VCU Palliative Care ECHO*

March 23, 2020

COVID-19 and Palliative Care

*ECHO: Extension of Community Healthcare Outcomes

JA Accreditation & Credit Designation Statements – LIVE Activities

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Disclosures

March 23, 2020 | 12:00 PM | teleECHO Conference

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The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Danielle Noreika, MD **Candace Blades, JD, RN**

No commercial or in-kind support was provided for this activity

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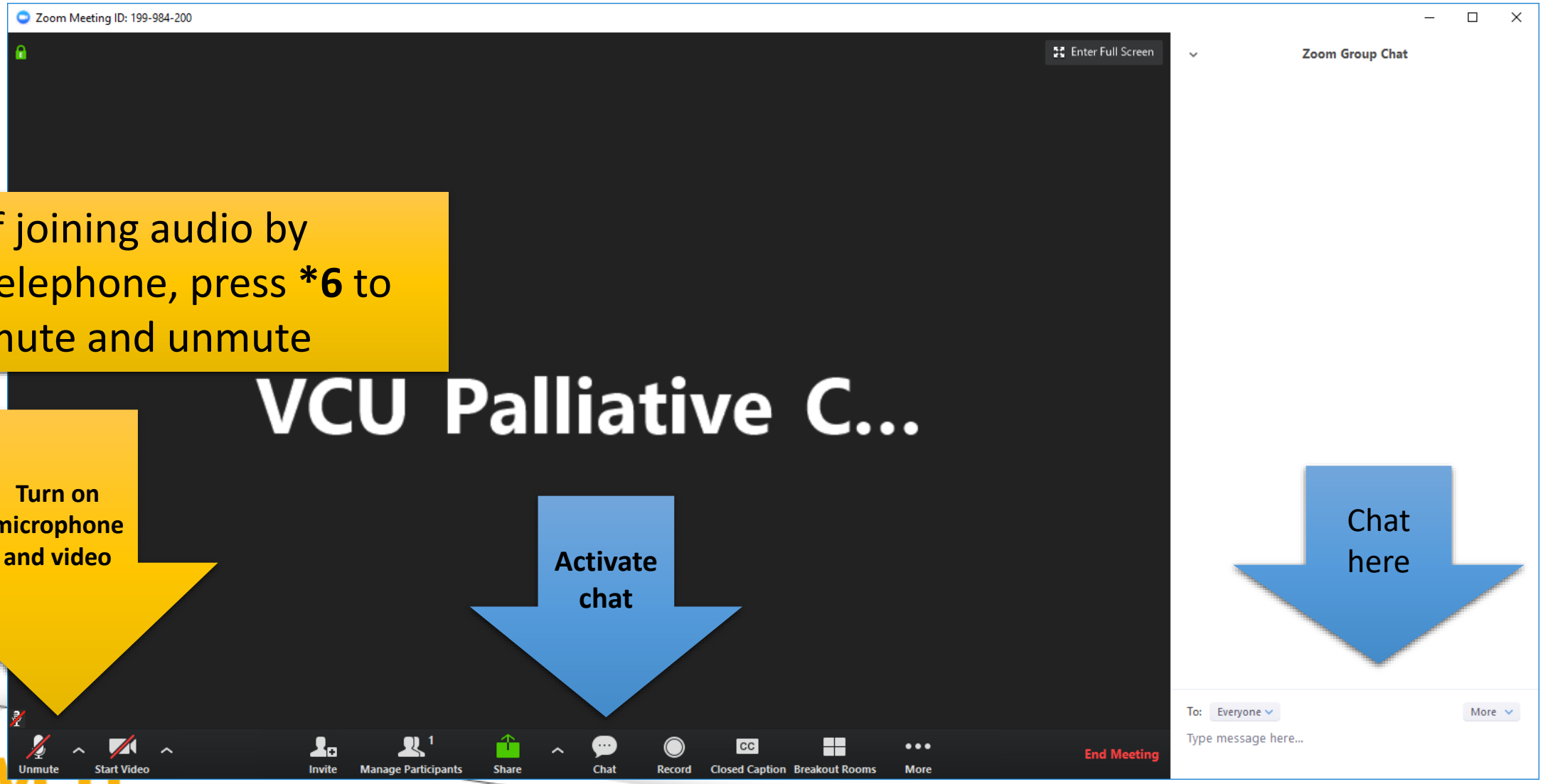
Audio and Chat



Our ECHO Team: Planning Committee

Clinical Leadership	**Egidio Del Fabbro, MD** VCU Palliative Care Chair and Program Director **Danielle Noreika, MD, FACP, FAAHPM** Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Research Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN – Nurse Navigator Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff	
Program Managers	Teri Dulong-Rae & Bhakti Dave, MPH
Telemedicine Practice Administrator	David Collins, MHA
IT Support	Frank Green

Introductions

COVID-19 and Palliative Care

Project ECHO, March 2020

Agenda

- Background
- Signs/Symptoms
- Challenges for Palliative Providers
- Resources
- Discussion—what are you seeing where you are?

