Palliative Medicine Comfort Care Communications Team | COVID-19

Banner Palliative Care

This is a fluid situation and material is subject to change
Updated: June 23, 2020

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The Care Team | COVID-19

Team Members:

- Palliative Care Physician (if available) | Team Lead
- Upskilled* Hospitalist and/or Ambulatory Physicians
- Upskilled* APPs
- Social Workers
- Care Management
- Banner Hospice Liaison
- Spiritual Care
- RNs
- Others as needed

Functions:

- Liaison to Critical Care Department & Triage Officers
  - Capacity of staffing & beds
  - Anticipated patients
  - Family & patient conflicts
- Delivery of comfort care & symptom management
- Family communication & updates
- Spiritual & cultural needs
- Facilitate transfer to off campus alternative sites
- Notification of death

Training | Upskilling*:

- COVID-19 Triage Protocols
- Symptom management & comfort care (physicians|APPs)
- Goals of care conversations | Advance Care Planning

Not responsible for decisions made or appeals of decisions

Purpose: to direct palliative care & communication for patients, families & critical care team

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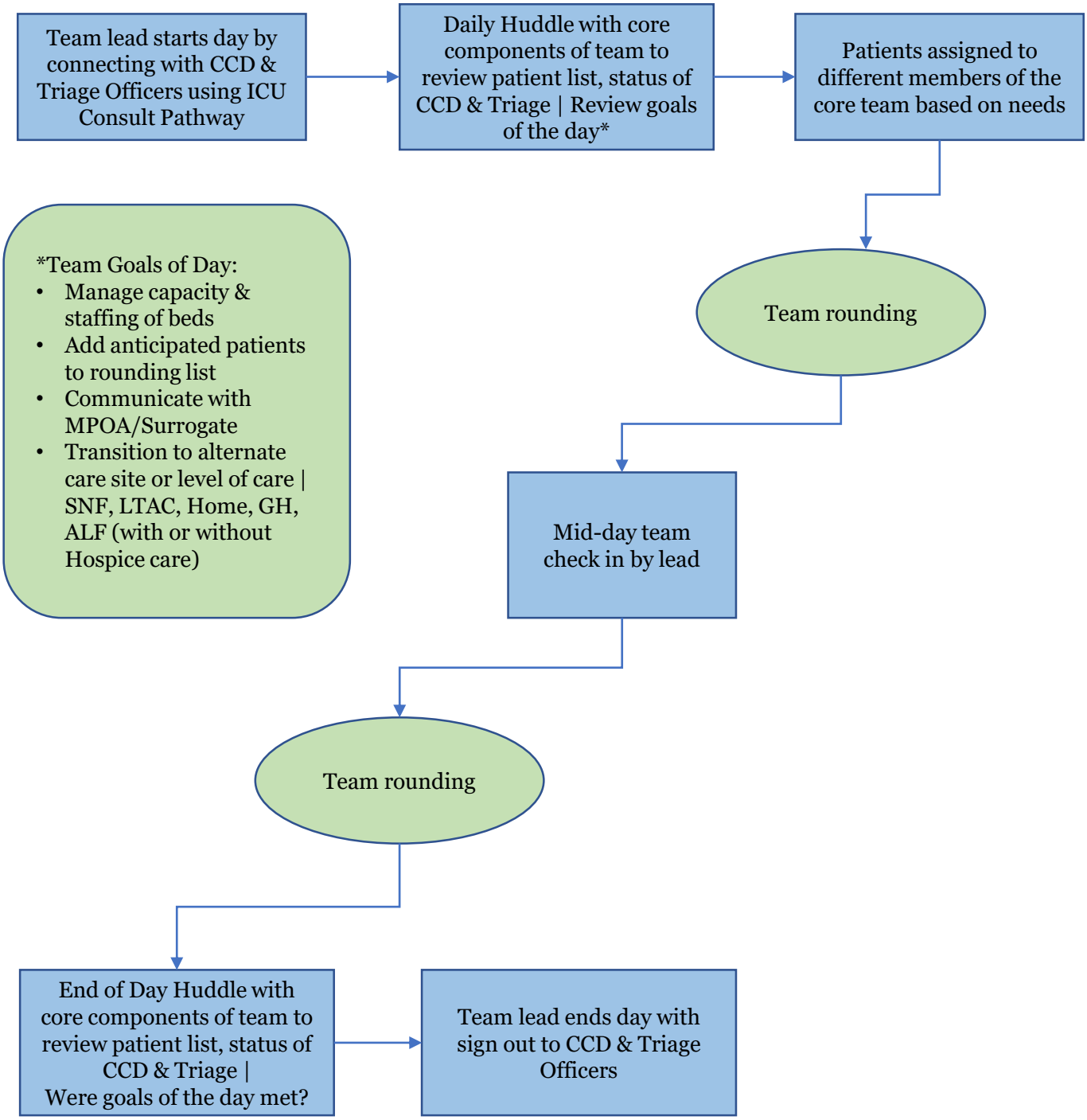

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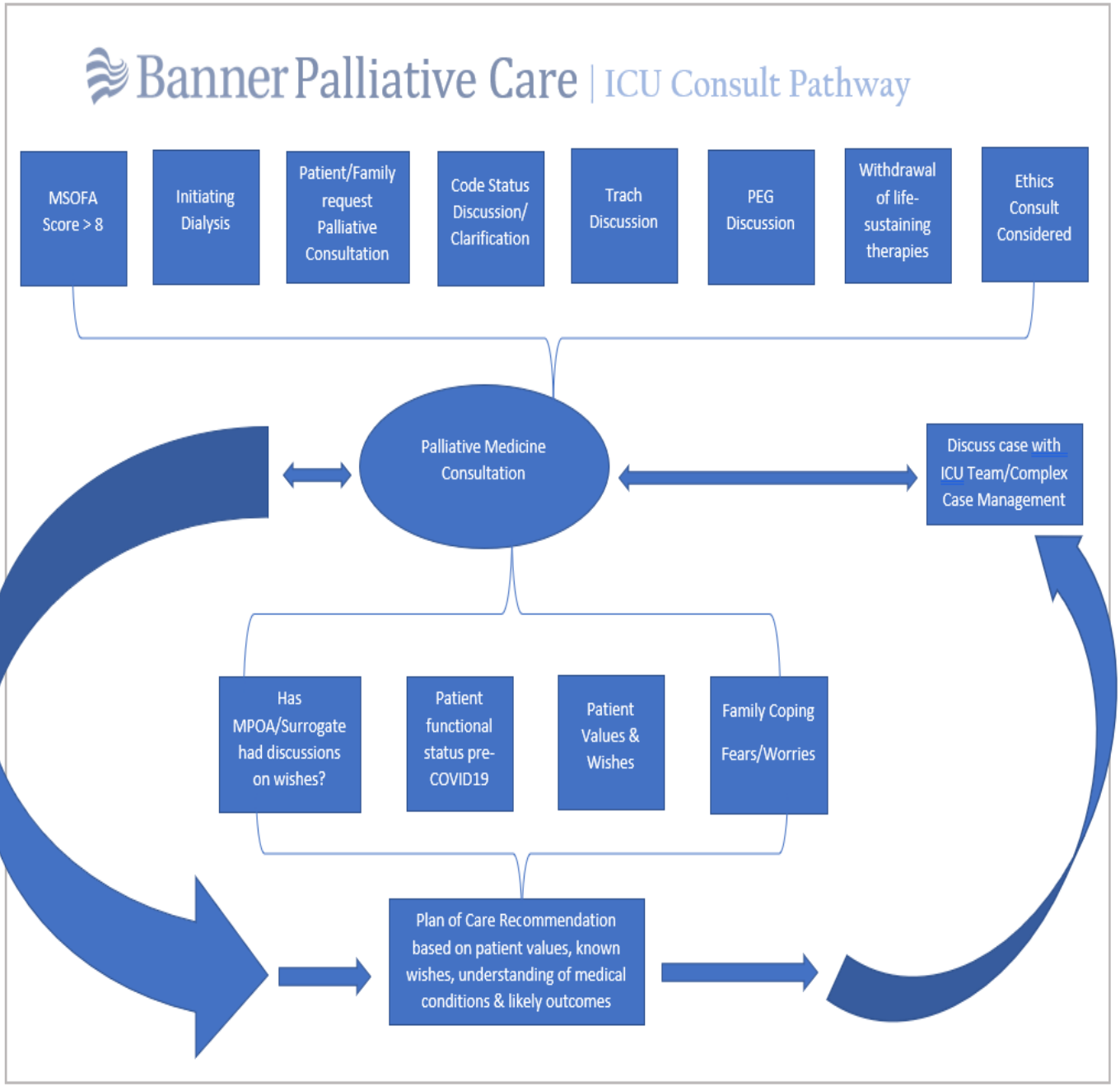
ICU Consult Pathway | COVID -19



Training Syllabus | Palliative Medicine Comfort Care Communications Team COVID-19

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Determining Capacity | Pocket Guide

A critical first step in having a goals of care discussion is determining if the patient has capacity or not

Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient.

