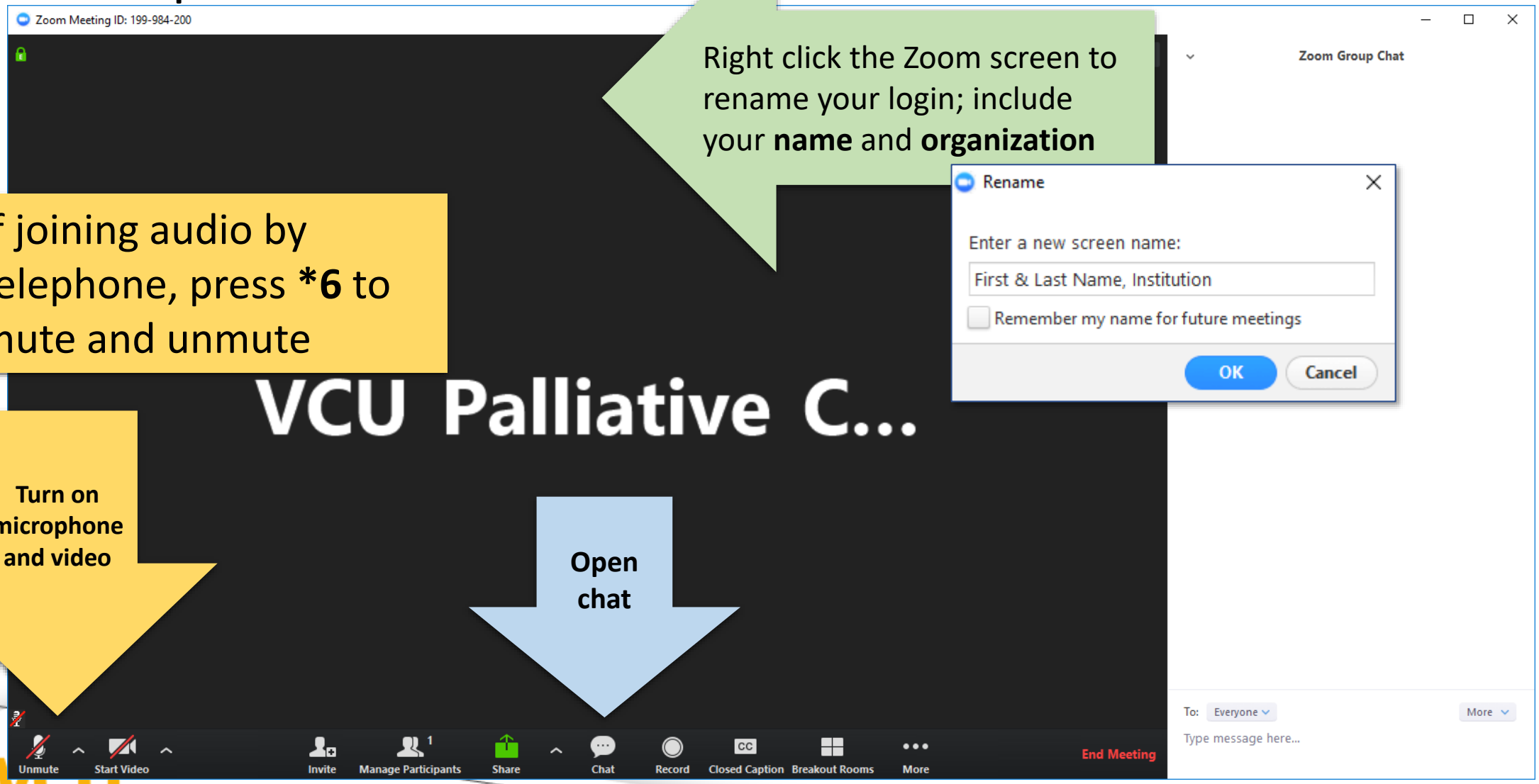
VCU Health

Project ECHO
Virginia Commonwealth University

Symptom Management for COVID-19

Palliative Care Project ECHO
April 13, 2020

Setup



Right click the Zoom screen to rename your login; include your **name** and **organization**

If joining audio by telephone, press ***6** to mute and unmute

Turn on microphone and video

Open chat

JA Accreditation & Credit Designation Statements – LIVE Activities

VCU Health Continuing Education

In support of improving patient care, VCU Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

VCU Health designates this live activity for a maximum of **1.00 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

1.00 ANCC contact hours

1.00 CE credits will be awarded for psychologists attending the entire program. Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibly for the content of the programs.