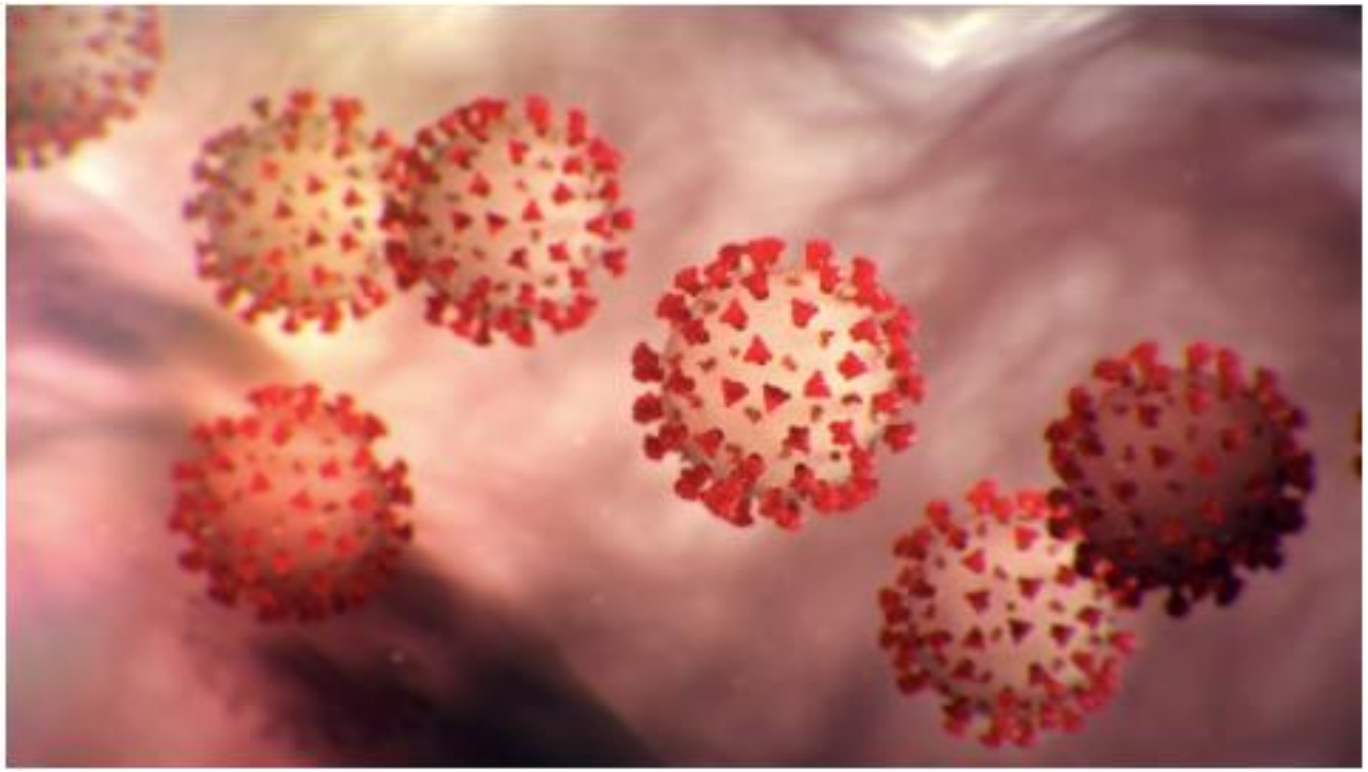
First a moment of levity if we can

3. Notwithstanding the provisions of this section, if I am determined to be medically and legally dead, as defined by Section 54.1-2972 of the Code of Virginia, as amended from time to time, the provisions of such statute shall apply and all life support systems and treatment shall be withheld or withdrawn.