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	• Have you decided whether to follow your doctor's [or my] recommendation for treatment? • Can you tell me what that decision is? • If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: • The problem with your health now • The recommended treatment • The possible benefits and risks (or discomforts) of the treatment • Any alternative treatments and their risks and benefits • The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment0 and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	• What do you believe is wrong with your health now? • Do you believe that you need some kind of treatment? • What is treatment likely to do for you? • What makes you believe it will have that effect? • What do you believe will happen if you are not treated? • Why do you think your doctor has [or I have] recommended this treatment?	• Courts have recognized that patients who do not acknowledge their illnesses (often referred to as a "lack of insight") cannot make valid decisions about treatment • Delusions or pathologic levels o distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	• How did you decide to accept or reject the recommended treatment? • What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not th outcome of the patient's choice, since patients have the right to make "unreasonable" choices

*Questions are adapted from Grisso and Appelbaum. Patients' responses to these questions need not be verbal.

Patty Mayer, MD, MS
Clinical Ethics

Banner Palliative Care

AZ Surrogate Decision Maker | When Patient Lacks Capacity

If they lack capacity:

- Do they have a MPOA? Do we have the paperwork?
- If they do not have an MPOA or there is no paperwork, a surrogate decision maker needs established

Patty Mayer, MD, MS
Clinical Ethics
4/1/2020

Decision-making for patients in Arizona (once the patient lacks capacity)

Establish a decision maker for every patient in case that patient loses medical decision-making capacity and cannot speak for him/herself. The decision maker's task would be to tell us what the patient would say if s/he could speak. With no visitors allowed in any hospitals, this is critically important; staff must know whom to call for updates and decisions.

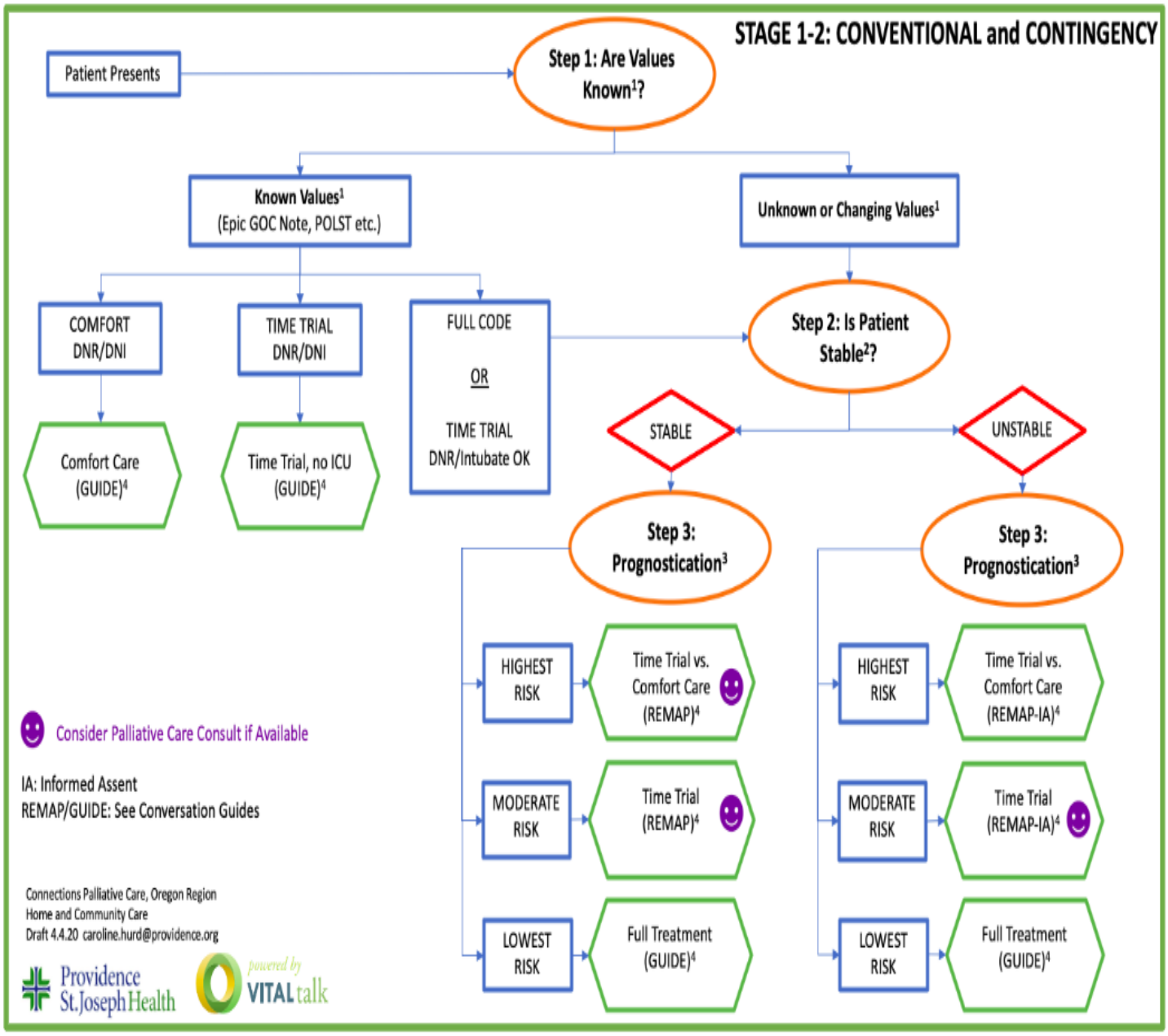
Go down the list until you find the first one that exists for that patient.

1) Court appointed guardian (rare)
2) MPOA (Medical Power of Attorney) – this is a signed, dated, witnessed document present in the chart or in your possession. In the EMR, open the Advance Directives tab on the far left. It only counts if there is a scanned document in the chart which you can open and read. If the patient has no MPOA but has capacity – have her fill one an MPOA asap. In the absence of an actual document - there is no MPOA.
3) If there is no MPOA you proceed to the AZ Statutory surrogate list. This is Arizona state law. You must take the first one on the list who is "willing to serve and reasonably available" – phone contact only is always acceptable. If a person declines, you go to the next one on the list; a person who declines cannot "assign" the duty to another person.
    a. Spouse, unless legally separated
    b. Majority of biological and/or legally adopted adult children
    c. Parent(s)
    d. Domestic partner of unmarried patient
    e. Adult sibling
    f. Close friend
4) If none of the above can be found (due diligence must occur in the search): Attending Physician
    a. In consultation with ethics committee (EC)
    b. If EC is not possible – attending must consult with a second physician

COVID-19: NURSE(S) RESPONDING TO EMOTIONS

STEP	WHAT YOU SAY OR DO	TIPS/SKILLS
NAME	*"You sound concerned."*	**Acknowledges** the emotion. Be careful to suggest only, most people don't want to be told how they feel but appreciate the acknowledgement. In general, turn down the intensity (e.g. scared→concerned).
UNDERSTAND	*"I can imagine this is difficult news to hear."* *"Many people in your situation might feel…"*	**Normalizes** the emotion or situation. Avoid suggesting you understand their experience, because we often can't.
RESPECT	*"I can see you really care about your mother."*	Expression of praise or **gratitude** about the things they are doing. This can be especially helpful when there is conflict.
SUPPORT	*"We will do everything we can to support you during this illness."*	Expression of what you can do for them and a good way to express **non-abandonment**. Making this kind of commitment can be a powerful statement.
EXPLORE	*"Can you **tell me more** about…"*	Emotion cues can be expressions of underlying concerns or meaning. Combining this with another NURSE(S) skills can be very effective and help you understand their reasoning or actions. Make sure to avoid judgment and come from a place of **curiosity**.
(S)ILENCE	Can be used in many situations, but often effective after delivering serious news	It is often more therapeutic for family members to provide emotional support to each other. Using silence allows room for this opportunity. Silence can also make **space** for the person to share more. Use silence intentionally, too much can leave people feeling uncomfortable.
BONUS: "I wish" statements	*"**I wish** we had better treatments… [more testing ability….that we were in a different situation…that your father wasn't so sick… etc.]"*	I wish statements allow you to affirm your commitment even when don't have the ability to provide something that is desired.