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This activity was planned by and for the healthcare team, and learners will receive **1.00 Interprofessional Continuing Education (IPCE)** credit for learning and change.

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The following Planning Committee and Presenting Faculty Members report having **no relevant financial relationships**:
Danielle Noreika, MD; Egidio Del Fabbro, MD; Diane Kane, LCSW; Tamara Orr, PhD, LCP, PMHNP-BC; Brian Cassel, PhD; Felicia Barner, RN; Candace Blades, JD, RN; Jason Callahan, MDiv

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

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The course code for this event is:

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View recorded sessions at vcuhealth.org/pcecho

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

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Challenges to Covid EOL care

- Provider/nursing teams may not be comfortable with end-of-life care
- Potential short term process changes: nurses may do exam for pronouncement (with goal of limiting room entry), avoidance of offering autopsies
- Processes in many areas will be new/frequently shifting
- Families may be viewing patients remotely which offers new challenges for symptom communication

Table 1. Demographic and Clinical Characteristics of Patients in the First 24 Hours of ICU Admission for COVID-19 in Lombardy, Italy

	Patients by age, y, No. (%)								
	All	0-20	21-40	41-50	51-60	61-70	71-80	81-90	91-100
No. (%)	1591 (100)	4 (<1)	56 (4)	143 (9)	427 (27)	598 (38)	341 (21)	21 (1)	1 (<1)
Age, median (IQR), y	63 (56-70)	16 (14-19)	34 (31-38)	47 (44-49)	56 (54-59)	65 (63-68)	74 (72-76)	83 (81-84)	91
Males	1304 (82)	3 (75)	44 (79)	119 (83)	355 (83)	484 (81)	279 (82)	19 (90)	1 (100)
Females	287 (18)	1 (25)	12 (21)	24 (17)	72 (17)	114 (19)	62 (18)	2 (10)	0
Comorbidities, No. with data	1043	3	35	82	273	380	253	1	1
None	334 (32)	0	23 (66)	50 (61)	107 (39)	107 (28)	47 (19)	0	0
Hypertension	509 (49)	0	4 (11)	21 (26)	121 (44)	195 (51)	156 (62)	12 (75)	0
Cardiovascular disease[a]	223 (21)	0	1 (3)	4 (5)	43 (16)	87 (23)	81 (32)	6 (38)	1 (100)
Hypercholesterolemia	188 (18)	0	1 (3)	1 (1)	30 (11)	92 (24)	59 (23)	5 (31)	0
Diabetes, type 2	180 (17)	0	1 (3)	4 (5)	40 (15)	86 (23)	46 (18)	3 (19)	0
Malignancy[b]	81 (8)	0	0	2 (2)	10 (4)	33 (9)	33 (13)	3 (19)	0
COPD	42 (4)	0	1 (3)	0	8 (3)	12 (3)	20 (8)	1 (6)	0
Chronic kidney disease	36 (3)	0	0	2 (2)	10 (4)	17 (4)	7 (3)	0	0
Chronic liver disease	28 (3)	0	0	2 (2)	8 (3)	13 (3)	5 (2)	0	0
Other[c]	205 (20)	3 (100)	6 (17)	10 (12)	49 (18)	77 (20)	55 (22)	5 (31)	0
Respiratory support, No.	1300	2	46	108	351	487	287	18	1
Invasive mechanical ventilation	1150 (88)	2 (100)	37 (80)	87 (81)	315 (90)	449 (92)	246 (86)	14 (78)	0
Noninvasive ventilation	137 (11)	0	8 (17)	16 (15)	33 (9)	36 (7)	39 (14)	4 (22)	1 (100)
Oxygen mask	13 (1)	0	1 (2)	5 (5)	3 (1)	2 (<1)	2 (1)	0	0