Other Entertaining Write-Ins:

- (from what appeared to be a physician AD): “If two ICU attendings agree then box me”
- In end of life wishes: “I want a six pack of beer, a box of Marlboro’s (red), and tell Bubba to kiss my a**”
- Visitation instructions: “No Donald Trump”

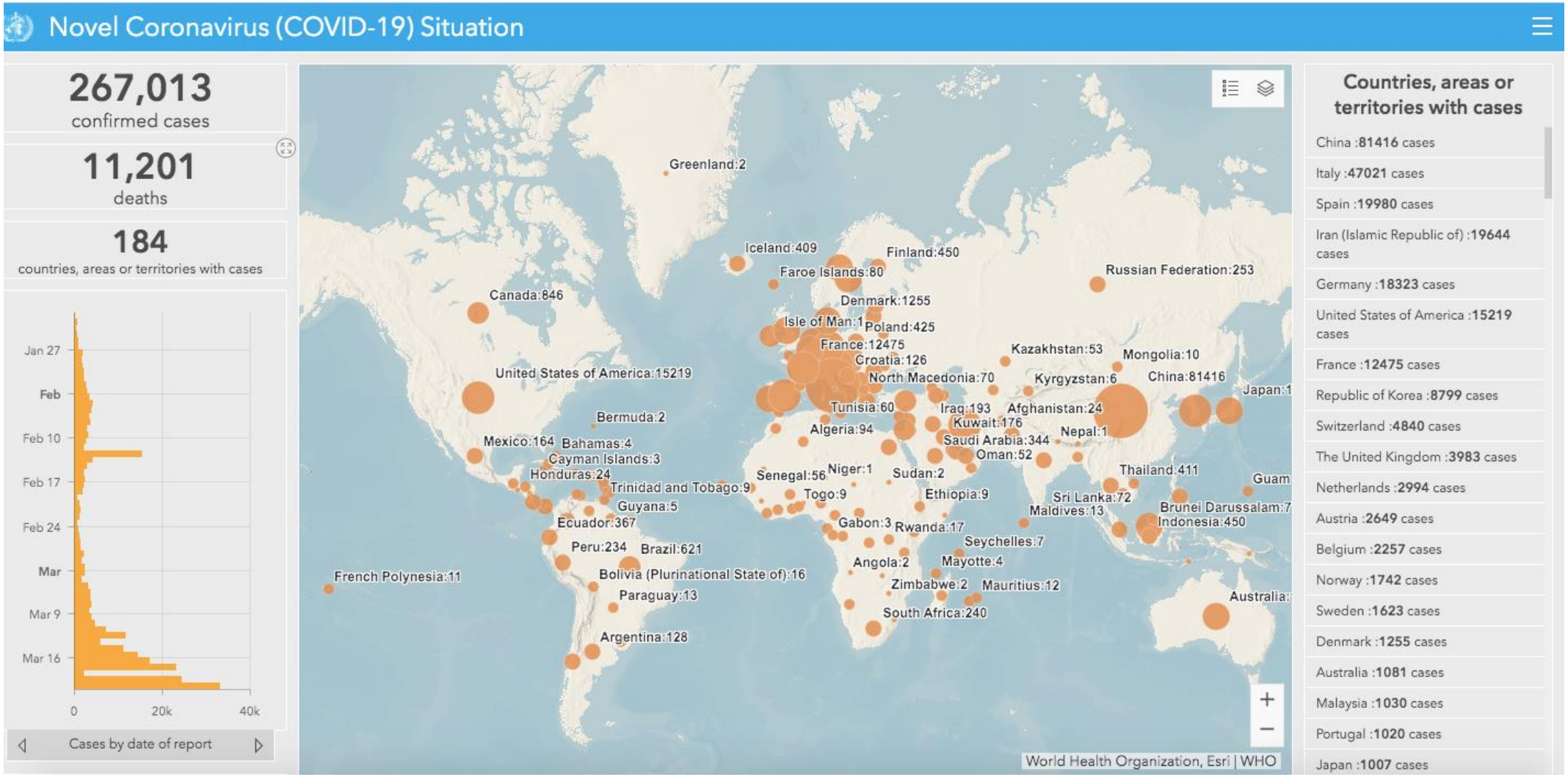
SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2)



- Virus in the coronavirus family, which is a large family of viruses common in humans and some animals
- It is a betacoronavirus, like MERS-CoV and SARS-CoV
- Statistics are still being worked out, mortality rate ranges depending on source
- Community spread has occurred, became a pandemic March 11, 2020

Overview (who.int)

[WHO COVID-19 Situation Dashboard]



CDC Re: Symptoms/Patients and Families

Coronavirus Self-Checker
A guide to help you make decisions and seek appropriate medical care

Watch for symptoms

Reported illnesses have ranged from mild symptoms to severe illness and death for confirmed coronavirus disease 2019 (COVID-19) cases.

These symptoms may appear **2-14 days after exposure** (based on the incubation period of MERS-CoV viruses).

