<table>
<thead>
<tr>
<th>Time (MT)</th>
<th>Presentation</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 1:05 pm</td>
<td>Welcome, Announcements, Introductions</td>
<td>Lachelle Smith, Director, ECHO Idaho</td>
</tr>
<tr>
<td>1:05 – 1:10 pm</td>
<td>Idaho Epidemiology Curves and Public Health Updates</td>
<td>Carolyn Buxton Bridges, MD FACP</td>
</tr>
<tr>
<td>1:10 – 1:30 pm</td>
<td>COVID-19: Advance Care Planning, End-of-Life, &amp; Palliative Care</td>
<td>Jessica Evert, MD</td>
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<td>Gail Vasquez, LCSW</td>
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<td>JD Henry, MDiv, Lead Chaplain</td>
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<td>Gail Vasquez, LCSW</td>
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<tr>
<td>1:30 – 1:55 pm</td>
<td>Patient Case Review and Q&amp;A</td>
<td>Jessica Evert, MD</td>
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<td>JD Henry, MDiv, Lead Chaplain</td>
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<td>Gail Vasquez, LCSW</td>
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<td>Andrea Christopher, MD MPH</td>
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<td>Megan Dunay, MD MPH</td>
</tr>
<tr>
<td>1:55 – 2:00 pm</td>
<td>Closing, Announcements, Call to Action</td>
<td>Megan Dunay, MD MPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lachelle Smith, Director, ECHO Idaho</td>
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</table>
COVID-19: Advance Care Planning, End-of-Life, & Palliative Care

April 10, 2020

Jessica Evert, MD
JD Henry, MDiv
Gail Vasquez, MSW LCSW

Carolyn Buxton Bridges, MD FACP
Andrea Christopher, MD MPH
Megan Dunay, MD MPH
Idaho Epidemiology Curves and Public Health Updates

Carolyn Buxton Bridges, MD, FACP
Governor’s Coronavirus Working Group, Former CDC Public Health Physician and Researcher
At least 127 (9.4%) hospitalized
At least 33 (2.4%) ICU, 26% of hospitalized in ICU
At least 143 (10.6%) healthcare personnel

https://coronavirus.idaho.gov
Idaho Stay-at-Home order started on March 25.

To be re-assessed before April 15.
SARS-CoV-2 PCR Testing in Idaho

• 73% increase in testing at commercial labs in 7 days.

• Reminder of high priority for IBL
  • Hospitalized patients
  • Symptomatic healthcare workers
  • Symptomatic patients in long-term care facilities

• Non-symptomatic/non-COVID-19 hospitalized patients that can transfer to LTCF are not high priority (e.g. hip fracture patient going to inpatient rehab)


<table>
<thead>
<tr>
<th>Date</th>
<th>Number of people tested through the Idaho Bureau of Laboratories (IBL)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/30</td>
<td>1,567</td>
</tr>
<tr>
<td>4/2</td>
<td>1,851</td>
</tr>
<tr>
<td>4/6</td>
<td>2,263</td>
</tr>
<tr>
<td>4/9</td>
<td>2,571</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of people tested through commercial laboratories**</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/30</td>
<td>4,145</td>
</tr>
<tr>
<td>4/2</td>
<td>6,094</td>
</tr>
<tr>
<td>4/6</td>
<td>8,983</td>
</tr>
<tr>
<td>4/9</td>
<td>10,523</td>
</tr>
</tbody>
</table>
Serologic (antibody) Testing

- First antibody/serologic test (Cellex, Inc.) with Emergency Use Authorization (EUA) from FDA.
- Moderate or high complexity CLIA-certified labs.
- Use of tests without an EUA not recommended.
- Seroconversion SARS-CoV-2 estimated 7-11 days after illness onset.
- Caveat - should not be used alone for Dx
- Help estimate population immunity

<table>
<thead>
<tr>
<th>Source of patients’ serum</th>
<th>No.</th>
<th>IgM/IgG +</th>
<th>IgM/IgG -</th>
<th>Sensitivity/specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR-positive with mild or no Sx</td>
<td>98</td>
<td>91</td>
<td>7</td>
<td>91/98=93%</td>
</tr>
<tr>
<td>Serum pre-Sept 2019</td>
<td>180</td>
<td>6</td>
<td>174</td>
<td>174/180=96.6%</td>
</tr>
<tr>
<td>Clinically ill probable COVID-19</td>
<td>30</td>
<td>29</td>
<td>1</td>
<td>29/30=96.6%</td>
</tr>
<tr>
<td>Serum pre-Sept 2019</td>
<td>70</td>
<td>5</td>
<td>65</td>
<td>65/70=93%</td>
</tr>
</tbody>
</table>

