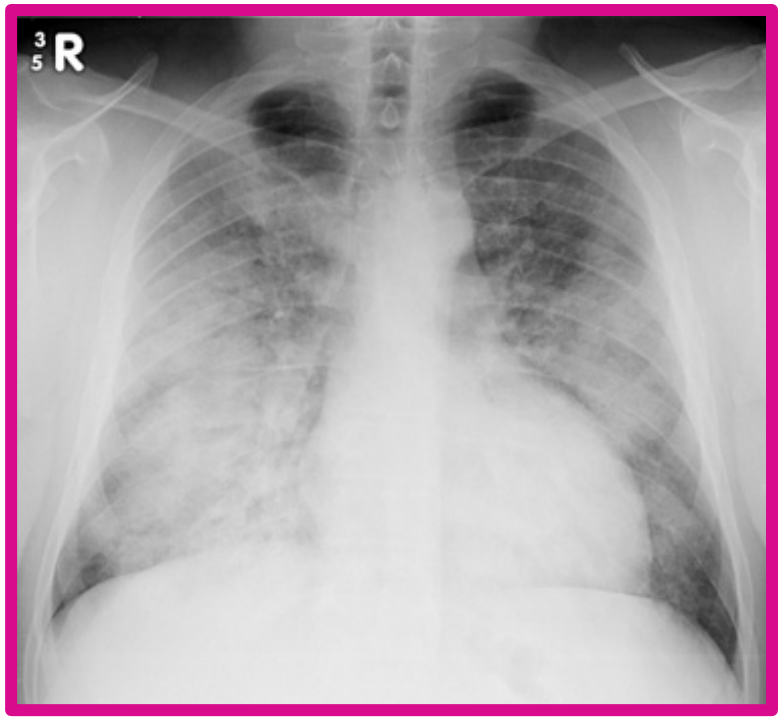
Imaging: CXR

BMJ Best Practice. https://bestpractice.bmj.com/topics/en-us/3000168#important-update. Accessed 3/30/20.

Clinical presentation

Later Symptoms

- Demand ischaemia
- Transaminitis
- Acute kidney injury
- **Respiratory distress**
- **Moderate to severe Acute Respiratory Distress Syndrome**



Standard Care & Ventilation Options

- Respiratory assessment & supplemental O2
- Ventilation options
- Adjunct care
- Triage decisions

- Up to 6L/min via NC
- 100% NRB (avoiding Venturi masks)

- Pre-oxygenation with NRB
- RSI + video laryngoscopy

- Sedation, neuromuscular blockade
- Antibiotics; Sepsis care
- Vasopressors

- Other co-morbidities
- Available resources

SCCM Surviving Sepsis Campaign COVID-19 Guidelines. https://www.sccm.org/disaster . Accessed 3/30/20

Post-Intubation Management and Treatments

- Low tidal volume ventilation
- Higher PEEP (especially for the obese)
- Standard ARDS & sepsis management
- Off-label:
  - Hydroxychloroquine, azithromycin
  - Antivirals, anti-IL6 agents
- Clinical trials

Initial Vent Settings

- Volume control mode (AC/VC)
- 4-8cc/kg IBW (go LOW!)
- PEEP 8-10
- FiO2 50-100%

Front Line Realities

- Isolation
- PPE
- Staffing
- Ventilators

- Separate section in ED to reduce patient exposure
- Negative pressure for any aerosolizing

- Policies for Face masks, N95 vs. surgical masks, and gowns
- Extended use & re-use planning

- Minimizing exposure
- Trainees & support staff

- Training of ongoing vent mgmt
- Vent rationing and splitting
- Goals of care conversations

Thank you!
Any questions?

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Dr. Martine Sanon

Assessment, Critical Conversations, Advance Care Planning and Symptom Management with Older COVID-19 Patients