- Fever
- Cough
- Shortness of breath

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

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CDC for Providers

Clinical Course

Clinical presentation among reported cases of COVID-19 varies in severity from asymptomatic infection to mild illness to severe or fatal illness. Some reports suggest the potential for clinical deterioration during the second week of illness.[2,5] In one report, among patients with confirmed COVID-19 and pneumonia, just over half of patients developed dyspnea a median of 8 days after illness onset (range: 5–13 days). [2] In another report, the mean time from illness onset to hospital admission with pneumonia was 9 days.[1] Acute respiratory distress syndrome (ARDS) developed in 17–29% of hospitalized patients, and secondary infection developed in 10%. [2,4] In one report, the median time from symptom onset to ARDS was 8 days.[3]

Approximately 20-30% of hospitalized patients with COVID-19 and pneumonia have required intensive care for respiratory support.[2–3] Compared to patients not admitted to an intensive care unit, critically ill patients were older (median age 66 years versus 51 years), and were more likely to have underlying co-morbid conditions (72% versus 37%). [3] Among critically ill patients admitted to an intensive care unit, 11–64% received high-flow oxygen therapy and 47-71% received mechanical ventilation; some hospitalized patients have required advanced organ support with endotracheal intubation and mechanical ventilation (4–42%).[3–4,9] A small proportion have also been supported with extracorporeal membrane oxygenation (ECMO, 3–12%).[3–4,9] Other reported complications include cardiac injury, arrhythmia, septic shock, liver dysfunction, acute kidney injury, and multi-organ failure. Post-mortem biopsies in one patient who died of ARDS reported pulmonary findings of diffuse alveolar damage. [14]

An overall case fatality proportion of 2.3% has been reported among confirmed cases of COVID-19 in China. [9] However, the majority of these cases were among hospitalized patients and therefore this estimate of mortality is likely biased upward. Among hospitalized patients with pneumonia, the case fatality proportion has been reported as 4–15%.[2–4] Among critically ill COVID-19 patients in China, the reported case fatality proportion was 49%. In a report from one hospital, 61.5% of critically ill patients with COVID-19 had died by day 28 of ICU admission. [9,15]

CDC Re: discharge of Covid-19 patients from the hospital

Disposition of Hospitalized Patients with COVID-19:

- Patients can be discharged from the healthcare facility whenever clinically indicated.
- Isolation should be maintained at home if the patient returns home before the decision is made to discontinue Transmission-Based Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments and should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations, and potential risk of secondary transmission to household members with immunocompromising conditions. See CDC Interim Guidance for Home Care of patients with confirmed COVID-19 and persons under investigation for COVID-19, Interim Guidance for Preventing 2019-nCoV from Spreading to Others in Homes and Communities and Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19.

Zhou et al, *Lancet* March 2020

https://doi.org/10.1016/S0140-6736(20)30566-3

	Total (n=191)	Non-survivor (n=54)	Survivor (n=137)	p value
Treatments*				
Antibiotics	181 (95%)	53 (98%)	128 (93%)	0·15
Antiviral treatment	41 (21%)	12 (22%)	29 (21%)	0·87
Corticosteroids	57 (30%)	26 (48%)	31 (23%)	0·0005
Intravenous immunoglobin	46 (24%)	36 (67%)	10 (7%)	<0·0001
High-flow nasal cannula oxygen therapy	41 (21%)	33 (61%)	8 (6%)	<0·0001
Non-invasive mechanical ventilation	26 (14%)	24 (44%)	2 (1%)	<0·0001
Invasive mechanical ventilation	32 (17%)	31 (57%)	1 (1%)	<0·0001
ECMO	3 (2%)	3 (6%)	0	0·0054
Renal replacement therapy	10 (5%)	10 (19%)	0	<0·0001
Outcomes				
Sepsis	112 (59%)	54 (100%)	58 (42%)	<0·0001
Respiratory failure	103 (54%)	53 (98%)	50 (36%)	<0·0001
ARDS	59 (31%)	50 (93%)	9 (7%)	<0·0001
Heart failure	44 (23%)	28 (52%)	16 (12%)	<0·0001
Septic shock	38 (20%)	38 (70%)	0	<0·0001
Coagulopathy	37 (19%)	27 (50%)	10 (7%)	<0·0001
Acute cardiac injury	33 (17%)	32 (59%)	1 (1%)	<0·0001
Acute kidney injury	28 (15%)	27 (50%)	1 (1%)	<0·0001
Secondary infection	28 (15%)	27 (50%)	1 (1%)	<0·0001
Hypoproteinaemia	22 (12%)	20 (37%)	2 (1%)	<0·0001
Acidosis	17 (9%)	16 (30%)	1 (1%)	<0·0001
ICU admission	50 (26%)	39 (72%)	11 (8%)	<0·0001
ICU length of stay, days	8·0 (4·0–12·0)	8·0 (4·0–12·0)	7·0 (2·0–9·0)	0·41
Hospital length of stay, days	11·0 (7·0–14·0)	7·5 (5·0–11·0)	12·0 (9·0–15·0)	<0·0001
Time from illness onset to fever, days	1·0 (1·0–1·0)	1·0 (1·0–1·0)	1·0 (1·0–1·0)	0·16
Time from illness onset to cough, days	1·0 (1·0–3·0)	1·0 (1·0–1·0)	1·0 (1·0–4·0)	0·30
Time from illness onset to dyspnoea, days	7·0 (4·0–9·0)	7·0 (4·0–10·0)	7·0 (4·0–9·0)	0·51
Time from illness onset to sepsis, days	9·0 (7·0–13·0)	10·0 (7·0–14·0)	9·0 (7·0–12·0)	0·22
Time from illness onset to ARDS, days	12·0 (8·0–15·0)	12·0 (8·0–15·0)	10·0 (8·0–13·0)	0·65
Time from illness onset to ICU admission, days	12·0 (8·0–15·0)	12·0 (8·0–15·0)	11·5 (8·0–14·0)	0·88
Time from illness onset to corticosteroids treatment, days	12·0 (10·0–16·0)	13·0 (10·0–17·0)	12·0 (10·0–15·0)	0·55
Time from illness onset to death or discharge, days	21·0 (17·0–25·0)	18·5 (15·0–22·0)	22·0 (18·0–25·0)	0·0003
Duration of viral shedding after COVID-19 onset, days	20·0 (16·0–23·0)	18·5 (15·0–22·0)†	20·0 (17·0–24·0)	0·024