Adapted by Caroline.Hurd@providence.org using work from VitalTalk, Ariadne Labs, Elizabeth Lindenberger, Lindsay Dow, Amy Kelley, Diane Meier, Elke Lowenkopf and Rachelle Bernacki version 4.4.20


STAGE 1-2: CONVENTIONAL and CONTINGENCY
Patient Presents
Step 1: Are Values Known[1]?
Known Values[1] (Epic GOC Note, POLST etc.)
Unknown or Changing Values[1]
COMFORT DNR/DNI
TIME TRIAL DNR/DNI
FULL CODE
OR
TIME TRIAL DNR/Intubate OK
Step 2: Is Patient Stable[2]?
Comfort Care (GUIDE)[4]
Time Trial, no ICU (GUIDE)[4]
STABLE
UNSTABLE
Step 3: Prognostication[3]
Step 3: Prognostication[3]
HIGHEST RISK
Time Trial vs. Comfort Care (REMAP)[4]
MODERATE RISK
Time Trial (REMAP)[4]
LOWEST RISK
Full Treatment (GUIDE)[4]
HIGHEST RISK
Time Trial vs. Comfort Care (REMAP-IA)[4]
MODERATE RISK
Time Trial (REMAP-IA)[4]
LOWEST RISK
Full Treatment (GUIDE)[4]
Consider Palliative Care Consult if Available
IA: Informed Assent
REMAP/GUIDE: See Conversation Guides
Connections Palliative Care, Oregon Region
Home and Community Care
Draft 4.4.20 caroline.hurd@providence.org
Providence St.Joseph Health
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COVID-19: GUIDE Delivering Serious News about COVID-19 and Anticipatory Guidance

Example: Patients with KNOWN values that are DNR/DNI

Before You Start: **This talking map is for patients who have clear goals of care. If a patient has DNR/DNI preferences documented in the chart (POLST, GOC note etc.) Confirm their preferences first before having the conversation below. If this information is incorrect, or they want to change their preferences, use the REMAP talking map instead.**

GET READY

[Key Information] Make sure you have the key **information** (COVID-19 test results, prognosis, POLST etc.)

[Key People] Make sure you have the key **people** (patient, family, surrogate and interprofessional clinicians etc.)

[Key Space] If possible, find a **private**, quiet space and allow adequate time

UNDERSTAND what they know

[Warning Statement] *"I have some serious news to talk about today."*

[Assess Prior Knowledge] *"So I know where to begin, it's helpful to know what you've **already been told**. What do you **already know** about [your test results for the coronavirus, how coronavirus affects your lungs…what to expect with a coronavirus infection… etc.]"*

[Always assess what the patient or family knows before giving information, this allows you to tailor your response.]

INFORM using a headline

[Ask Permission] *"Thank you, that's helpful. You've heard some important information already. Would it **be okay** if I share what I know?"* [If **yes**, proceed, if **no** explore concerns]

[Headline = Information + Meaning]

Information (1-2 sentences of key information):

Example 1: *"The test results show that you have the coronavirus."*

Example 2: *"The CT scan shows that the coronavirus has caused serious damage to your lungs…"*

Meaning:

Known Values for DNR/DNI Time Trial: *"This **means** that while we **hope** you will recover quickly, **some people with your other medical conditions** get sick quickly and do not survive."*

Known Values for DNR/DNI Comfort Care: *"This **means** that while we **hope** you will improve; we **are worried** you may get sicker quickly and not survive."*

STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

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DEMONSTRATE EMPATHY

[Use the **NURSE(S)** tool to explicitly empathize before giving more information]

Name: *"This must be hard news to hear."*

Understand: *"I can only imagine how difficult this is to think about."*

Respect: *"I really appreciate you having this difficult conversation with me."*

Support: *"Our teams are here to support you through this."*

Explore: *"Tell me more about what you are thinking…"*

I wish: *"**I wish** I had better news…"*

EQUIP for next steps

[Align First] "I want you to know that our team will do everything we can to support you."

[Anticipatory Guidance] [Provide a spectrum of potential outcomes and signpost potential challenges]
*"I also want you to be **prepared** for what's to come. Our plan right now is to…"*

Option 1: Known DNR/DNI Time Trial *"…admit you to the hospital for a **trial** of medications and treatments to help you **get better**. We will monitor you closely on our acute care floor. We **hope** you improve quickly and we can get you home as soon as possible. Sometimes people's condition worsens, despite our best efforts. Given your prior wishes, and their unlikely benefit in people with serious underlying medical conditions, if you became critically ill and were dying, we would not do CPR or put a tube into your lungs and connect you to a ventilator machine that breathes for you. Instead we would **shift our focus** to comfort during the dying process."*
[Remember you will likely need to respond to emotions again after this recommendation]

Option 2: Known DNR/DNI Comfort Care *"…admit you to the hospital and start medications and treatments to help you **feel better**. Because of the severity of this illness, your other medical conditions, and your previously expressed wishes, we will focus our care on treating symptoms to ensure your **comfort**. We will not do treatments that don't provide comfort like CPR, ventilator breathing machines that require a tube into the lungs, or transfer you to the intensive care unit. Some patients, even when we focus on comfort, will recover from this illness. However, even if you worsen, we will pay close attention to shortness of breath, or any other signs of discomfort, and we will give medications and other treatments that will help you feel more comfortable during the dying process."*

[Remember you will likely need to respond to emotions again after this recommendation]

[Check-in] *"That is a lot to process, what **questions** do you have?"*

[Affirm and Close] *"Thank you for talking with me about this today. I will write our discussion down in your chart, so everyone on our healthcare teams knows the plan. We are committed to making sure you get the best care possible."*

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete/recommend as appropriate.

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COVID-19: REMAP For Goals of Care

Example: Stable Moderate Risk Patients who are FULL code or DNR/Intubate Okay (Acute Care Focus)

1. INTRODUCE the idea

[Set Agenda, Normalize] *"Things can change quickly when people have the coronavirus. Because of this, I am asking **all my patients** about **what matters** most and what they might **expect** for their situation. This way, we can be prepared during your hospital stay and makes sure you get the kind of medical care you want."*

[Ask Permission] *"Would it be okay if we talk about this today?"*

YES: Go to Step 2
NO: [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, offer to revisit at another encounter.

2. ELICIT questions

[Elicit Agenda] *"Are there things you want to make sure we talk about during our conversation?"*

YES: [Bracket Questions] *"Great, thank you, I will make sure I address those by the end of our conversation."* Then go to Step 3.
NO: Go to Step 3

3. REFRAME we are in a different place

[Assess What They Know] *"So I know where to begin, what have you **heard so far** about the coronavirus and how it could affect your particular situation?"*

[Ask Permission] *"Thank you, that's helpful. You've heard some important information. Would it **be okay** if I share what I know?"*

[Headline = Information + Meaning]
Information: *"Because of your other medical conditions, you are at risk for serious complications if the coronavirus makes you very sick."*

Meaning: *"This **means** that if you become so sick that you needed intensive care, I **worry** that you may not survive, even with maximal medical support."*

STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

4. EXPECT EMOTION

[Use the **NURSE(S)** tool to explicitly empathize before giving more information]
Name: *"You seem worried...."*
I wish: *"**I wish** I had better news..."*
[see NURSE(S) tool for more responses]

5. MAP out values

[Context, Ask Permission] *"**Given this situation**, I'd like to step back and talk about what would be most important to you if your health situation **worsened**. Is that okay?"* [If **yes**, proceed, if **no**, explore emotions first]

[Hopes] *"What are you **hoping** for in the coming days?...What/who else is important to you?...What does a 'good day' look like?"*

[Concerns] *"When you think about the future, what are your biggest **concerns** or **worries**?"*

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MAP out values (cont.)

[Tradeoffs] *"If you become sicker, how much would you be **willing to go through** for the possibility of gaining more time?"*

- Longevity: *"Some people would want to try all life support treatments to **live as long** as possible, even if this meant living on machines permanently, or not being aware of their surroundings. They would even want CPR attempted if their heart stopped and they died."*

- Function: *"Other people would want a **trial** of life support treatments, such as a ventilator machine which requires a tube down into the lungs to help you breathe. But if the treatments weren't working, and they weren't able to get back to **doing** important things, they would want them stopped. They would also not want CPR."*

- Comfort: *"Other people, if they got very sick from the coronavirus, would only want treatments focused on comfort. They would not want a ventilator or CPR and they would want to have a natural peaceful death, even if they lived a shorter time."*

"How about you?"