Martine Sanon, MD
March 30, 2020

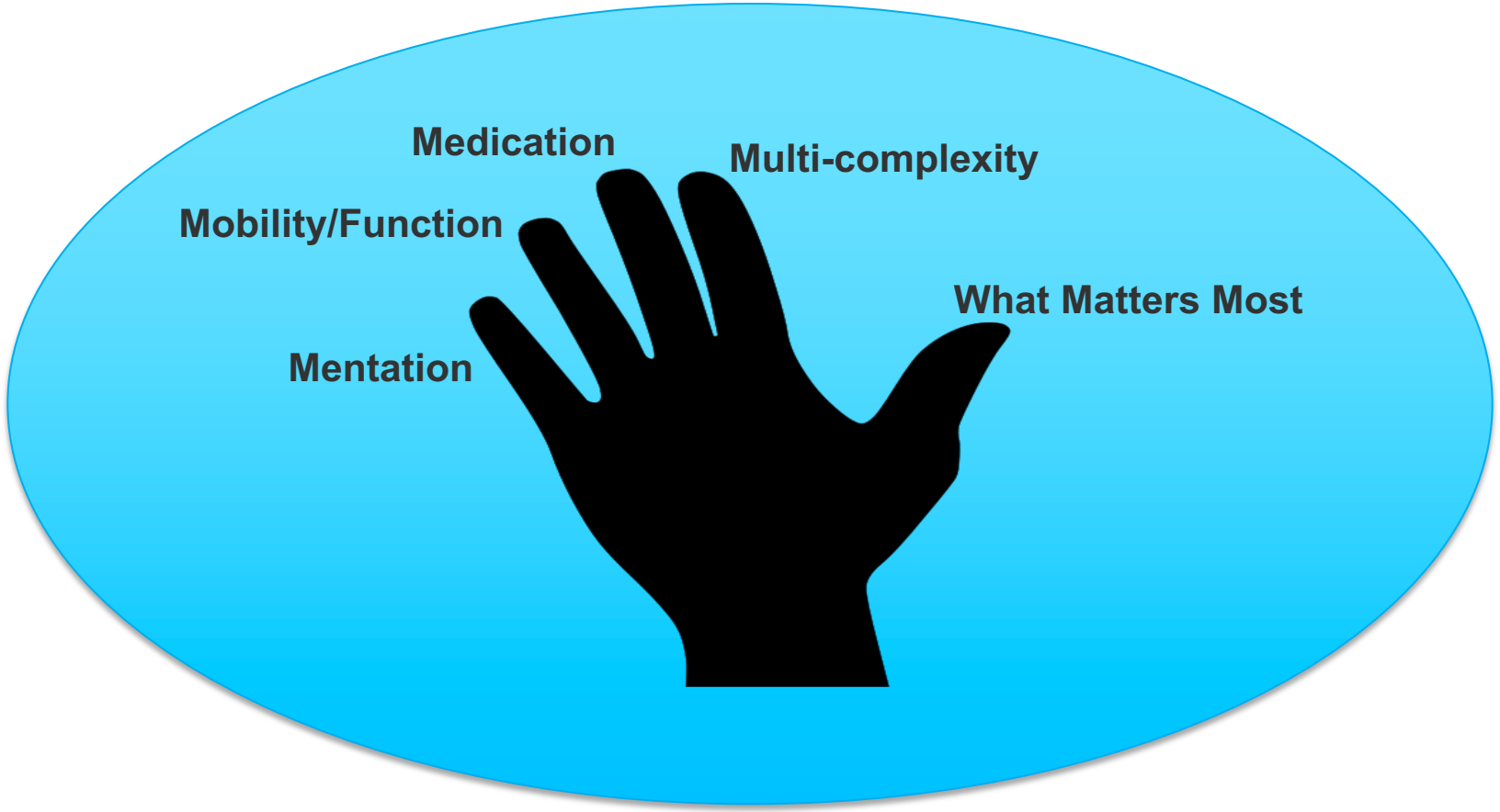
Mount Sinai

Outline

- Assessments To Guide Clinical Decisions for Older Adults in the ED
- Provide a Framework for Critical Conversations
- Recommendations for Palliative Symptom Management
- How To Engage Palliative Care Support

Assessments To Guide Clinical Decisions in ED for Older Adults

Geriatric 5M's



Tinetti, Molnar; JAGS June 2017

Assessments To Guide Clinical Decisions in ED for Older Adults

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

•MOLST NUMBER (THIS IS NOT AN •MOLST FORM)

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions When the Patient Has No Pulse and/or Is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS Law.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

DOH-5003 (6/10) Page 1 of 4 *HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment.*