Data are median (IQR) or n (%). p values were calculated by Mann-Whitney U test, χ^2 test, or Fisher's exact test, as appropriate. ECMO=extracorporeal membrane oxygenation. ARDS=acute respiratory distress syndrome. ICU=intensive care unit. COVID-19=coronavirus disease 2019. *Ordered by escalating scale of respiratory support. †Detectable until death.

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Zhou et al. *Lancet.* March 2020

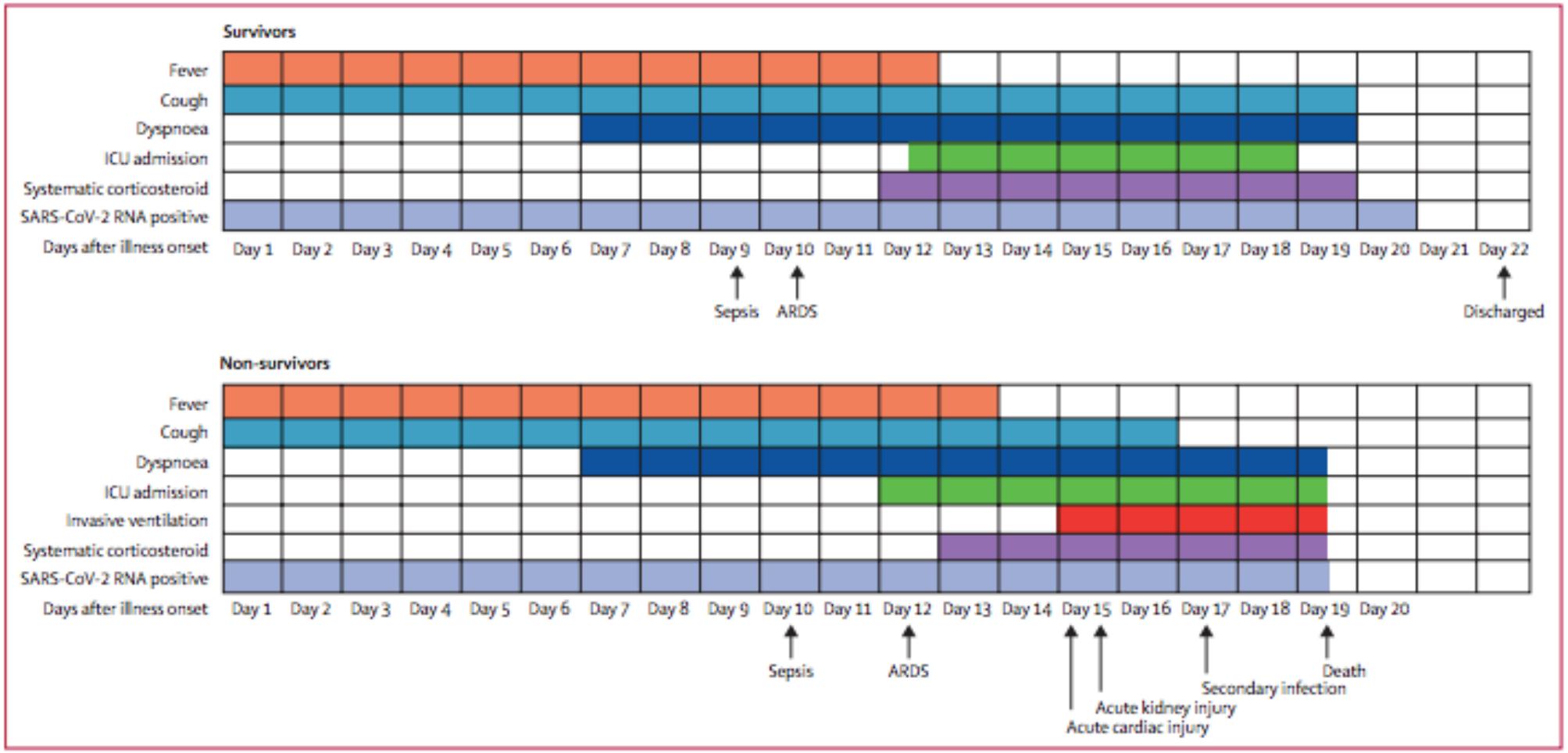

Figure 1: **Clinical courses of major symptoms and outcomes and duration of viral shedding from illness onset in patients hospitalised with COVID-19**
Figure shows median duration of symptoms and onset of complications and outcomes. ICU=intensive care unit. SARS-CoV-2=severe acute respiratory syndrome coronavirus 2. ARDS=acute respiratory distress syndrome. COVID-19=coronavirus disease 2019.

https://www.nejm.org/doi/full/10.1056/NEJMoa2002032

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Clinical Characteristics of Coronavirus Disease 2019 in China

W. Guan, Z. Ni, Yu Hu, W. Liang, C. Ou, J. He, L. Liu, H. Shan, C. Lei, D.S.C. Hui, B. Du, L. Li, G. Zeng, K.-Y. Yuen, R. Chen, C. Tang, T. Wang, P. Chen, J. Xiang, S. Li, Jin-lin Wang, Z. Liang, Y. Peng, L. Wei, Y. Liu, Ya-hua Hu, P. Peng, Jian-ming Wang, J. Liu, Z. Chen, G. Li, Z. Zheng, S. Qiu, J. Luo, C. Ye, S. Zhu, and N. Zhong, for the China Medical Treatment Expert Group for Covid-19*

ABSTRACT

BACKGROUND

Since December 2019, when coronavirus disease 2019 (Covid-19) emerged in Wuhan city and rapidly spread throughout China, data have been needed on the clinical characteristics of the affected patients.

METHODS

We extracted data regarding 1099 patients with laboratory-confirmed Covid-19 from 552 hospitals in 30 provinces, autonomous regions, and municipalities in mainland China through January 29, 2020. The primary composite end point was admission to an intensive care unit (ICU), the use of mechanical ventilation, or death.

RESULTS