6. ALIGN

[Respect and Reflect Values] *"Thank you for sharing this with me. As I listen, it **sounds** like what matters most is....[summarize values]. Did I miss anything?"*

7. PLAN

[Recommend] *"Given what I know about your medical situation and what you said is most important, would it be okay if I made a **recommendation** about next steps?"*

[Response 1-Value Longevity]: *"For now, I would **recommend** all available medical treatments to help you live as long possible.* [Affirm] *I want you to know that, if you get sicker, we will do everything we can to help you recover."* [Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"* [Provide Anticipatory Guidance] *"I also want you to be prepared that even with this plan, there may come a time when you are so sick that you would die even with these treatments. If this happens, your doctors might not even recommend a ventilator machine to breathe for you, or CPR, because these treatments would not help."*

[Response 2-Value Function/Time Trial]: *"For now, I would **recommend a trial** of all available medical treatments that would help you get back to doing things that are important to you. If you get sicker, and you are dying despite these treatments, I don't think we should put you on a machine that breathes for you, or do CPR, but instead shift our focus to your comfort during the dying process and allow a natural death.* [Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"* [Affirm] *I want you to know that, if you get sicker, we will do everything that **we think** will help you recover."*

[Response 3-Comfort]: *"I **recommend** that we focus our care on treating symptoms to ensure your comfort. We call this 'comfort care.' This would mean that we don't do treatments that would cause discomfort, like CPR, breathing machines or moving you to the intensive care unit. But we aggressively treat any symptoms that are causing you to be uncomfortable. Some patients, even when we focus on comfort, will recover from this illness. However, even if you worsen, we will pay close attention to shortness of breath, or any other signs of discomfort, and we will give medications and other treatments that will help you feel more comfortable during the dying process."* [Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"* [Affirm] *I want you to know that we will do everything we can to keep you **comfortable**."*

[Close] *"Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what's important to you. Our team will do everything we can to help you through this."*

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.

COVID-19: REMAP-Informed Assent For Goals of Care

Example: Unstable High Risk Patients Unlikely to Benefit from CPR or Intubation (ED Focus)

1. INTRODUCE the idea

[Context] *"I am **worried** you are very sick and might have the coronavirus. Things can change quickly and we want to make sure you have all the information you need about what to **expect** for **your situation** and we also want to know **what matters** most to you if you become critically ill and you cannot communicate with us."*

[Ask Permission] *"Is that okay?"*

YES: Go to Step 2
NO: [Explore Concerns] Emotions are often under these concerns, address these first and try again. If concerns cannot be addressed, at least try to complete step 2 to identify a health care representative.

2. ASK about a Health Care Representative

[Normalize] *The first thing I want to know is if there is someone you trust to make medical decisions for you if you become too sick to communicate your own wishes. Not everyone has someone they could trust to make medical decisions for them, and others already have someone in mind. How about you?"*

YES: Ask who the person is, and if they've legally designating this person. If they have, ask your team to help get the paperwork.

NO: [Affirm] *"That's okay, many people don't have someone who could speak for them. In this situation it is even more important that we know your wishes and preferences before a crisis happens and we can't communicate with you."*

3. REFRAME we are in a different place + informed assent for DNR/DNI

[Context] *The next thing I want to talk about are your wishes if you suddenly become critically ill.*

[Assess What they Know] *"So I know where to begin, what have you **heard so far** about the coronavirus and how it could affect your particular situation?"* [Actively listen so you can tailor your information to what they already know]

[Ask Permission] *"Thank you, that's helpful. You already have important information. Would it **be okay** if I share what I know?"*

[Headline = Information + Meaning]
Information: *"The test results show that it is very likely that you have the coronavirus. I am worried that you have developed a serious complication in which the virus has affected your lungs."*

Meaning Part 1
*"This **means** that if the infection becomes severe, despite our best efforts, **most** people who already have serious medical conditions, don't survive, even with maximal medical support.* [Pause]
Meaning Part 2
[Informed Assent] *Therefore we don't recommend invasive treatments like CPR, or a ventilator breathing machine that requires a tube into your lungs to help you breathe, because these treatments would only cause harm."*

STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

4. EXPECT EMOTION

[Use the NURSE(S) tool to explicitly empathize before giving more information]
Name: *"I can see this is upsetting to hear."*
I wish: *"**I wish** I had better news…"*
[see NURSE(S) tool for more responses]

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5. MAP out values

[Ask Permission] *"**Given this situation**, I want to know how best to care for you. I know this can be hard to think about. Is it okay if we go on?"*
[If **yes**, proceed, if **no**, explore concerns and emotions.]

Option 1: Time Trial *"Some people hear this news and knowing that CPR and ventilator breathing machines would not be helpful, they want a **trial of all other available treatments*** that the doctors recommend.*

Option 2: Comfort Focused *"Other people hear this news and say that if are this sick, they only want treatments and medications that help with **comfort** and want to have a natural peaceful death. They also want any treatments that don't provide comfort stopped."*

"How about you?"

[Note: If a patient is **actively dying** and even a time trial would not be effective, skip to making a clear recommendation to transition to **comfort** focused care now, see **Option 2 below**.]

6. ALIGN

[Respect and Reflect Values] *"Thank you for sharing this with me. As I listen, it **sounds** like **what matters** most is….[summarize values]. Did I miss anything?"*

7. PLAN + informed assent for DNR/DNI

[Recommend] *"Given what I know about your medical situation and what you said is most important, would it be okay if I made a **recommendation** about next steps?"*

[Option 1-Value Function/Time Trial]: *"For now, I would **recommend a trial of available medical treatments*** that we think will help. We will not do CPR or use a ventilator breathing machine, because these would not help in your situation.* [Informed Assent] *If you get sicker, and you are dying despite these treatments, we would shift our focus to your comfort during the dying process. We would increase treatments and medications to manage your symptoms and we would stop any treatments that are not helping.* [Affirm] *I want you to know that our whole team **hopes** that we help you recover."*

[Option 2-Comfort]: *"I **recommend** that we focus our care on treating symptoms to ensure your comfort. We call this 'comfort care.' We will pay close attention to shortness of breath, or any other signs of discomfort, and we will give you medications and other treatments that help you feel more comfortable during the dying process. We will also stop or avoid treatments that cause discomfort, like CPR, breathing machines or moving you to the intensive care unit.* [Affirm] *I want you to know that we will do everything we can to keep you **comfortable**."*

[Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"*

[Close] *Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team is committed to supporting you through this."*

[*BiPAP and HFNC are controversial. Would only offer if these are available, recommended and would potentially offer benefit, they are **aerosolizing procedures** and require special PPE]

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.

COVID-19: REMAP-Informed Assent For Goals of Care

Example: Talking to Surrogates When Patients Are Dying Despite Critical Care (ICU Focus)

1. INTRODUCE the idea

[Context and Warning Statement] *"I have some serious news to talk about today about how [patient] is doing. Things have changed a lot in the last few [hrs, days etc.] and I want to give you a medical update and then talk about a plan together for next steps."*

[Ask Permission] *"Is that okay?"*

YES: Go to Step 2
NO: [Explore Concerns] Emotions are often under these concerns, address these first and try again. If emotions are too high, and the situation is urgent, ask if there is another surrogate to talk to, if the situation is non-urgent arrange another time to talk.

2. REFRAME we are in a different place

[Assess What they Know] *"Before I begin, it's helpful to hear, from your perspective, how you think [patient] is doing, and what you already know about his current condition."* [Actively listen so you can tailor your information and plan to their needs.]

[Ask Permission] *"Thank you, that's helpful. You already have important information. Would it **be okay** if I share what I know?"*

[Deliver Headline = Information + Meaning]

Information:
Option 1: *"Despite our best efforts, in the past few [hours/days], [patient] has not improved...."*

Option 2: *"Despite our best efforts, in the past few [hours/days], [patient] has become sicker]."*

Meaning + Informed Assent
Option 1: *"This **means** that we are **worried** that the infection and damage are so severe that [patient] won't survive and may even die in the next couple of [hrs/days]."*

Option 2: *"This **means** that the infection and damage are so severe that even with maximal medical support, [patient] is **dying**."*

STOP! Emotions means they heard the reframe. Respond to emotions before giving more medical information.

3. EXPECT EMOTION

[Use the **NURSE(S)** tool to explicitly empathize before giving more information]
Name: *"I can see this is unexpected."*
Understand: *"I can only imagine how difficult this is to think about."*
Respect: *"I really appreciate you having this difficult conversation with me."*
Support: *"Our teams are here to support you through this."*
Explore: *"Tell me more about what you are thinking..."*
I wish: *"**I wish** we had better treatments to fight this infection..."*

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4. MAP out values

[Ask Permission] *"**Given this situation**, I want to know how best to care for [patient]. This can be hard, is it okay if we go on?"*
[If **yes**, proceed, if **no**, explore concerns and emotions.]

Option 1: Time Trial *"Some people hear this news and even though they understand that their loved one is unlikely to survive, they want to continue all **recommended** medical treatment for another few days to see if there is any improvement."*

Option 2: Comfort Focused *"Other people hear this news and say that if [patient] is likely to die/is dying no matter what, their loved one would only want treatments and medications that help with **comfort.** They would want all life support treatments stopped to allow their loved one to have a natural peaceful death. This would include stopping the ventilator and any other treatments that cause discomfort and starting more medications and treatment to improve comfort."*

[Empty Chair] *"If [patient] **could sit with us** and understand the situation and talk to us, what would he **say**?"*

[Note: If a patient is **actively dying** and even a time trial would not be effective, skip to making a clear recommendation to transition to **comfort** focused care now, see **Option 2 below**.]