MOLST: Medical Orders for Life-Sustaining Treatment

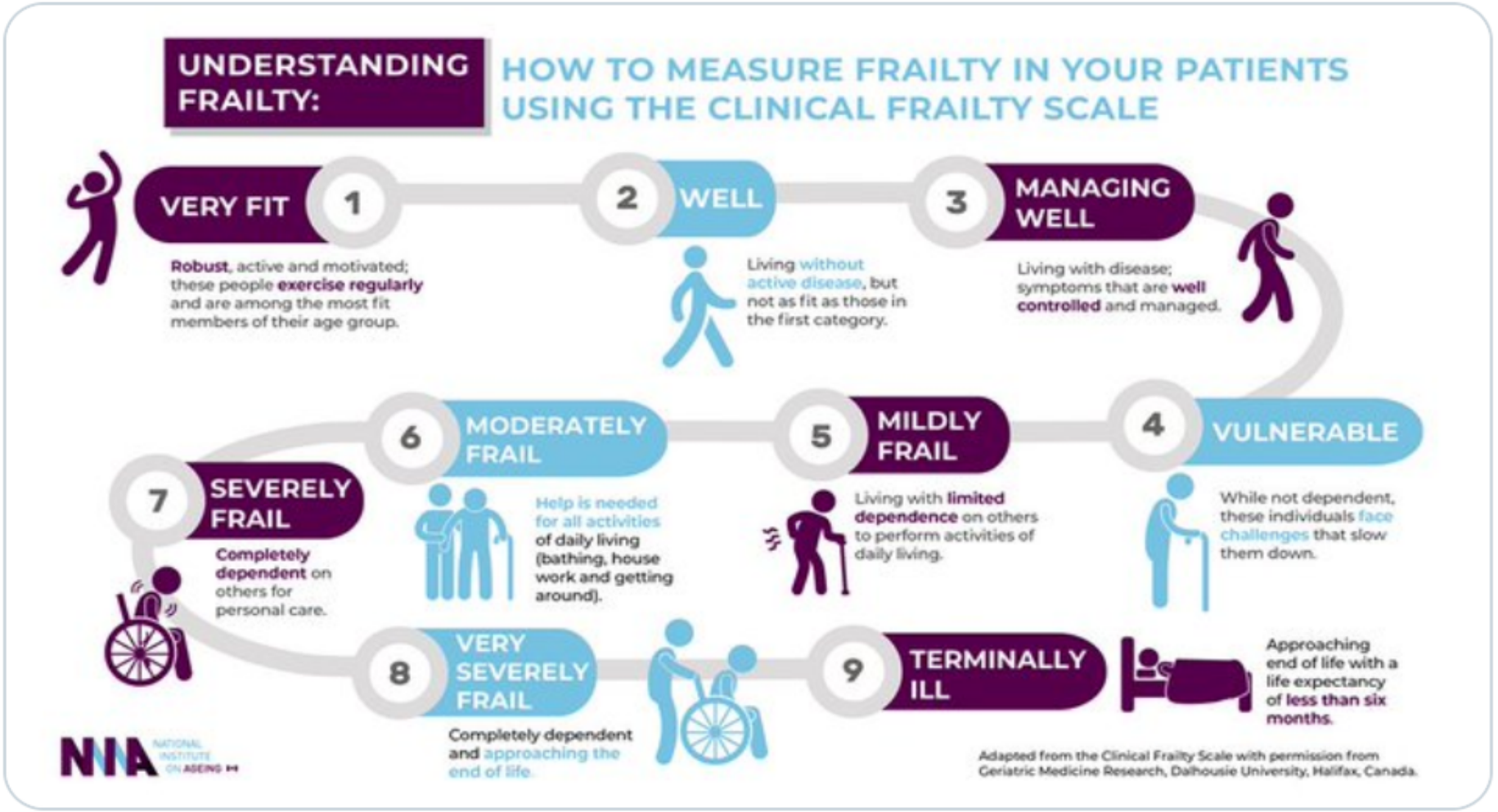
MOLST is intended for patients with serious health conditions who:

- Want to avoid or receive any or all life-sustaining treatment
- Reside in a long-term care facility or require long-term care services
- Prognosis is less than one year.

https://www.health.ny.gov/professionals/patients/patient_rights/molst/

Assessments To Guide Clinical Decisions in ED for Older Adults

Clinical Frailty Scale



https://www.nia.nih.gov/

Provide A Framework for Critical Conversations

Communication Tools

REMAP- Late Goals of Care conversation

- **REFRAME** the big picture.
- **EXPECT EMOTION** respond with empathy.
- **MAP** out what's important.
- **ALIGN** with patient's values.
- **PLAN** treatments to match values

NURSE(S) – Name Emotions

- **NAME** "You seem upset…"
- **UNDERSTAND** "I can't imagine…"
- **RESPECT** "I am impressed that…"
- **SUPPORT** "I'll be available for you…"
- **EXPLORE** "It would help me to know more about…"
- **SILENCE** "…"

VITALtalk

https://www.vitaltalk.org/guides/covid-19-communication-skills/

Provide A Framework for Critical Conversations

Communication Tools

CALMER

C - Check in: "Would it be okay if we talk about you and COVID-19?"

A - Ask about Covid:

"You are in one of the groups at higher risk for serious complications from COVID-19. I am sure you have thought about this. There are key things I want to ask you about…. (HCP? And Do they know?)

L - Lay out the issues

"This is a very difficult time. We know from the experiences of the people with the COVID-19 infection that if you are in an older age group or have underlying medical conditions, that there's a very high risk that things will not go well.