The median age of the patients was 47 years; 41.9% of the patients were female. The primary composite end point occurred in 67 patients (6.1%), including 5.0% who were admitted to the ICU, 2.3% who underwent invasive mechanical ventilation, and 1.4% who died. Only 1.9% of the patients had a history of direct contact with wildlife. Among nonresidents of Wuhan, 72.3% had contact with residents of Wuhan, including 31.3% who had visited the city. The most common symptoms were fever (43.8% on admission and 88.7% during hospitalization) and cough (67.8%). Diarrhea was uncommon (3.8%). The median incubation period was 4 days (interquartile range, 2 to 7). On admission, ground-glass opacity was the most common radiologic finding on chest computed tomography (CT) (56.4%). No radiographic or CT abnormality was found in 157 of 877 patients (17.9%) with nonsevere disease and in 5 of 173 patients (2.9%) with severe disease. Lymphocytopenia was present in 83.2% of the patients on admission.

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Zhong at the State Key Laboratory of Respiratory Disease, National Clinical Research Center for Respiratory Disease, Guangzhou Institute of Respiratory Health, First Affiliated Hospital of Guangzhou Medical University, 151 Yanjiang Rd., Guangzhou, Guangdong, China, or at nanshan@vip.163.com.

*A list of investigators in the China Medical Treatment Expert Group for Covid-19 study is provided in the Supplementary Appendix, available at NEJM.org.

Drs. Guan, Ni, Yu Hu, W. Liang, Ou, He, L. Liu, Shan, Lei, Hui, Du, L. Li, Zeng, and Yuen contributed equally to this article.

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CDC Infection Control

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/index.html

How You Can Protect Yourself

Healthcare personnel caring for patients with confirmed or possible COVID-19 should adhere to CDC recommendations for infection prevention and control (IPC):

- Assess and triage these patients with acute respiratory symptoms and risk factors for COVID-19 to minimize chances of exposure, including placing a facemask on the patient and placing them in an examination room with the door closed.
- Use Standard and Transmission-Based Precautions when caring for patients with confirmed or possible COVID-19.
- Perform hand hygiene with alcohol-based hand rub before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled.
- Practice how to properly don, use, and doff PPE in a manner to prevent self-contamination.
- Perform aerosol-generating procedures, in an AIIR, while following appropriate IPC practices, including use of appropriate PPE.