Cellex Package insert: Negative Percent Agreement (NPA)= 96.0% (CI 92.8-97.8%)
Positive Percent Agreement (PPA): 93.8% (CI 88.2-96.8%)

https://mbio.asm.org/content/11/2/e00722-20/article-info
Theoretical Example of Antibody Response Relative to Viral Shedding

- **Pre-symptomatic**
  - Antibody - / PCR +/- Infectious

- **Symptomatic**
  - Antibody - /PCR + Infectious

- **+/− Symptomatic**
  - Antibody + / PCR + Infectious

- **No symptoms**
  - Antibody + / PCR − Not infectious

CDC Guidance Updates – Practically TNTC

• Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19

  • Published 4/8/2020
  • Includes first responders, hazard chemical responders, law enforcement, custodial staff, food and agriculture, critical manufacturing, informational technology, transportation, energy and government facilities
  • May continue to work after exposure BUT ...
    • Wear mask at all times
    • Screen for illness and fever daily before work
    • Frequently clean surfaces
    • Social distancing as permitted
    • Increase air exchange in building
    • Don’t congregate during breaks

Deadliness of COVID-19 vs. the seasonal flu

Chart compares COVID-19 mortality rate from China with seasonal flu mortality in the United States by age group.

Seasonal flu

- 0.004% (0-17 years)
- 0.02% (18-49 years)
- 0.06% (50-64 years)
- 0.8% (65+ years)

COVID-19

- 0.1% (0-19 years)
- 0.3% (20-49 years)
- 1.3% (50-59 years)
- 6% (60+ years)


Graphic by David H. Montgomery | MPR News

Coronavirus disease 2019 (COVID-19) hospitalizations, intensive care unit (ICU) admissions, and deaths, by age group — United States, February 12–March 16, 2020

COVID-19 Mortality & Morbidity
What happens when people get really sick?

- Broad spectrum of disease (asymptomatic [25%], mild, moderate, severe, critical)
- Increased risk of severe disease/mortality with age and co-morbidities (DM, HTN, CAD, ESRD)
- People who get really ill tend to do so between day 5-8 of symptoms, initially a respiratory decompensation and then can improve and later develop multi-organ failure/cardiogenic shock.
- Not utilizing usual interventions short of intubation – moving from nasal cannula oxygen/FM to intubation (generally avoiding high flow oxygen, positive pressure ventilation/CPAP/BIPAP).
Degree of Respiratory Failure in US-Based Adult ICU Patients with COVID-19

- No ARDS: 5%
- Mild/Moderate ARDS: 38%
- Severe ARDS: 57%

81% of hospitalized patients required ICU level care; 71% of those admitted required intubation.

100% of intubated patients developed ARDS

What happens when people get really sick?

- 67% mortality rate in those admitted to ICU, 52% of those admitted to hospital.
- Common to be intubated for 7-14 days (much longer than usual viral illness/COPD/CAP)
- Hospital experience is particularly isolating/debilitating (no visitors, limited PT/OT/speech consults if at all, everyone in PPE, telehealth visits by physicians/others)
- A sub-set are prone which has unique implications for comfort level and ability to do CPR/resuscitation
- Death usually from ARDS or multi-organ failure (with cardiogenic shock in a sub-set)
How do we as a health system and individual providers approach this disease focusing on palliative care, advance care planning, and end-of-life?
Before a patient ever gets COVID...

- Can primary care/pulm/cardiology/nephrology/others have proactive conversations with patients with high risk of severe disease, including pre-existing COPD/asthma, ESRD, cancer, poorly controlled DM, severe cardiac disease (utilize phone/telehealth when possible)?
- Conversations with providers who patient’s know have unique relevance and impact compared to hospital-based providers without existing relationship.
- Encouraging strict social distancing and strategizing to facilitate with patients and with office staff/med refill process/etc.
- Define surrogates for anyone who lacks capacity.
# Idaho Physician Orders for Scope of Treatment (POST)

**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT**
- This form must be signed by an authorized practitioner in Section E to be valid.
- If any section is NOT COMPLETE provide the most comprehensive treatment in that section.
- EMS: If questions arise contact on-line Medical Control.

