PALLIATING A PANDEMIC: "ALL PATIENTS MUST BE CARED FOR"

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OBJECTIVES

Definition(s),Scope and its Working Principles

Influence on Clinical Outcomes

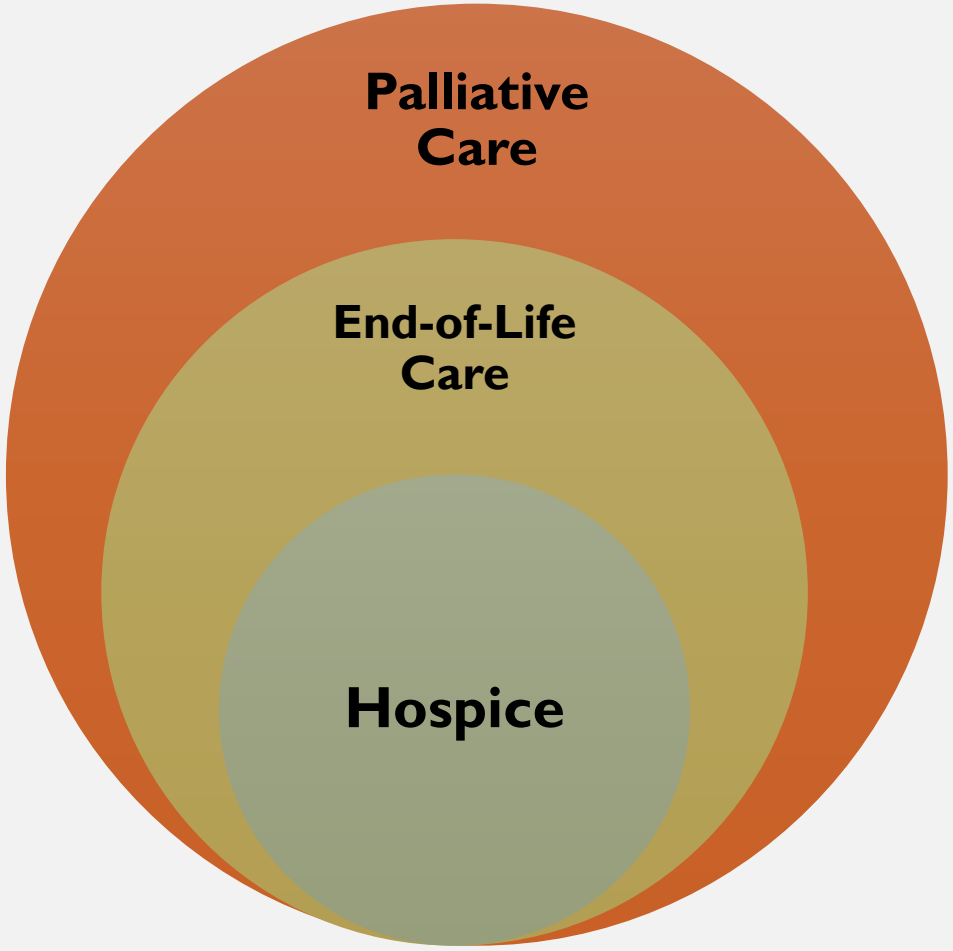
“Hospice Care” Difference between Hospice and Palliative Care

CONFLICT OF INTEREST

- No relevant disclosure(s)

THE BIG PICTURE

THE PALLIATIVE CARE MODEL



- Improving quality of life for those suffering with serious illnesses
- For those entering the last phase of life
- A model for delivering end-of-life care

DEFINITION(S) AND SCOPE OF PRACTICE

- Refers to a specialized care for people with serious illness
- Focusses on providing patients with relief from pain, other physical symptoms, and intellectual/emotional stress of serious illness, regardless of the diagnosis
- Goal is to improve quality of life(QOL) for both the patient and the family

DEFINITION(S) AND SCOPE OF PRACTICE

- Team approach, involves physicians, nurses, and other specialists who work with patient's medical providers to offer an ***extra layer of support***
- Palliative Care can be provided together with ***Curative treatment***
- Appropriate at ***any age*** and ***any stage*** of a serious illness

DEFINITION(S) AND SCOPE OF PRACTICE

- Hospice is a service delivery system that provides Palliative Care focusing on symptoms and quality of life for terminally ill patients, generally with an expected prognosis of 6 months or less, usually at home (can be any where)

- End-of-life care refers to the provision of care when death is imminent

VALUE OF CARE EQUATION

$$\text{Value} = \frac{\text{Quality (Outcomes of Care, Safety, Service)}}{\text{Cost Per Patient Over Time}}$$

- Is doing more always good?
  - What if it causes harm?
  - What if it doesn't help?
- We need to examine all implications

Smoldt and Cortese 2007 In *Mayo Clinic Proceedings*

WHY PALLIATIVE CARE (PC)

- The sickest, and thus costliest, 5% of patients in the US accounted for an estimated 60% of health care.