Challenges for Palliative Providers

- No family visitation
- PPE limitations—who to visit, who to not?
- Symptom management, deaths are significant respiratory failure
- We don’t have enough palliative providers—how to make more in a short period of time?
- Transition of patients out of the hospital—Covid-19 vs patients with other terminal disorders
- Communication challenges when families are not allowed to be physically present at the hospital and involved in care
- Potentially the hardest question of all: what if we don’t have enough resources for all?

VitalTalk Communication Skills for COVID-19

Available in PDF : English , Spanish / Español , French / Français , German / Deutsch

COVID-ready communication skills: A playbook of VitalTalk Tips

Updates in progress 22 March 2020. Now available in French, German, and Spanish.
Download PDFs here: English, Spanish. More later today.

Who?

To health care professionals everywhere: these are unprecedented times. There's no roadmap. We're facing conversations that we never expected—or wanted—to have.

Why?

In Seattle, it's real. We've had patients die, and not all were elderly. One of our colleagues is intubated. All over the country we are all getting calls and concerns about how to handle the possible surge. We're realizing that our professional duty might pose a risk to the people at home that we love. Worse, what we're seeing now might be the trickle that becomes a tsunami. Like

Resourcing: when limitations force you to choose, and even ration

What they say	What you say, and why
Why can't my 90 year old grandmother go to the ICU?	***This is an extraordinary time. We are trying to use resources in a way that is fair for everyone.*** Your grandmother's situation does not meet the criteria for the ICU today. I wish things were different. **[C]**
Shouldn't I be in an intensive care unit?	Your situation does not meet criteria for the ICU right now. The hospital is using special rules about the ICU because we are trying to use our resources in a way that is fair for everyone. ***If this were a year ago, we might be making a different decision. This is an extraordinary time.*** I wish I had more resources.**[C]**
My grandmother needs the ICU! Or she is going to die!	I know this is a scary situation, and I am worried for your grandmother myself. ***This virus is so deadly that even if we could transfer her to the ICU, I am not sure she would make it.*** So we need to be prepared that she could die. We will do everything we can for her.**[C]**
Are you just discriminating against her because she is old?	I can see how it might seem like that. No, we are not discriminating. ***We are using guidelines that were developed by people in this community to prepare for an event like this***. The guidelines have been developed over the years, involving health care professionals, ethicists, and lay people to consider all the pros and cons. I can see that you really care about her. **[C]**

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To our ECHO community

- To put it mildly, what is going on right now is inconceivable
- If our paths go according to what has happened in other places, we will all need to work together as closely as possible to work through the challenges ahead
- How can we help?

Additional resources available from national organizations

COVID-19 Communication Skills – VitalTalk

COVID-19 Response Resources: Toolkit – Center to Advance Palliative Care (CAPC) Toolkit

Coronavirus Disease (COVID-19) Resources for Older Adults, Family Caregivers and Health Care Providers (Updated 3/19) – John A Hartford Foundation

COVID-19 Information – National Hospice and Palliative Care Organization (NHPCO)

A Letter of Support For You and Thoughts About COVID19 – GeriPal

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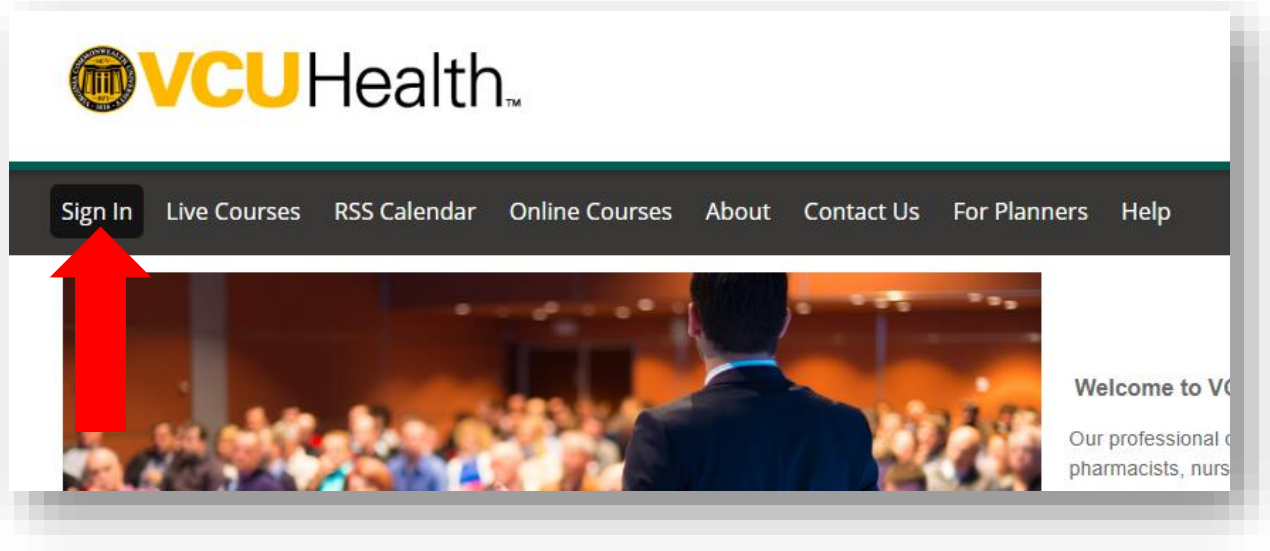