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Date of birth</th>
<th>Last four digits of SS #</th>
</tr>
</thead>
</table>

- **Cardiopulmonary Resuscitation:** Patient is not breathing and/or does not have a pulse
- **1. Do Not Resuscitate:** Allow Natural Death (No Code/DNR/DNAR): No CPR or advanced cardiac life support interventions
- **2. Resuscitate (Full Code):** Provide CPR (artificial respirations and cardiac compressions, defibrillation, and emergency medications as indicated by the medical condition)

**Additional resuscitation instructions:**

<table>
<thead>
<tr>
<th>Section</th>
<th>A</th>
<th>Select 1 OR 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Interventions: Patient has a pulse and is breathing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- **Comfort measures only:** Use medications by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suctioning and manual treatment of airway obstruction. Reasonable measures are to be made to offer food and fluids by mouth. **Transfer to higher level of care only if comfort needs cannot be met in current location.**
- **Limited additional interventions:** In addition to the care described above, you may include cardiac monitoring and oral/IV medications. **Transfer to higher level of care (e.g. from home to hospital)** and provide treatment as indicated in Section A. Do not admit to Intensive Care.
- **Aggressive interventions:** In addition to the care described above and in Section A, you may include other interventions (e.g. dialysis, ventricular support).

<table>
<thead>
<tr>
<th>Section</th>
<th>C</th>
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<tbody>
<tr>
<td>Artificial Fluids and Nutrition:</td>
<td></td>
</tr>
</tbody>
</table>
- Yes
- No Feeding tube
- Yes
- No IV fluids

| Antibiotics and blood products: |
|---|---|---|
| Yes | No Antibiotics |
| Yes | No Blood products |

**Other instructions:**

---

**ECHO IDAHO**

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Pearls on code status conversations

• Start with patient values and how they derive quality of life, rather than jumping into if they want CPR/resuscitation. (Asking what gives life meaning, what type of functional status they are used to/enjoy, and level of interaction that brings quality of life)

• Avoid language like “Do you want us to do everything” “save you” “bring you back to life”

• Consider language like “if your heart stops or you stop breathing would you want us to focus on comfort/peace or attempt to restart it with compressions, medications, and putting tube down your throat to help you breath. Are you someone who has preferences about that? I want to make sure I am respecting your preferences.”
Pearls on code status conversations

• Ascertain info on how long they would be ok with and under what circumstances they would want to remain on artificial life support. “If you require life support/machines, are you someone who would want to a trial for a period of days, or would you want to be maintained for weeks to months on machines.”

• Can have “modified” code to limit to just medication, only intubation, no compressions, or other preference
Once a patient gets COVID-19 and isn’t severely ill...

• Embed palliative care consultation in emergency room (if resources allow)
• “Required” palliative care consults for hospitalized patients when resources allow
• PCP/specialists with existing relationship reach out to hospitalized patients to discuss code status and connect with hospitalists/intensivists.
• Proactive conversation with all admissions 65+ with pre-existing disease, particularly if do not have a pre-existing DNR/DNI.
3 avenues to DNR decision

- Patient/surrogate clearly understand and communicate decision in real time or via POST.
- Patient/surrogate follow recommendation of provider to forgo CPR/resuscitation, either informed consent or informed assent.
- CPR is deemed non-beneficial and clinicians unilaterally decide DNR is medically appropriate (2 clinicians in Idaho).