- The literature reveals of an unmet need for improved care coordination, communication and symptom management for hospitalized patients close to the end of life.

Thompson, Ruth M, et al. 2017 In *Essentials 1: Medical Care of People with Serious Illness*

WHY PALLIATIVE CARE (PC)

Issues:

Inadequate symptom control, medicalization of depth, and higher use of technology, overwhelming costs, lack of personalized care

Remedy:

Palliative Care meets 8 Domains of Care (NCPQPC)	Offers patient centered, beneficial and timely quality care	Provides support for patients with critical illness during high intensity crises	Guides clinicians to meet patient and family's needs

GUIDING PRINCIPLES OF PC

- **Domaine 1**: Structure and Process of Care-Comprehensive assessment
- **Domain 2**: Physical Aspects of Care-Effective and efficient plan of care
- **Domain 3**: Psychological and Psychiatric Aspects-Evaluate and engage mental health support
- **Domain 4**: Social Aspects of Care-Assess and recognize social burden
- **Domain 5**: Spiritual, Religious, and Existential Aspects of Care-recognize spiritual needs and its effects
- **Domain 6**: Cultural Aspects of Care- Explore cultural variances
- **Domain 7**: Care of the Patient at the End of Life-Maximize the patient's priorities
- **Domain 8:** Ethical and Legal Aspects of Care-Ensure ethical and legal compliance with the plan of care

Thompson, Ruth M, et al. 2017 In *Essentials 1: Medical Care of People with Serious Illness*

COMMUNICATION AND COVID-19

What They Say	*What You Say*
How bad is this?	From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day**, and we will update you.
Is my mother going to make it?	**I imagine you are scared.** Here's what I can say: because she is 70. and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.**
Shouldn't she be in an intensive care unit?	You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.**
What happens if she gets sicker?	If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her.
How can you just take her off a ventilator when her life depends on it?	Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different.

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CPR-WHEN MORE HARM THAN BENEFIT

Resuscitation Status COVID-19	*Example Language*
Approach to when your clinical judgment is that a patient would not benefit from resuscitation	Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life.** My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear.
If in agreement:	These are really hard conversations. **I think this plan makes the most sense for you.**
If not in agreement:	These are really hard conversations. **We may need to talk about this again.**

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PROGNOSIS: US-CDC DATA-FEB 12TH-MARCH 16TH

Age group (no. of cases)	%* Hospitalization	ICU admission	Case-fatality
0–19 (123)	1.6–2.5	0	0
20–44 (705)	14.3–20.8	2.0–4.2	0.1–0.2
45–54 (429)	21.2–28.3	5.4–10.4	0.5–0.8
55–64 (429)	20.5–30.1	4.7–11.2	1.4–2.6
65–74 (409)	28.6–43.5	8.1–18.8	2.7–4.9
75–84 (210)	30.5–58.7	10.5–31.0	4.3–10.5
≥85 (144)	31.3–70.3	6.3–29.0	10.4–27.3
Total (2,449)	20.7–31.4	4.9–11.5	1.8–3.4

Bialek, Stephanie, et al. 2020 In *Morbidity and Mortality Weekly Report*

PROGNOSIS: INTERNATIONAL DATA FROM LANCET AND JAMA

	Case Fatality Rate (CFR)	
Age	China	ITALY (as of March 17th, 2020)
0–9	0.0%	0%
10–19	0.18%	0%
20–29	0.19%	0%
30–39	0.02%	0.3%
40–49	0.44%	0.4%
50–59	1.3%	1.0%
60–69	3.6%	3.5%
70–79	8.0%	13%
≥80	15%	20%

Onder, Graziano, et al. 2020 In *JAMA*; Verity, Robert, et al. 2020 In *The Lancet Infectious Diseases*

TIMELY SYMPTOM MANAGEMENT

Pain, Dyspnea, or Cough

ORAL or SL:

Morphine Sulfate: 15 mg, ½-1 tablet every 4 hours AROUND THE CLOCK. (Once we know what the average daily total requirement is to keep pain or dyspnea below a 5 out of 10, switch to a long acting pain medicine. See CAPC's pain card).

IV or SQ:

Morphine 5 mg IV or SQ every 3 hours around the clock. Increase by 50% for pain unrelieved by starting dose.

SYMPTOM MANAGEMENT

Nausea

ORAL or SUBLINGUAL:

Metoclopramide: 10 mg every 6 hours around the clock.

OR

Ondansetron: 4 mg every 8 hours, increase to 8 mg if no relief from starting dosage.

IV or SQ:

Metoclopramide 5 mg/ml, give 1 ml every 6 hours around the clock.

OR

Ondansetron: 0.15 mg/kg IV every 8 hours

**If using antiemetics for opioid-induced nausea, give 30 minutes before morphine to prevent nausea. This should only be necessary for 3-4 days as nausea wears off with time.

PREVENTING CONSTIPATION

Miralax powder: 1-2 capfuls in water or juice, or any liquid you like, every day. If no daily bowel movement, increase to 3 capfuls. Over the counter.

+

Dulcolax suppository: 1 or 2 per rectum every morning after breakfast. Over the counter.

RESCUE MEDICATIONS FOR SYMPTOM DISTRESS

Pain or Shortness of Breath or Cough

ORAL or SUBLINGUAL:

Morphine liquid: 10 mg per 5 ml, take 2.5 ml every 30 minutes until relief. Increase to 5 ml if no relief from starting dosage.

Morphine tablets: 15mg, ½ tablet PO every 30 minutes until relief. Increase to 1 tablet if no relief from starting dosage.

IV or SQ:

Morphine 5mg IV or SQ every 30 minutes until relief. Increase to 10 mg if no relief from starting dosage.

RESCUE MEDS

Nausea, Restlessness, Anxiety, Agitation, or Confusion

ORAL or SUBLINGUAL:

Haloperidol liquid (Haldol): 2 mg per ml, give ¼ ml to ½ ml by mouth or under tongue every hour until relief or calm.

Haloperidol tablets: 1 mg tablet, give half tablet every 1 hour until calm, increase to full tablet if no relief from starting dosage.

IV or SQ:

Haloperidol 2 mg/ml ¼ ml every hour until relief, increase to ½ ml if no relief from starting dosage

RESCUE MEDS

Anxiety, Restlessness, or Agitation (not relieved by haloperidol)

ORAL or SUBLINGUAL:

Lorazepam liquid (Ativan): 2 mg per ml, give ¼ to ½ ml by mouth or under tongue every hour until relaxed/calm, increase to 1 ml if no relief from starting dosage.

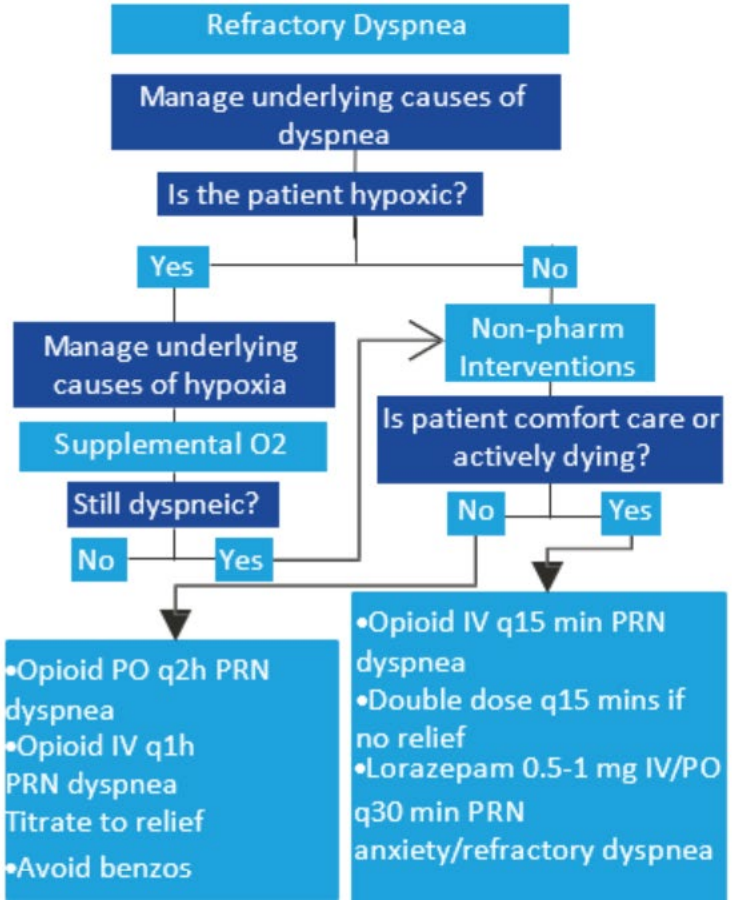
Lorazepam tablets: 1 mg tablet, give ½ tablet every hour until calm, increase to 1 tablet if no relief.

IV or SQ:

Lorazepam 1 mg/ml, give ½ ml every hour until relief, increase to 1 ml if no relief from starting dose.

REFRACTORY DYSPNEA

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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OPIOID QUICK TIPS

Pharmacodynamics of Opioids:

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

Other Opioid 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**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

Relative Strengths & Conversion

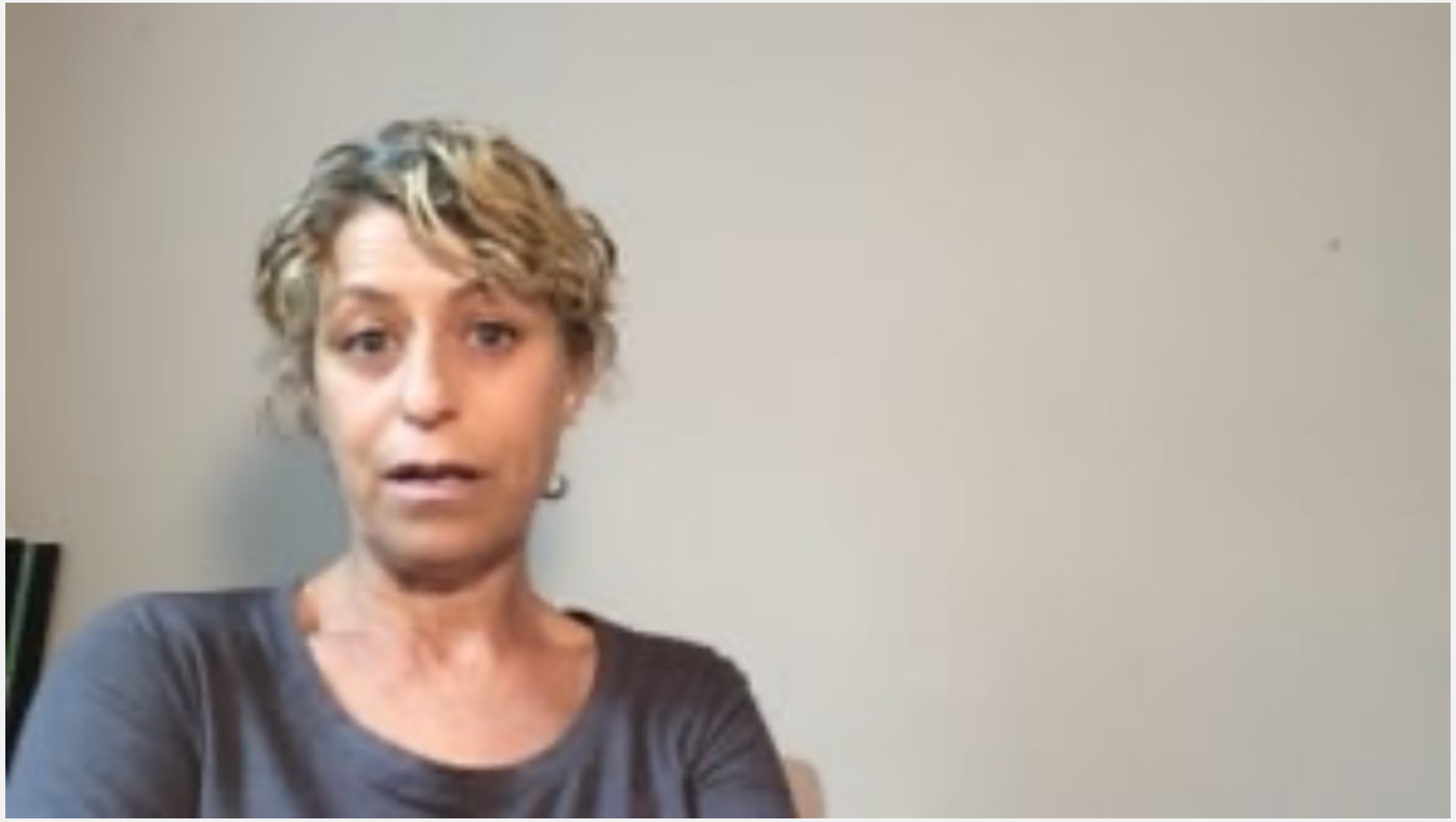
Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	–
Hydromorphone	7.5	1.5

*Avoid fentanyl due to shortage

If Using Opioids, Start a Bowel Regimen:

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

COVID GOALS OF CARE CONVERSATION



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WHAT PALLIATIVE CARE IS NOT

- Not only end-of-life care
- Not an attempt to contain medical cost or ration care
- Does Not hasten death
- Not a dichotomy of care–between "Do Everything" Vs "Giving up"
- Not always a choice–essential for incurable disease

ADDITIONAL RESOURCES

www.capc.org

www.vitaltalk.org

Palliative Care Fast Facts:
www.mypcnow.org

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