Grasselli G, *JAMA,* 6 April 2020

Symptom Assessment

Edmonton Symptom Assessment System Revised (ESAS-r)

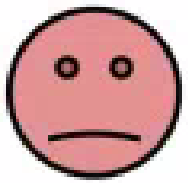
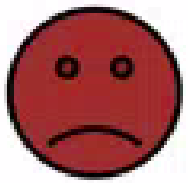
Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetitie
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(For example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

- Time for full assessments?
- Number of assessments (nursing may be less at times, family no longer part of assessment)
- Ability for palliative care assessment

From our colleagues in Switzerland

3D-Ticino 2019-nCov Score (3D-TiCoS)

	No Symptoms	Mild	Moderate	Severe	Very severe	Worst possible
Dyspnoea Distress Discomfort (pain)						
	0	1-3	4-6		7-9	10

Fusi-Schmidhauser T, *JPSM,* 8 April 2020

How to accomplish in the community?

Tran et al, *JPSM,* 8 April 2020.

Table 1. De-Escalation and Triaging of Community-Based Palliative Care Patients

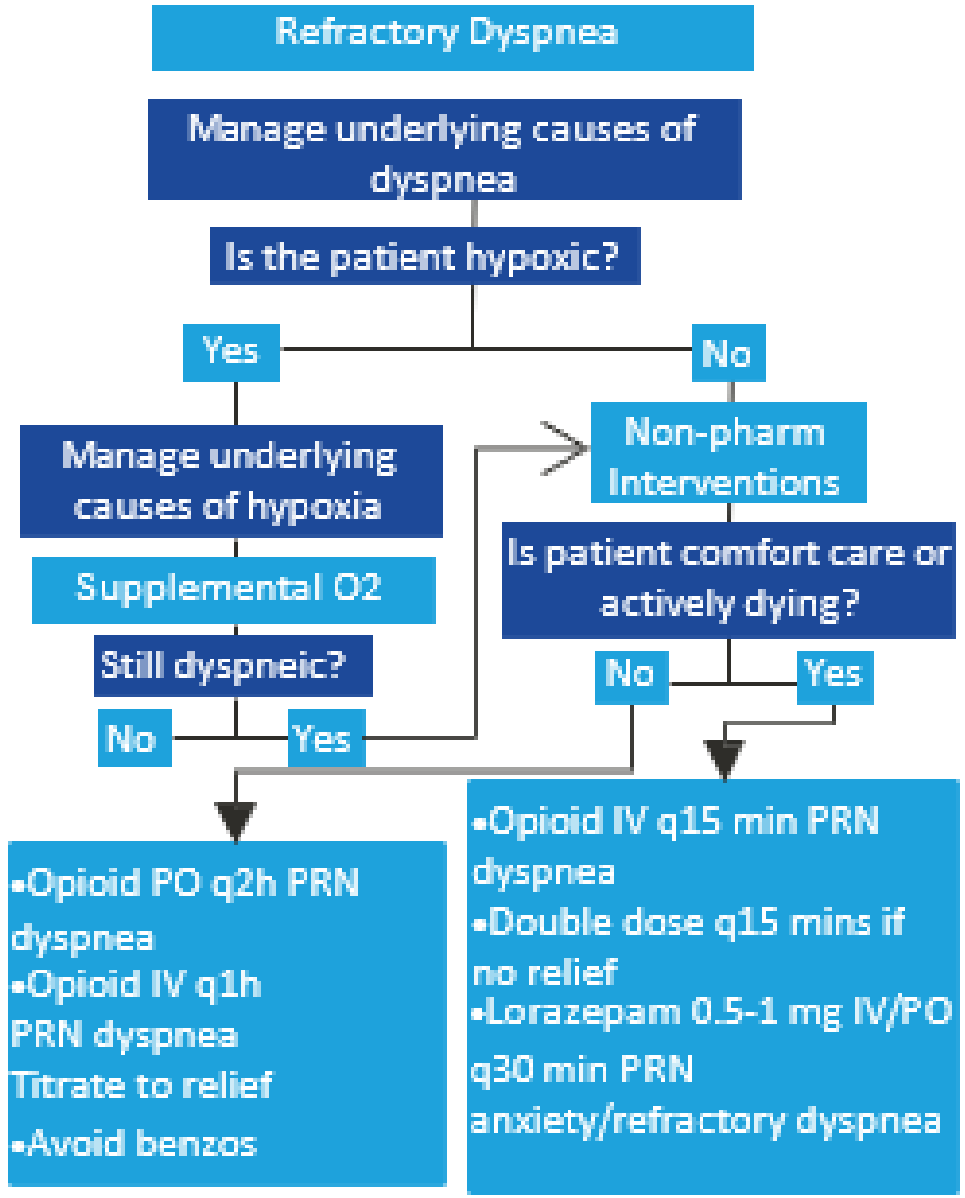
	Home	Facility (SNF, ALF, B&C), New Patient	Facility (SNF, ALF, B&C), Established Patient	Clinic
Urgent	Face-to-Face Visit (requires physician/APC approval)	Telephone Triage and/or Telehealth Visit	Telephone Triage and/or Telehealth Visit	Face-to-Face Visit (requires physician/APC approval)
Non-Urgent	Telephone Triage and/or Telehealth Visit	Interdisciplinary Triage & Telehealth Visit	Interdisciplinary Triage & Telehealth Visit by Acuity	Interdisciplinary Triage & Telehealth Visit by Acuity