5. ALIGN

[Respect and Reflect Values] *"Thank you for sharing this with me. As I listen, it **sounds** like **what matters** most is....[summarize values]. Did I miss anything?"*

6. PLAN (informed assent recommendation for DNR)

[Recommend] *"Given what I know about the medical situation and what you said is most important to [patient], would it be okay if I made a **recommendation** about next steps?"*

[Option 1-Time Trial]: *"For now, I would **recommend a trial of [time]** using all available medical treatments that we think will help. We will watch closely for signs of improvement, including [list signs]. We will also look for any signs that [patient] is getting worse, including [list signs].* **[Informed Assent for DNR]** *At a minimum I would recommend that if [patient] gets so sick that their heart stops and they die, we should not do CPR because it would only cause harm and not help [patient] survive. If [patient] gets sicker, and they are dying despite these treatments, we will likely recommend that we shift our entire focus to comfort during the dying process and stop the ventilator to allow a natural and peaceful death.* [Affirm] *We want you to know that whatever happens our team will support you through this."*

[Option 2-Comfort]: *"I **recommend** that we focus our care on treating symptoms to ensure [patient] comfort. We call this 'comfort care.' We will pay close attention to shortness of breath, or any other signs of discomfort, and we will [patient] medications and other treatments to help with comfort during the dying process. When we take people off the ventilator who are this sick, they usually die within minutes to hours, though occasionally it can be days.* [Affirm] *I want you to know that we will do everything we can to keep [patient] **comfortable**."*

[Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"*

[Close] *Thank you for talking with us about this today. I will write down our discussion in your medical record, so everyone on your healthcare teams knows what is important to you. Our team is committed to supporting you through this."*
[offer supportive/bereavement services from the interprofessional team as appropriate]

[Note: you may have to address visitation policies etc.]

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (Green Goals of Care Tile in Epic], if the patient does not have an advance directive, health care representative and/or POLST, complete as appropriate.

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Saying Goodbye | Talking to family on phone or video through saying goodbye to a patient in their last hours or minutes

Lead the way forward

"I am [name], one of the [professionals] on the team."

"For most people, this is a tough situation."

"I'm here to walk you through it if you'd like."

"Here's what our institution / system / region is doing for patients with this condition." (State the part directly relevant to that person.)

Offer the four things that matter to most people

"So we have the opportunity to make this time special."

"Here are five things you might want to say. Only use the ones that ring true for you."

- "Please forgive me"
- "I forgive you"
- "Thank you"
- "I love you"
- "Goodbye"

"Do any of those sound good?"

Validate what they want to say

"I think that is a beautiful thing to say"

"If my [daughter] were saying that to me, I would feel so valued and so touched."

"I think he/she can hear you even if they can't say anything back"

"Go ahead, just say one thing at a time. Take your time."

Expect emotion

"I can see that he/she meant a lot to you."

"Can you stay on the line a minute? I just want to check on how you're doing"

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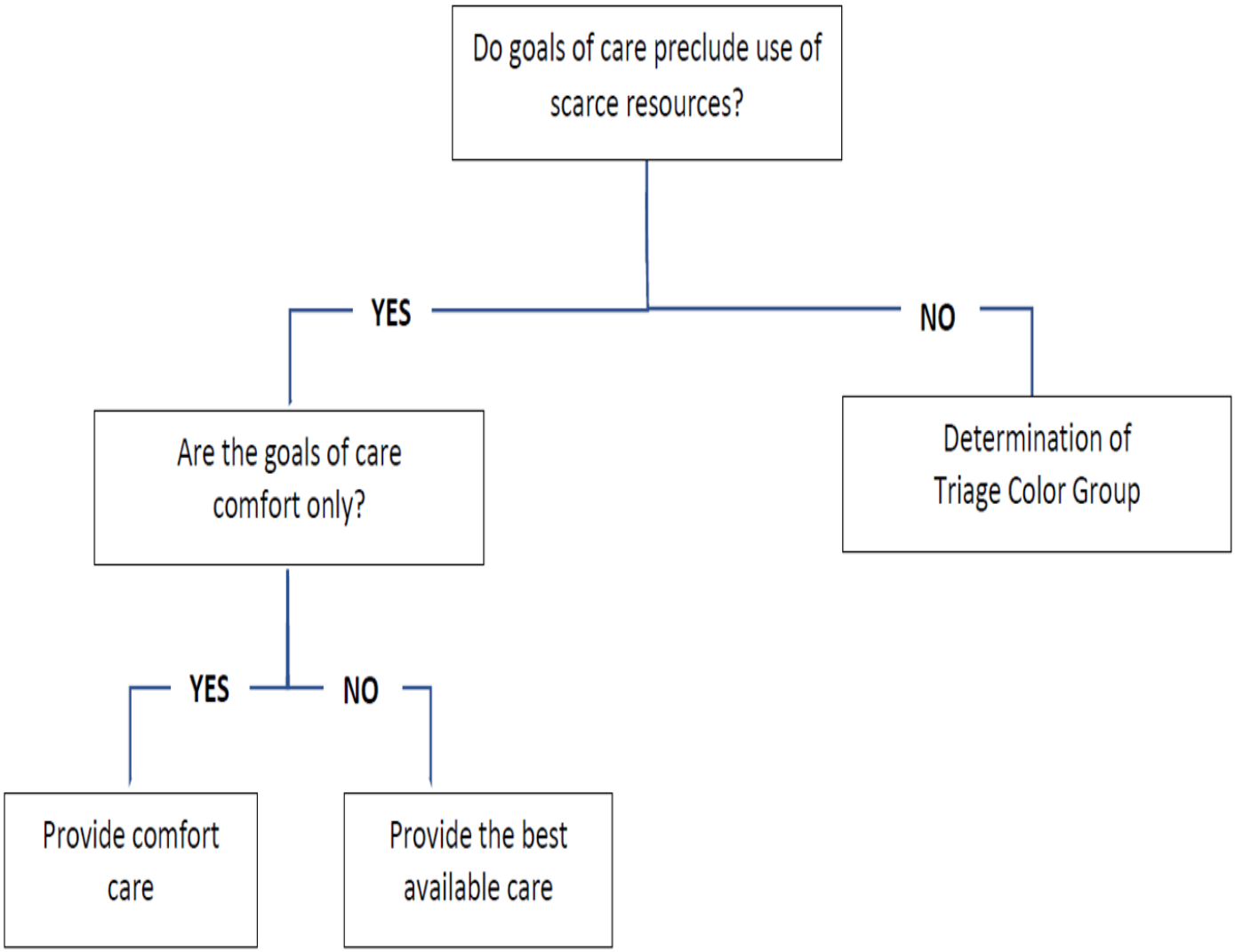
Triage During the Pandemic | COVID-19



AZ CSC Plan Pandemic Triage Addendum

- Concepts of Triage
- Triage Priority Score
  - SOFA Score +
  - Prognosis
    - Add 2 points: death expected <5 years
    - Add 4 points: death expected <1 year
- Score corresponds to assigned color Triage Color Group
- Equal Priority Resolution Process
- Allocation vs. Reallocation
- Conflict resolution

Triage During the Pandemic | COVID-19

Summary Table 1: Multi-principle Strategy for Determining Triage Priority Score for an Individual Pa
Based on Pittsburgh, California and Maryland Frameworks

	0 POINTS	1 POINT	2 POINTS	3 POINTS	4 POINTS
SOFA score (Table 1-A) Or PELOD-2 score (Table 1-P)		ADULT SOFA SCORE (<6) OR PEDIATRIC PELOD-2 SCORE <12	ADULT SOFA SCORE (6-8) OR PEDIATRIC PELOD-2 SCORE 12-13	ADULT SOFA SCORE (9-11) OR PEDIATRIC PELOD-2 SCORE 14-16	ADULT SOFA SCORE (≥12) OR PEDIATRIC PELOD-2 SCORE ≥ 17
----------PLUS----------					
	ADD 0 POINTS		ADD 2 POINTS		ADD 4 POINTS
Additional considerations	Expected to live more than 5 years if patient survives the acute illness		Death expected within 5 years despite successful treatment of acute illness		Death expected within 1 year despite successful treatment of acute illness

Summary Table 2: Determining Triage Color Group for an Individual Patient

Triage Color Group	Triage Priority Score from Summary Table 1
RED HIGHEST PRIORITY FOR CRITICAL CARE RESOURCES	1-3
YELLOW INTERMEDIATE PRIORITY FOR CRITICAL CARE RESOURCES	4-5
BLUE LOWEST PRIORITY FOR CRITICAL CARE RESOURCES	6-8

Table 3. Examples of Major Comorbidities and Severely Life Limiting Comorbidities*

Examples of Major comorbidities (associated with significantly decreased long-term survival)	**Examples of Severely Life Limiting Comorbidities** (commonly associated with survival < 1 year)
• Moderate Alzheimer's disease or related dementia • Malignancy with a < 10 year expected survival • New York Heart Association Class III heart failure • Moderately severe chronic lung disease (e.g., COPD, IPF) • End-stage renal disease in patients < 75 • Severe multi-vessel CAD • Cirrhosis with history of decompensation	• Severe Alzheimer's disease or related dementia • Cancer being treated with only palliative interventions (including palliative chemotherapy or radiation) • New York Heart Association Class IV heart failure plus evidence of frailty • Severe chronic lung disease plus evidence of frailty • Cirrhosis with MELD score ≥20, ineligible for transplant • End-stage renal disease in patients older than 75

*This Table only provides examples. There are likely other reasonable approaches to designating 0, 2, or 4 points according to the "save the most life-years" principle. Indices such as Elixhauser or COPS2 may be used, but these scores may be difficult to calculate quickly.