Unique considerations with COVID-19 include risk to healthcare workers during resuscitation, scarce resources, and extremely poor prognosis in certain situations.
88 yo F HTN, CAD, DM pre-hospital DNR/DNI presents with fever, shortness of breath, requiring 15L of oxygen, COVID-19 positive, has been in hospital for 5 days, NPO, no visitors, and worsening mental status. Daughter is calling nursing station 10 times a day for updates, physician is calling her daily, she is increasingly distressed, tearful, and anxious about her mother.
SOCIAL WORK IN PALLIATIVE CARE

NASW STANDARDS FOR PALLIATIVE AND END OF LIFE CARE:

• ETHICS AND VALUES
• KNOWLEDGE
• ASSESSMENT
• INTERVENTION/TREATMENT PLANNING
• ATTITUDE/SELF AWARENESS
• EMPOWERMENT AND ADVOCACY
• DOCUMENTATION
• INTERDISCIPLINARY TEAMWORK
• CULTURAL COMPETENCY
• CONTINUING EDUCATION
• SUPERVISION/LEADERSHIP/TRAINING
TOP 10 Key Tasks for Palliative Social Workers:

Results of a 2019 nationwide hospice and palliative care social work job analysis designed for development of an evidence-based certification exam. 482 social workers across 46 states responded.

• Perform psychosocial assessment from a patient/family centered care perspective.
• Assessment of patient’s current and desired quality of life
• Assessment of patient’s coping skills
• Assessment of family/caregiver coping
• Identify support systems
• Provide emotional support
• Facilitate communication among patient/family caregivers and team members.
• Advocate for patient-entered care within interdisciplinary team
• Provide individual/family counseling to assist the patient/family to cope with suffering
• Educate patient/family/caregivers regarding advance health care directives

COVID-19 CONSIDERATIONS FOR GRIEF

ANTICIPATORY GRIEF: A feeling of grief occurring before an impending loss. Typically, the impending loss is the death of someone close due to illness.

PREPARATORY GRIEF: A feeling of grief a patient at end of life undergoes to prepare themselves for death.

COMPLICATED GRIEF: has been defined as a deviation from the normal (in cultural and societal terms) grief experience in either time course, intensity, or both, entailing a chronic and more intense emotional experience or an inhibited response, which either lacks the usual symptoms or in which onset of symptoms is delayed.

Due to visitation restrictions at hospitals and most long-term care facilities people are isolated from friends and families. Those that typically cope through socialization are unable due to social distancing and stay in place orders. Often family members in the same household are sick as well making it difficult to take patients home for end of life care.
84 M unknown PMH found down at home, house disheveled, 4 dogs with feces everywhere, patient is cachectic with confusion, fever to 39.2, hypoxia and infiltrates on CXR. Patient not oriented and initially difficult to arouse. No POST seen by EMS. Diagnosed with COVID-19 and possible aspiration PNA, found to have stigmata of COPD, CKD, and malnutrition.

A niece is located who says patient has been losing his memory for years, has avoided doctors/hospitals/medications, was fiercely independent and wanted to always be on his own. She has never spoken to him about his advance care wishes/planning.

Patient has worsening respiratory status, renal failure, and heart failure/shock. Physicians are considering whether he would want intubation or intubation should be considered. Patient is refusing lab draws, requiring restraints to not pull off oxygen, and is telling nursing to “leave me alone.” Niece is willing to help make decisions but wants the doctors to tell her what they think should happen.
How can we make decisions on behalf of an incapacitated person?

“Substituted Judgment” is the principle of decision making that requires implementation of the course of action which comports with the incapacitated person’s wishes expressed prior to their incapacitation.

“Reasonable Person Standard” is utilizing what a reasonable person would want/consent to in such circumstances as the incapacitated person.
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72 yo F with HTN metastatic lung cancer on palliative chemotherapy develops diarrhea she thought was from chemo, then has fever and chest pain. She has become increasingly weak and presents to the emergency room. She is found to be hypoxic, with lymphopenia, and presumptively diagnosed with COVID-19. She is too weak to walk or get out of bed on her own. The admitting PA discusses goals of care and code status. She does not have an advanced directive. Her main goal is to keep doing chemo for her cancer.
Next Week- Submit Clinical Questions Online

Next week’s Idaho’s COVID-19 patient cases are expected to peak. In response, ECHO Idaho’s COVID-19 sessions on **Tuesday, April 14 (COVID-19 Case Conversations: Inpatient and Critical Care)** and **Friday, April 17 (COVID-19 Case Conversations: Outpatient/ED)** are dedicated entirely to attendee questions – no didactic presentations. Send us your clinical and patient case questions today so that our panelists can prioritize responding to YOU.

Submit your Questions
https://www.uidaho.edu/academics/wwami/echo/covid-19/clinical-question-form