Urgent/Crisis is defined as patients with acute and uncontrolled urgent symptom need, or high risk of death

Telephone triage: Physician/APC or RN call to assess urgency and need for telehealth versus face-to-face visit

CAPC.org

Relief of Dyspnea



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 titrated to relief is more effective and safe compared to starting an opioid infusion

Dosing Tips:

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

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Possible stepped approach

Table 1. Recommendations for conservative and palliative care management of Covid-19 patients

Phases of illness	Monitoring (nursing)	Drugs for symptom control
Stable: EWR1: ≤ 7 RR: ≤ 25/min O2 Sat: > 88% (with Venturi mask up to 60%)	• 3D assessment and vital signs once per shift • Evaluate pressure areas & need for pressure relieving mattress • Intensify communication with the family and prepare that sick enough to die	Dyspnea/pain: Morphine orally 2-5 mg, 4 hrly with rescue doses (10% of the total daily dose) or PRN Anxiety: Lorazepam sub-lingual 1-2.5 mg, 8 hrly or PRN or Levomepromazine PO 7.5 mg PRN Fever: Paracetamol PO 1 g or rectal 600 mg, 6 hrly or PRN Shivers: Morphine 2-5 mg PO PRN or Pethidine 25 mg SC PRN Prescribing in Renal Insufficiency and opioids: choose Hydromorphone (accordingly to palliative care consultation) Temporary de-prescribing of usual drugs

Fusi-Schmidhauser T, *JPSM,* 8 April 2020

Possible stepped approach

Table 1. Recommendations for conservative and palliative care management of Covid-19 patients

Phases of illness	Monitoring (nursing)	Drugs for symptom control
Unstable: EWR1 > 7 RR: > 25/min O2 Sat: < 88%	• 3D assessment twice per shift if patient alert • O2 delivery max. 4 L • Observe respiratory effort • Inform the family now terminal and propose visit	Dyspnea/pain: Morphine IV/SC 5 mg, 4 hrly with rescue doses (10% of the total daily dose) or PRN Anxiety/delirium/distress: Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hrly with rescue doses PRN or Chlorpromazine 12.5-25 mg IV PRN or Levomepromazione 6.25-12.5 mg SC PRN Fever: Diclofenac 75 mg IV PRN (max. BD) or Paracetamol rectal 600 mg PRN (max. 4/day) Shivers: Morphine 5 mg IV PRN or Pethidine 25 mg SC PRN Hydration max. 250 ml/day Suspend futile treatments
End-of-Life: ARDS O2 Sat: < 70%	• 3D assessment twice per shift if patient alert • Assess ABDT2 once per shift if patient does not comunicate • Stop O2 • Inform the family and re-evaluate for family visits • Basic care and mouth care	Terminal dyspnea – Respiratory distress: • Morphine IV/SC 5 mg, 4 hrly with rescue doses (10% of the total daily dose) or PRN • Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hrly with rescue doses PRN Hyperactive delirium: • Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hrly with rescue doses PRN • Chlorpromazine 12.5-25 mg IV PRN or Levomepromazione 6.25-12.5 mg SC PRN Fever: Diclofenac 75 mg IV PRN (max. BD) or Paracetamol rectal 600 mg PRN (max. 4/day) Shivers: Morphine 5 mg IV PRN or Pethidine 25 mg SC PRN

Fusi-Schmidhauser T, *JPSM,* 8 April 2020

Communication Challenges

- Communication and physical presence are a large part of the typical grief process
- Provide support from a distance: this takes careful communication
- Transition plans for comfort care may be more challenging to create
- Lack of presence of family may increase symptom burdens patients experience
- Other IDT members may support communication re: symptom burden and management

Draft VCU Comfort Care Guidelines

Thoughtfully consider higher risk respiratory interventions

- Nebulized meds
  - *If inhaled med needed (e.g. albuterol) can use MDI*
- Suctioning
- High flow nasal cannula
  - *Requires airborne precautions*
  - *Can wean to regular nasal cannula (droplet precautions) once patient on opiate CADD*
  - *Can use boluses to manage dyspnea/tachypnea*
- BiPAP

Draft VCU Comfort Care Guidelines

Facilitate remote monitoring & limit room entry

- If able/applicable, place any infusion pumps outside of room to allow bolusing of medication without entering room
- OK to continue cardiac monitor, continuous pulse ox if allows for some degree of distance monitoring and not appearing to burden
- Tablets during nursing assessment to minimize staff exposure/PPE
- ******Make sure there is a balance here*—some assessments need to be done in the room, the staff at the bedside need support

Dyspnea: first line

IV Morphine CADD

Only in non-renal failure patients

- Initiate at 1-2mg/hr basal rate based on prior use
- Nursing bolus 2-4 mg as needed, increased work of breathing, tachypnea >20 breaths per minute

IV Hydromorphone CADD

Can be used with caution in renal & liver failure pts

- Initiate at 0.1-0.2 mg.hr basal
- Nursing bolus 0.5 mg as needed, increased work of breathing, tachypnea >20 breaths per minute

IV Fentanyl CADD

Can be used in renal and liver failure pts.

- Initiate at 10-20 mcg/hr basal
- Nursing bolus of 25-50 mcg, increased work of breathing, tachypnea <20 breaths per minute

- Re-assessment until tachypnea improves
- Doses will need to be higher for opioid tolerant patients
- If patient is already on a basal opioid can continue and use IV for symptoms as needed

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Avoid Nebs – can aerosolize virus

Dyspnea refractory to opioids

(not improved after escalations of opioids)
Second line = benzodiazepines

Lorazepam

- IV pushes: Lorazepam 1mg IV Q1H PRN for refractory dyspnea
- If requiring recurrent boluses can begin scheduled regimen of lorazepam or consider longer acting benzodiazepine (for instance diazepam)
- Dose titration may be necessary for symptom effect in tolerant patients

Midazolam (in consultation with PC)

- IV pushes; Initiate with Midazolam 1mg IV Q15min PRN for dyspnea that is refractory to opiate boluses
- If requiring recurrent boluses can consider a continuous rate in addition to nursing directed bolus

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

Cases…….details blurred somewhat for privacy ☺

- Middle aged male with comorbidities, quick decompensation on a medical floor. Patient and decision maker declined transfer to ICU, developed significant respiratory distress at end of life with active symptom management on the floor

- Elderly female admitted for evaluation of multiple symptoms and found to be Covid +, comfort level of care per family (patient with baseline dementia), discussions with nursing facility to return with hospice care, overall relatively few symptoms

- Middle aged female Covid + with comorbidities, patient and family wanted to go home with hospice so family could spend time (although family concerns regarding managing care at home), developed delirium prior to discharge home worked with team and family re: transition plan

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THANK YOU!

We hope to see you at our next ECHO