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NEUROLOGIC DISEASE

(Criteria are very similar for chronic degenerative conditions such as ALS, Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)
The patient must meet at least one of the following criteria (1 or 2A or 2B):

1. Critically impaired breathing capacity, with all:
Dyspnea at rest, Vital capacity < 30%, Need O_2 at rest, patient refuses artificial ventilation

OR

2. Rapid disease progression with either A or B below:
Progression from :
independent ambulation to wheelchair or bed-bound status
normal to barely intelligible or unintelligible speech
normal to pureed diet
independence in most ADLs to needing major assistance in all ADLs

AND

A. Critical nutritional impairment demonstrated by all of the following in the preceding 12 months:
Oral intake of nutrients and fluids insufficient to sustain life
Continuing weight loss
Dehydration or hypovolemia
Absence of artificial feeding methods

OR

B. Life-threatening complications in the past 12 months as demonstrated by ≥1:
Recurrent aspiration pneumonia, Pyelonephritis, Sepsis, Recurrent fever, Stage 3 or 4 pressure ulcer(s)

RENAL FAILURE

The patient has 1, 2, and 3.

1. The pt is not seeking dialysis or renal transplant

AND

2. Creatinine clearance* is < 10 cc/min (<15 for diabetics)

AND

3. Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)

Supporting documentation for chronic renal failure includes:
Uremia, Oliguria (unne output < 400 cc in 24 hours), Intractable hyperkalemia (> 7.0), Uremic pericarditis, Hepatorenal syndrome, Intractable fluid overload.

Supporting documentation for acute renal failure includes:
Mechanical ventilation, Malignancy (other organ system) Chronic lung disease, Advanced cardiac disease, Advanced

STROKE OR COMA

The patient has both 1 and 2.

1. Poor functional status PPS* ≤ 40%

AND

2. Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ≥1 of the following:
≥ 10% weight loss in past 6 months
≥7.5% weight loss in past 3 months
Serum albumin <2.5 gm/dl

Current history of pulmonary aspiration without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events

Supporting documentation includes:
Coma (any etiology) with 3 of the following on the 3rd day of coma:
Abnormal brain stem response
Absent verbal responses
Absent withdrawal response to pain
Serum creatinine > 1.5 gm/dl

REFERENCES:

1.Centers for Medicare & Medicaid services, HHS § 418.22 Certification of terminal illness. https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec418-22.pdf Accessed 4/12/18

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3.Anderson F, Downing GM, Hill J. Palliative Performance Scale (PPS): a new tool. J Palliat Care. 1996; 12(1): 5-11.

4.Morita T, Tsunoda J, Inoue S, et al. Validity of the Palliative Performance Scale from a survival perspective. J Pain Symp Manage. 1999; 18(1):2-3.

5. Virik K, Glare P. Validation of the Palliative Performance Scale for inpatients admitted to a palliative care unit in Sydney, Australia. *J Pain Symp Manage*. 2002; 23(6):455-7.

6. Myers J, Kim A, Flanagan J. Palliative performance scale and survival among outpatients with advanced cancer. Supportive Care in Cancer 2015; 23.4: 913-918.

Hospice Criteria Card

Hospice is a program designed to care for the dying & their special needs. All hospice programs should include:
(a) **Control of pain and other symptoms** through medication, environmental adjustment and education.
(b) **Psychosocial support** for both the patient and family, including all phases from diagnosis through bereavement.
(c) **Medical services** commensurate with patient needs.
(d) **Interdisciplinary Team (IDT)** approach to patient care, patient/ and family support, and education.
(e) Integration into existing facilities where possible.
(f) Specially trained personnel with expertise in care of the dying and their families.

Hospice Eligibility Criteria

In order to be eligible to elect hospice care under Medicare, an individual must be— (a) Entitled to Part A of Medicare; and (b) Certified as being terminally ill in accordance with § 418.22.

Duration of hospice care coverage—Election periods:
(1) An initial 90-day period;
(2) A subsequent 90-day period; or
(3) An unlimited number of subsequent 60-day periods.*

Hospice Face-To-Face (FTF) encounter Must include documentation that a hospice physician or a hospice nurse practitioner had a FTF encounter with the patient. This encounter is used to gather clinical findings to determine continued eligibility for hospice care. The FTF must occur within 30 days calendar prior to the start of the *3rd benefit period and every subsequent recertification period.

Hospice Levels of Care

Routine Home Care (RHC): Core services of hospice interdisciplinary team provided at patient's home (place of residence)
Continuous Home Care (CHC): intended to support patient and their caregivers through brief periods of crisis. CHC provides care for 8-24 hours a day. ≥50% of care must be primarily provided by an LPN or RN. Home health aid or homemaker services can be used to cover the needs.
Inpatient Respite Care (IRC): short term care to provide relief to family/ primary caregiver. Limited to 5 consecutive days
General Inpatient Care (GIP): care provided in acute hospital or other setting with intensive nursing & other support outside of the home. For management of uncontrolled distressing physical symptoms (e.g. uncontrolled pain, respiratory distress, etc.) or psychosocial problems (e.g. unsafe home or imminent death when family can't cope at home)

Hospice Principal Diagnosis

Identify the condition that is the main contributor to the person's terminal prognosis. Non-specific diagnoses such as Debility or Adult Failure to Thrive (AFTT) may no longer be listed as a principal terminal diagnosis. Debility and AFTT can and should be listed as secondary (related) conditions to support prognosis if indicated.

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Palliative Care

Triage During the Pandemic | COVID-19

Terminal Illness: GENERAL (non-specific)

Terminal condition not attributed to a single specific illness.

AND

Rapid decline over past 3-6 months as evidenced by:
Progression of disease evidenced by sx, signs & test results
Decline in PPS to ≤ 50%
Involuntary weight loss >10% and/or Albumin <2.5 (helpful)

CANCER

Patient meets ALL of the following:

1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing symptoms worsening lab values and/or evidence of metastatic disease
2. Palliative performance Scale (PPS) ≤ 70%
3. Refuses further life-prolonging therapy OR continues to decline in spite of definitive therapy

Supporting documentation includes:
Hypercalcemia > 12
Cachexia or weight loss of 5% in past 3 months
Recurrent disease after surgery/radiation/chemotherapy
Signs and sx of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

Functional Assessment Scale (FAST) for Alzheimer's Type Dementia

1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances e.g. forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.*
6	Occasionally or more frequently over the past weeks. * for the following **A)** Improperly putting on clothes without assistance or cueing . **B)** Unable to bathe properly (not able to choose proper water temp) **C)** Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) **D)** Urinary incontinence **E)** Fecal incontinence
7	**A)** Ability to speak limited to approximately ≤ 6 intelligible different words in the course of an average day or in the course of an intensive interview. **B)** Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview **C)** Ambulatory ability is lost (cannot walk without personal assistance.) **D)** Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) **E)** Loss of ability to smile. **F)** Loss of ability to hold up head independently.

* Scored primarily on information obtained from a knowledgeable informant.

Palliative Performance Scale (PPS)

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days A	B	C
100	Full	Normal /No Disease	Full	Normal	Full	N/A	N/A	108
90	Full	Normal /Some Disease	Full	Normal	Full			
80	Full	Normal with Effort/ Some Disease	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job/work/ Some Disease	Full	Normal or Reduced	Full	145		
60	Reduced	Can't do hobbies/ housework /Significant Disease	Occasional Assistance Needed	Normal or Reduced	Full or Confusion	29	4	
50	Mainly sittle	Can't do any work /Extensive Disease	Considerable Assistance Needed	Normal or Reduced	Full or Confusion	30	11	41
40	Mainly in Bed	Can't do any work /Extensive Disease	Mainly Assistance	Normal or Reduced	Full /Drowsy/ Confusion	18	8	
30	Bed Bound	Can't do any work Extensive Disease	Total Care	Reduced	As above	8	5	
20	Bed Bound	Can't do any work / Extensive Disease	Total Care	Minimal sips	As above	4	2	6
10	Bed Bound	Can't do any work /Extensive Disease	Total Care	Mouth care only	Drowsy or Coma	1	1	
0	Death	-	-	-	--	--	--	--

A Survival post-admission to an inpatient palliative unit, all diagnoses (Virik 2002). B Days until inpatient death following admission to an acute hospice unit, diagnoses not specified (Anderson 1996). C Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1999).