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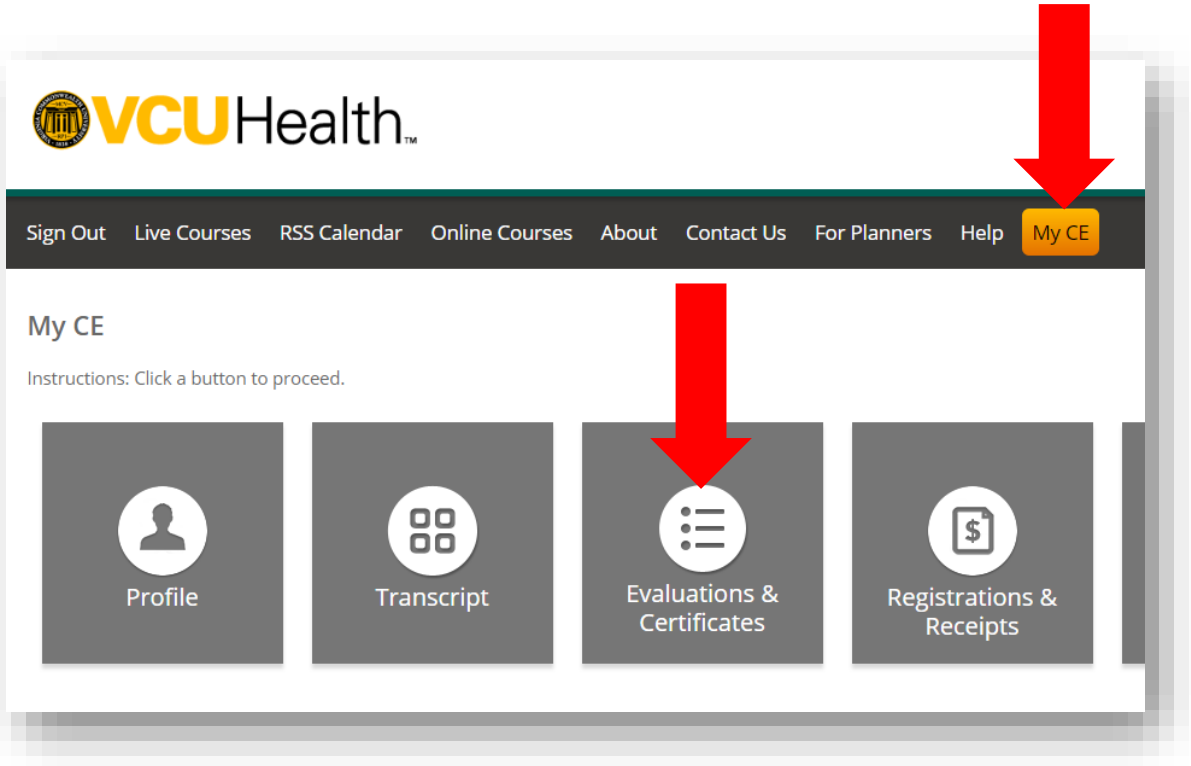

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VCU Health Palliative Care ECHO

Our VCU Health Palliative Care ECHO program partners with community practices caring for patients with serious illness and applies our interdisciplinary care team - a mix of physicians, nurses, social workers, psychologists, chaplains and more - to provide pati care support and education throughout Virginia.

We have a l standing palliative care program with an inpatient unit, consult service and supportive care clinic to provide serious illn are. Many communities in Virginia do not have access to palliative care and we're here to help.

- View Palliative Care ECHO sessions (CME/CEU available).
- Submit a case study (registered participants only).
- Subscribe to our mailing list to receive announcements and invitations to ECHO sessions.

Contact us for more information or help with any questions about our program.

About Palliative Care

THANK YOU!

We hope to see you at our next ECHO