M - Motivate them to Choose a Proxy and say if ICU care would be "worth it":

"I want you to know that we are going to take care of you and make sure you are comfortable. In case your condition gets worse, I want you to know that if something catastrophic happens - if your heart or breathing stops - our ability to help you with things like CPR at the time of your death is really minimal. And so at this point, we don't recommend CPR because it will not be successful in helping you survive."

E - Expect Emotion: "Tell me what you are thinking."

R - Reach a decision re: proxy and ICU and record in the chart

I'm not sure

I want you to do anything to keep me alive

I don't want to be on a ventilator

VITALtalk https://www.vitaltalk.org/guides/covid-19-communication-skills/

Recommendations for Palliative Symptom Management

Symptom Management

- ❑ Dyspnea
- ❑ Anxiety
- ❑ Agitation

Non-Pharmacologic Interventions:

- Bring patient upright or to sitting position
- Consider mindfulness, mindful breathing

Pharmacologic Interventions:

- Opioids are treatment of choice for refractory dyspnea
- For symptomatic patients, using PRN or bolus dosing is more effective and safe compared to starting an opioid infusion

➢ *Morphine*
- Pain
- Work of breathing

➢ *Lorazepam*
- Shortness of Breath
- Agitation/Anxiety

Opioid Quick Tips

Dosing Tips:

- For opioid naïve patients
  - PO Morphine 5-10mg
    - PO Oxycodone 2.5-5mg
  - IV/SC Morphine 2-4mg
  - IV/SC Hydromorphone 0.4-0.6mg
- Consider smaller doses for elderly/frail

Pharmacodynamics of Opioids:

- Time to peak effect / Duration of Action
- PO Opioids: 30-60 minutes / 3-4 hours
- IV Opioids: 5-15 minutes / 1-2 hours
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

Other Opioids Principles:

- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, should not change more than every 6-hours. Should adjust based on the use of PRNs

If Using Opioids, Start a Bowel Regimen:

- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs qHS, can increase to 4 tabs BID
- Add Miralax 17gm daily, can increase to BID
- Dulcolax 10mg suppository if no BM in 72hrs

Relative Strengths & Conversion Table

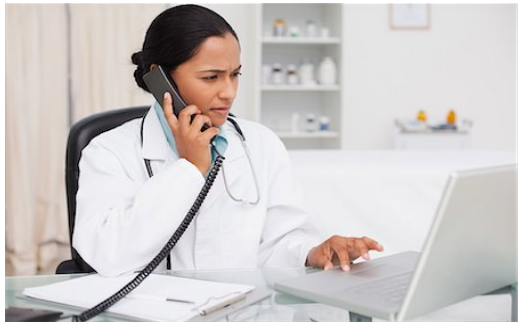
Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	--
Dilaudid	7.5	1.5
Fentanyl	--	100mcg

*For single dose IV push (NOT patch) conversion only

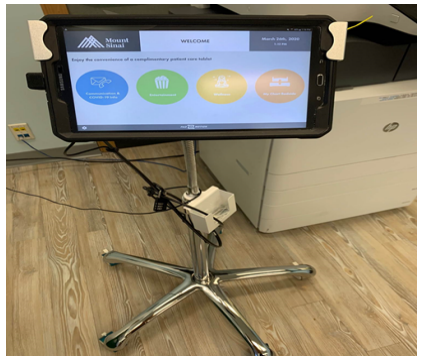
capc https://www.capc.org/toolkits/covid-19-response-resources

How To Engage Palliative Care Support

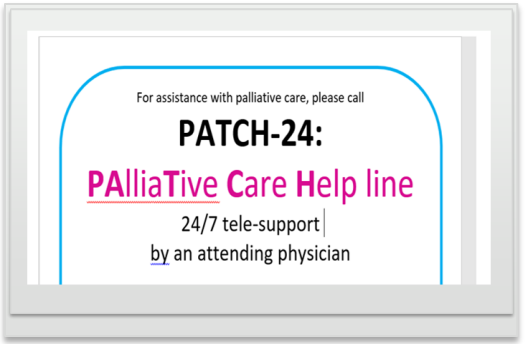
Proactive Telephone Outreach



Social Isolation



Palliative Care Resources



Sympathetic Thoughts…

"Cure sometimes,

Treat often,

Comfort Always"

Martine.Sanon@mssm.edu

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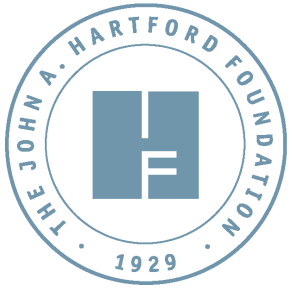

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