DEMENTIA

The patient has both 1 and 2:
1. Stage 7C or beyond according to the FAST Scale
AND
2. One or more of the following conditions in the 12 months:
Aspiration pneumonia
Pyelonephritis
Septicemia
Multiple pressure ulcers (stage 3-4)
Recurrent Fever
Other significant condition that suggests a limited prognosis
Inability to maintain sufficient fluid and calorie intake in the past 6 months (10% weight loss or albumin < 2.5 gm/dl)

HEART DISEASE

The patient has 1 and either 2 or 3.
1. CHF with **NYHA Class IV* symptoms & both:**
Significant symptoms at rest
Inability to carry out even minimal physical activity without dyspnea or angina
2. Patient is optimally treated
(ie diuretics, vasodilators, ACEI, or hydralazine and nitrates)
3. The patient has angina pectoris at rest, resistant to standard nitrate therapy, and is either not a candidate for/or has declined invasive procedures.

Supporting documentation includes:
EF ≤ 20%, Treatment resistant symptomatic dysrythmias
h/o cardiac related syncope, CVA 2/2 cardiac embolism
H/o cardiac resuscitation, concomitant HIV disease

HIV/AIDS

The patient has either 1A or 1B and 2 and 3.
1A. CD4+ < 25 cells/mcL **OR** 1B. Viral load > 100,000
AND
2. At least one (1) : CNS lymphoma, untreated or refractory wasting (loss of > 33% lean body mass), (MAC) bacteremia, Progressive multifocal leukoencephalopathy
Systemic lymphoma , visceral KS, Renal failure no HD, Cryptospondium infection, Refractory toxoplasmosis
AND
3. PPS* of < 50%

LIVER DISEASE

The patient has both 1 and 2.
1. End stage liver disease as demonstrated by
A or B, & C:
A. PT> 5 sec
OR
B. INR > 1.5
AND
C. Serum albumin <2.5 gm / dl
AND
2. One or more of the following conditions:
Refractory Ascites, h/o spontaneous bacterial peritonitis, Hepatorenal syndrome , refractory hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documents includes:
Progressive malnutrition, Muscle wasting with decreased strength. Ongoing alcoholism (> 80 gm ethanol/day), Hepatocellular CA HBsAg positive, Hep. C refractory to treatment

PULMONARY DISEASE

Severe chronic lung disease as documented by 1, 2, and 3.
1. The patient has all of the following:
Disabling dyspnea at rest
Little of no response to bronchodilators
Decreased functional capacity (e.g. bed to chair existence, fatigue and cough)
AND
2. Progression of disease as evidenced by a recent h/o increasing office, home, or ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure.
AND
3. Documentation within the past 3 months ≥1:
Hypoxemia at rest on room air (p02 < 55 mmHg by ABG) or oxygen saturation < 88%
Hypercapnia evidenced by pC02 > 50 mmHg

Supporting documentation includes:
Cor Pulmonale and right heart failure.
Unintentional progressive weight loss

Equal Priority Resolution Process

- Pediatric patients <18
- First responders, HCWs
- Single caretakers for minors or dependent adults
- Pregnant patients
- Opportunity to experience life stages
  - Childhood
  - Young adulthood
  - Middle years
  - Older years

Conflict Resolution: Appeals

- Must be based on suspected error in calculating score
- Cannot be based on disagreement with criteria used
- If time allows, TO separate from first TO will rescore
- May involve additional triage “eyes” (CMO? ICU?)
- Decisions are final
- PEG-T takes responsibility

Ongoing Triage

- Under Contingency/Crisis everyone aware ICU is “trial”
- Ongoing discussions with family (“navigator)”)
- Transparency about allocation/reallocation possibilities
- Triage Scores and Color Groups calculated daily
- Triage applies to all patients: COVID and non-COVID

Allocation in Crisis: worst case scenario (could include withhold)

- Each patient has score graphed over time to see trends
- Awareness of catastrophic events
- Local ICU aware of patient scores
- ICU, ED, local TO, CMO connected re: available resources
- Daily (or more) decisions
  - Rank ICU patients
  - Match ranked priority to available resources to decide who gets a resource

Reallocation in Crisis: even worse (could include withdraw)

- Withdrawing and withholding are normally ethically equivalent
- They are NOT equivalent in triage (involuntary)
- Score does not change just due to continued use of scarce resource
- Extended time on vent is common/expected with COVID
- If patient not worse, single organ failure, generally continues vent
- Reallocation generally when
  - Patient worse over time
  - Devastating complication occurs
  - Multi-organ failure with poor prognosis
  - Another patient with much better score is waiting and will die without the resource

Banner Palliative Care

Comfort Care & Hospice Power Plan| Adult | Tip Sheet | General Notes

- Before initiating comfort care, verify patient's code status
  - These patients should be listed as a DNR/DNI

- Specific dosages are less important than the goal of symptom relief

- It may take higher than expected doses to achieve comfort

- Goal = comfort!
  - Keep the respiratory rate <20 and eliminate grimacing and agitation
  - Nonverbal signs of distress = restlessness, tachypnea, tachycardia, labored breathing, grunting, grimacing

- Appropriately titrated opioids and benzodiazepines are appropriate in relieving distress
  - Opiates are used to relieve breathlessness via the depression of opioid receptors found in the lungs, spinal cord, and central respiratory centers, including the medullary respiratory center
  - Benzodiazepines are conjointly used to relieve anxiety
  - Studies have shown that these therapies *do not hasten death* but effectively relieve the symptoms of breathlessness, anxiety, and pain

- Oxygen should be weaned based on comfort and not oxygen saturation levels

- Discontinue paralytics; do not use paralytic agents for withdrawal of life sustaining therapies

Signs of approaching end of life:

- Loss of radial pulse; mandibular movement during breathing; anuria; apneic pauses; Cheyne-Stokes breathing; loud and excessive oral secretions; non-reactive pupils; decreased response to verbal/visual stimuli; inability to close the eyelids; drooping of both nasolabial folds (face may appear more relaxed); neck hyperextension (head tilted back when supine); and grunting of vocal cords, chiefly on expiration; peripheral cyanosis; proximal mottling (e.g. knees)
- For end-of-life patients' alterations in respiration may be related to the dying process *and not* opioid induced respiratory depression

References available

Banner Palliative Care

Comfort Care Power Plan| Adult | Tip Sheet

Opioids:

For Opioid Naïve Patients:

- **Oral opioid analgesics**
  Use only in patients will be going home on hospice

- **Intravenous opioid analgesics**
  Check off one opioid. If symptoms are not controlled after 2 doses, see: For Opioid Tolerant Patients below on starting an infusion of basal opioid and bolus dose opioid

For Opioid Tolerant Patients:
Select one basal opioid infusion AND one bolus dose opioid

- Start the basal opioid infusion at 50% of an effective opioid bolus dose in mg/hr.
  - Example: If Morphine 8mg IVP relieved symptoms, start Morphine basal rate at 4mg/hour
- Patients need to be closely monitored by both physician and RN at the initiation of a basal opioid infusion to ensure comfort is achieved quickly
  - Assessment & documentation should occur every 30min x 2, then; every hour x 4, then; every 4 hours if stable
- If distress is witnessed immediately give a bolus dose. If bolus is ineffective after 2 doses, increase both the basal opioid infusion AND the bolus opioid dose by 50%
  - Example: Morphine 4mg/hr infusion is running. Morphine 8mg IVP given x2 and patient still has RR of 40. Increase Morphine continuous infusion by 50% to 6mg/hour. Increase bolus by 50% to 12mg IVP q15min prn
- Consider a consult to Palliative Medicine if the patient's symptoms are not well controlled

Sedative Anxiolytic:

- Choose one
- Benzodiazepines should be administered concurrently with opioids for relief of anxiety and breathlessness

References available

Banner Palliative Care

Comfort Care Power Plan| Adult | Tip Sheet

Gastrointestinal Medications

- ALWAYS check a bisacodyl suppository daily when opioids are ordered
- Only check one anti-nausea medication in awake patients with nausea/vomiting

Delirium

- Only check off in patients with severe agitated delirium

Sleep

- Only check off in patients who complain of difficulty sleeping

Miscellaneous Medications

- Dexamethasone – consider adding in patients with severe pain related to bone/liver/renal metastases, bowel obstructions, or increased intracranial pressure
- Glycopyrrolate – check off in patients with oral secretions

Laboratory

- Check off if COVID-19 lab test is pending

Consults:

- Check off hospice consult if patient's prognosis is days to weeks
- Consider a consult to Palliative Medicine if the patient's symptoms are not well controlled

References available

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Hospice Inpatient Power Plan| Adult | Tip Sheet

Opioids:

For Opioid Naïve Patients:

- **Intravenous opioid analgesics**
  - Check off one opioid with PRN dosing
  - If symptoms are not controlled after 2 doses, see: For Opioid Tolerant Patients below on starting an infusion of basal opioid and bolus dose opioid

For Opioid Tolerant Patients:

Select one basal opioid infusion AND one bolus dose opioid

- Start the basal opioid infusion at 50% of an effective opioid bolus dose in mg/hr.
  - Example: If Morphine 8mg IVP relieved symptoms, start Morphine basal rate at 4mg/hour
- Patients need to be closely monitored by both physician and RN at the initiation of a basal opioid infusion to ensure comfort is achieved quickly
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  - Example: Morphine 4mg/hr infusion is running. Morphine 8mg IVP given x2 and patient still has RR of 40. Increase Morphine continuous infusion by 50% to 6mg/hour. Increase bolus by 50% to 12mg IVP q15min prn

If at any time you have questions or are uncomfortable ordering please call Banner Hospice to speak to the physician or NP on call
We are here to help!
480.657.1100 | 24/7

References available

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Sedative Anxiolytic:

- Choose one
- Benzodiazepines should be administered concurrently with opioids for relief of anxiety and breathlessness

Delirium

- Check in patients with severe agitated delirium

Gastrointestinal Medications

- Bisacodyl suppository daily is pre-checked; DO NOT uncheck
- Check one anti-nausea medication in awake patients with nausea/vomiting

Miscellaneous Medications

- Glycopyrrolate – check off in patients with oral secretions
- Acetaminophen suppository for patients with fever

If at any time you have questions or are uncomfortable ordering please call Banner Hospice to speak to the physician or NP on call
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References available

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Goals of Care | Advance Care Planning Quick Text Template | Long Version

Advance Care Planning | Goals of Care
Date: _
Time In: _ Time Out: _
At least 16 minutes were spent today providing advance care planning. Total time spent providing information & discussion around advance care planning: _
Present & Involved in discussion today: _ (physician, staff, patient, family)

Does the patient have decision making capacity at the time of the goals of care conversation?
_ Yes
_ No
To have capacity, patients must be able to understand information, appreciate the situation and its consequences, reason about treatment options, and clearly communicate a choice. Capacity can fluctuate and is decision dependent.

Preference for receiving information
_

Patient and/or MPOA/Surrogate/Proxy Understanding of Illness
_

Prognosis (I wish…. I worry that….. I hope that….)
_

Goals
_ Live as long as possible no matter what
_ Be mentally aware
_ Be physically comfortable
_ Be independent
_ Not be a burden
_ Have medical decisions respected
_ Be emotionally and spitiually at peace
_ Reach a particular goal _
_ Other _

Fears & worries about the future with your health?
_ Pain
_ Other symptoms (shortness of breath, anxiety, restlessness, etc)
_ Loss of dignity
_ Loss of control
_ Finances
_ Burden to others
_ Spiritual distress
_ Getting unwanted treatments
_ Family concerns
_ Loss of ability to care for others (significant other, children, etc)

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What is/are your source(s) of strength?
_

Critical Abilities
_ Being conscious
_ Being able to care for myself (Activities of Daily Living)
_ Being able to interact with others
_ Being able to be myself
_ Other _

Tradeoffs (If you become sicker, how much are you willing to go through for the possibility of gaining more time?)
_ Resuscitation (compressions, shock, medications)
_ Pacemaker and/or AICD
_ Intubation (breathing machine)
_ Feeding tube or artificial nutrition
_ Dialysis
_ Hospitalization
_ Nursing Home
_ Blood transfusions
_ IV Fluids/Hydration
_ Antibiotics

Family (How much does your family know about your priorities & wishes?)
_

Advance Directive: _
MPOA: _
Surrogate/Proxy: _
Code Status Pre-Conversation: _

At the patient/family request and with permission, I discussed advance care planning and written directives including a living will and medical power of attorney. I reviewed their importance to the patient's care. I educated that the MPOA comes into effect only when the patient cannot communicate their wishes. It then becomes the responsibility of the MPOA to make the best substituted judgement (what the patient would say could they speak for themselves) and communicate the patient's wishes, values, and preferences for treatment.
Discussed at length today about the patient's condition, diagnosis, illness trajectory, symptoms, treatment options, goals of care, quality of life, and overall prognosis. Explained what Palliative Medicine is and how it can support through serious illness. Explained what Hospice Medicine is, it's philosophy of care, and the levels of care within hospice.

Reviewed & discussed code status.
Code Status Post-Conversation: _
Order updated in Cerner: _ (yes; no; n/a)
I've heard you say that _ is important to you. Keeping that in mind, and what we know about your illness, I recommend that we _. This will help us make sure that your treatment plans reflect what's important to you.

Banner Palliative Care

Advance Care Planning
Quick Text Template | Short Version

Advance Care Planning
Date: _
Time In: _ Time Out: _
At least 16 minutes were spent today providing advance care planning. Total time spent providing information & discussion around advance care planning: _
Present & Involved in discussion today: _ (physician, staff, patient, family)

Does the patient have decision making capacity at the time of the goals of care conversation?
_ Yes
_ No
To have capacity, patients must be able to understand information, appreciate the situation and its consequences, reason about treatment options, and clearly communicate a choice. Capacity can fluctuate and is decision dependent.

Advance Directive: _
MPOA: _
Surrogate/Proxy: _
Code Status Pre-Conversation: _

At the patient/family request and with permission, I discussed advance care planning and written directives including a living will and medical power of attorney. I reviewed their importance to the patient's care. I educated that the MPOA comes into effect only when the patient cannot communicate their wishes. It then becomes the responsibility of the MPOA to make the best substituted judgement (what the patient would say could they speak for themselves) and communicate the patient's wishes, values, and preferences for treatment. Discussed at length today about the patient's condition, diagnosis, illness trajectory, symptoms, treatment options, goals of care, quality of life, and overall prognosis. Explained what Palliative Medicine is and how it can support through serious illness. Explained what Hospice Medicine is, it's philosophy of care, and the levels of care within hospice.

Reviewed & discussed code status.
Code Status Post-Conversation: _
Order updated in Cerner: _ (yes; no; n/a)

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Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services

This document answers frequently asked questions about billing advance care planning (ACP) services to the Physician Fee Schedule (PFS) under CPT codes 99497 and 99498 beginning January 1, 2016.

CPT Code 99497- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT Code 99498- each additional 30 minutes (List separately in addition to code for primary procedure)

1. CPT codes 99497 and 99498 are time-based codes (a base code and an add-on code). Are there minimum amounts of time required to bill these codes?

In the calendar year (CY) 2016 PFS final rule (80 Fed. Reg. 70956), we adopted the CPT codes and CPT provisions regarding the reporting of timed services. Practitioners should consult CPT provisions regarding minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member(s) and/or surrogate to bill CPT codes 99497 or 99498, the practitioner may consider billing a different evaluation and management (E/M) service such as an office visit, provided the requirements for billing the other E/M service are met.

2. Are there limits on how often I can bill CPT codes 99497 and 99498?

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

3. In what settings can ACP services be provided and billed- Inpatient? Nursing home? Other?

There are no place of service limitations on the ACP codes. As we stated in the CY 2016 PFS final rule (80 Fed. Reg. 70956), ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary. The codes are separately payable to the billing physician or practitioner in both facility and nonfacility settings and are not limited to particular physician specialties.

4. Who can perform ACP services?

As we said in the CY 2016 FPS final rule (80 Fed. Reg. 70956), the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician. The CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore, only these practitioners may report CPT codes 99497 or 99498. The ACP services described by these codes are primarily the provenance of patients and physicians; accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision. The usual PFS payment rules regarding "incident to" services apply, so that when the services are furnished incident to the billing physician or practitioner all applicable state law and scope of practice requirements must be met and there must be a minimum of direct supervision in addition to other incident to rules.

5. Can ACP services be furnished without beneficiary consent?

Since ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services. Beneficiaries, family members and/or surrogates may receive assistance for completing legal documents from others outside the scope of the Medicare program in addition to, or separately from, the physician or NPP.

6. What must be documented for the service?

Practitioners should consult their Medicare Administrative Contractors (MACs) regarding documentation requirements. Examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter.

7. Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

8. Can ACP be reported in addition to an E/M service (e.g., an office visit)?

CMS adopted the CPT codes and CPT provisions regarding the reporting of CPT 99497 and 99498 (see #1). This includes the CPT instructions that CPT codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods. CMS also adopted the CPT guidance prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.

9. What diagnosis must be used?

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an ICD-10-CM code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV)