CAPTURING THE OPPORTUNITY- ADVANCED CARE PLANNING IN THE TIME OF COVID

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FINANCIAL DISCLOSURES

- NONE

CAPTURING THE OPPORTUNITY- ADVANCED CARE PLANNING IN THE TIME OF COVID-19

The importance of goal-concordant care is not new or even substantially different in the context of this pandemic, but the importance of providing goal-concordant care is now heightened in several ways.

J Randall Curtis JAMA Opinion March 10, 2020

GOALS OF CARE (OBJECTIVES)
UPON COMPLETION OF THIS ACTIVITY, PARTICIPANTS WILL BE ABLE TO

- Review the differences of **advance directives versus advance care planning** in the setting of a pandemic or serious illness
- Assess how **advanced care planning** discussions can ensure therapies match a patient's healthcare goals when facing serious illness
- Outline a facilitated advance care planning conversation including how to respond to the emotions surrounding the conversations

EVERY FAMILY HAS A STORY

90% of people say that talking with their loved ones about end-of-life care is important.

but

27% have actually done so.

Source: The Conversation Project National Survey 2013.

82% of people say it's important to put their wishes in writing

but

23% have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012)

60% of people say that making sure their family is not burdened by tough decisions is "extremely important"

but

56% have not communicated their end-of-life wishes

Source: Centers for Disease Control (2005)

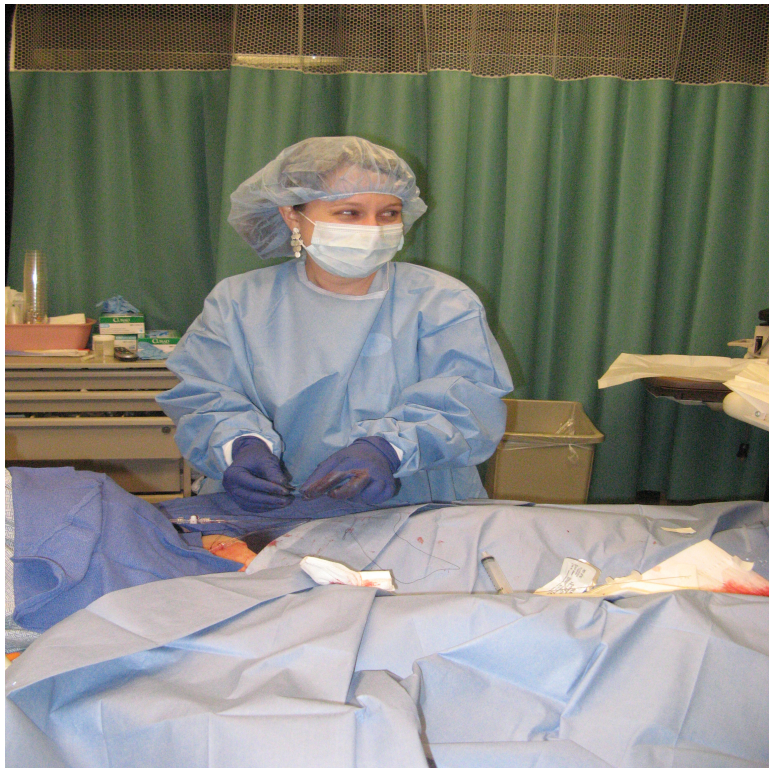
	For patients with HIV the prevalence of ACP is even lower
8% - 47%	The completion rate of advance directives in 4 studies
7.6%	Completed advance directives prior to hospital admission

SANGARLANGKARN, A. ET AL. TOPICS IN ANTIVIRAL MEDICINE VOL 23 ISSUE 5 2015

MS. M HAS END STAGE COPD AND HIV

- 72 YO
- LIVES INDEPENDENTLY WITH HER HUSBAND
- NO CHILDREN OR EXTENDED FAMILY
- APPOINTMENT WITH PCP IN ID CLINIC EVERY 6 MONTHS
- APPOINTMENT WITH PULMONOLOGY YEARLY
- 3 HOSPITALIZATIONS IN LAST YEAR FOR COPD
- PALLIATIVE CARE WAS CONSULTED ON 3rd HOSPITALIZATION FOR "GOALS OF CARE" DURING AN ADMISSION FOR COVID LIKE SYMPTOMS

OUR PROCEDURE IS THE "GOALS OF CARE" TALK (COMPLEX MEDICAL DECISION MAKING)



- ""I have had these diseases for years… but this COVID thing is scary"
- "I've never asked my doctors about the future"
- "My husband and I have never talked about the what ifs"
- "My husband is my decision maker if I need one"

WHO WAS RESPONSIBLE FOR DISCUSSING THE FUTURE WITH MRS. M?

CURTIS JR, PATRICK DL, CALDWELL E, GREENLEE H, COLLIER AC. THE QUALITY OF PATIENT-DOCTOR COMMUNICATION ABOUT END-OF-LIFE CARE: A STUDY OF PATIENTS WITH ADVANCED AIDS AND THEIR PRIMARY CARE CLINICIANS. AIDS. 1999;13(9):1123-1131.

THERE ARE FEW STUDIES OF ADVANCE CARE PLANNING IN PATIENTS INFECTED WITH HIV BUT WE KNOW A FEW THINGS

- Fewer than one third of patients with end-stage medical diagnoses reported discussing end-of-life (EOL) preferences with physicians
- Patients with HIV:
  - The majority of AD are completed in inpatient settings when very ill (7.6% OUTPATIENT)
  - Physicians over estimate the quality of the conversations had
  - Higher satisfaction with communication results in higher completion of advance directives

1990 PATIENT SELF DETERMINATION ACT POPULARIZED ADVANCE DIRECTIVES

THERE ARE A VARIETY OF DOCUMENTS THAT HELP EXPLAIN THE TYPE OF CARE A PATIENT WANTS

- DURABLE POWER OF ATTORMEY FOR HEALTH CARE (HCPOA)

  ANY LEGAL ARRANAGEMENT FOR A SPECIFIC PERSON OR PERSONS TO MAKE DECISIONS ABOUT YOUR MEDICAL CARE OR TREATEMNT IF YOU CAN NOT MAKE DECISIONS FOR YOURSELF

- ADVANCE DIRECTIVE

  A FORM THAT SUMMARIZES PREFERENCES FOR LIFE SUSTAINING TREATMENT IN THE EVENT ONE LOSES DECISIONAL CAPACITY AND REQUIRES MEDICAL CARE

- LIVING WILL

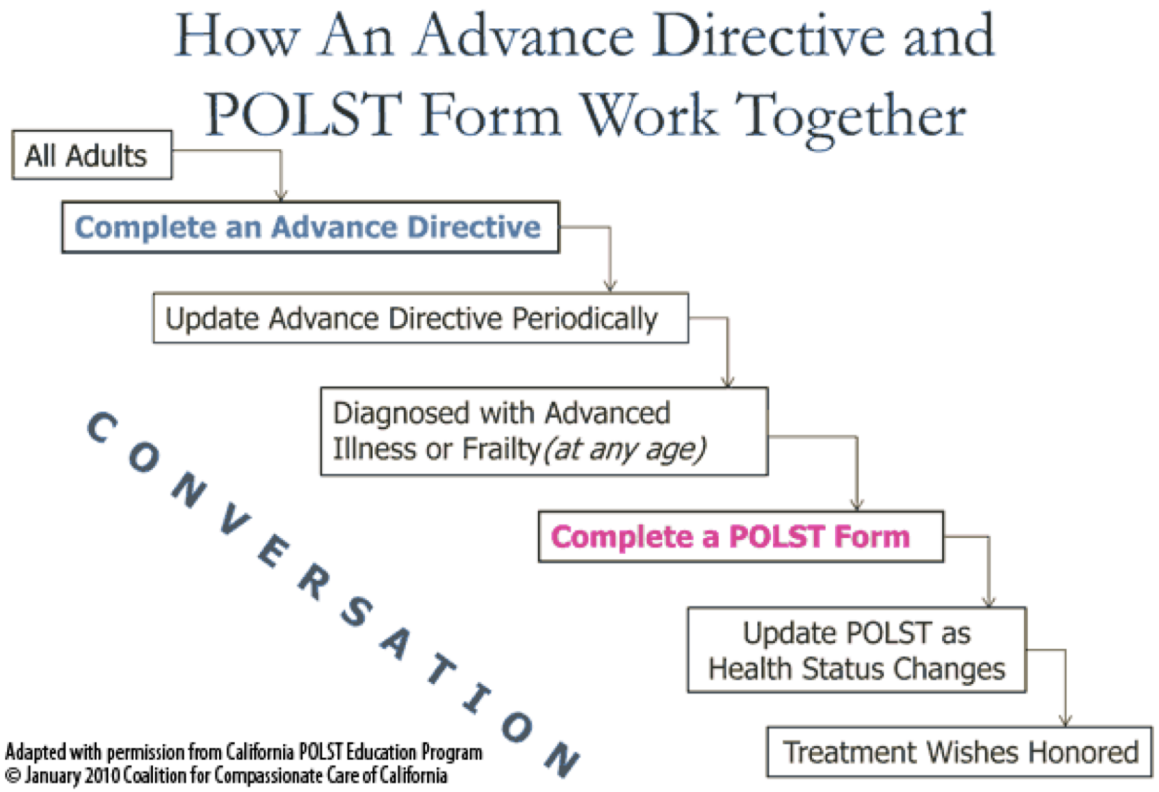
  WRITTEN INSTRUCTIONS ABOUT THE TREATMENT OR CARE YOU WANT TO RECEIVE DURING THE FINAL DAYS OF LIFE INCLUDING NAMING A SURROGATE

- MEDICAL ORDERS OF CARE

  CODE STATUS

  MOST/POLST FORM

LEGAL AND MEDICAL FORMS CAN WORK TOGETHER



MOST

Medical Orders for Scope of Treatment

This document is based on this person's medical condition and wishes. Any section not completed indicates a preference for full treatment for that section.

Patient's Last Name:	Effective Date of Form: _____ Form must be reviewed at least annually
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A
Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING.

❑ **Attempt Resuscitation (CPR)** ❑ **Do Not Attempt Resuscitation**

When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.

Section B
Check One Box Only

MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING.

❑ **Full Scope of Treatment**: Use intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, IV fluids, and provide comfort measures. **Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures.**

❑ **Limited Additional Intervention**: Use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments.**

❑ **Comfort Measures**: Keep clean, warm and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in the patient's current location (e.g. hip fracture).**

Other Instructions _____

Section C
Check One Box Only

ANTIBIOTICS

❑ **Antibiotics if indicated for the purpose of maintaining life**
❑ **Determine use or limitation of antibiotics when infection occurs.**
❑ **Use of antibiotics to relieve pain and discomfort.**
❑ **No Antibiotics (use other measures to relieve symptoms).**

Other instructions: _____

Section D
Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: the provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631.

❑ **Long term IV fluids if indicated**
❑ **IV fluids for a defined trial period. Goal:** _____
❑ **No IV fluids** (provide other measures to ensure comfort)

❑ **Long term feeding tube if indicated**
❑ **Feeding tube for a defined trial period. Goal:** _____
❑ **No feeding tube**

Special instructions _____

Section E
Check The

Patient Preferences as a Basis for This MOST Form:

❑ Adult Patient with decisional capacity
❑ Parent/guardian of minor patient
❑ Surrogate per advance directive
❑ Spouse
❑ Majority of patient's reasonably available adult children
❑ Parent

ADVANCE DIRECTIVES ARE ASSOCIATED WITH BENEFITS TO PATIENTS

- Enhanced goal-concordant care
  - Presence of DNR on AD does reduce CPR use and increase hospice use
  - Present of a DNH does reduce subsequent hospitalizations and increase hospice use
- Increased likelihood that clinicians and families understand and comply with wishes
- Improved quality of life
- Higher patient satisfaction with communication and reports of knowing what to expect
- More and earlier hospice care

TEMO J AM GERIATR SOC 2007
BRINKMAN-STOPPELENBURG, RIETJENS, VAN DER HEIDE PALLAIT MED 2014
BLOCK, SUSAN CAPC

BEREAVED FAMILY MEMBERS INTERVIEW SHOW COMPLETION OF AN ADVANCE DIRECTIVE IS ASSOCIATED WITH IMPROVED QUALITY MARKERS OF END OF LIFE CARE

Characteristic	Advance Directive Reported	No Advance Directive Reported	*P*-value
Sample size, actual (weighted)	1,130 (1,367,560)	423 (565,632)	
Location of care, %			
Last place of care*			<.001
Home, with no formal services	8.7	16.8	
Home with visiting nurse	3.6	3.6	
Home with hospice	18.5	10.1	
Nursing home	35.2	20.3	
Hospital	34.0	49.2	
Died in an intensive care unit	11.8	22.0	.002
Processes of care, %			
Respirator during last month of life, %	25.6	36.7	.005
Feeding tube during last month of life, %	17.3	26.8	.002
Length of time in hospice, mean number of days	48.7	59.3	.55
Decision-making about life-sustaining treatment, %			
Patient had specific wishes for care	72.4	32.1	.002

BEREAVED FAMILY MEMBERS INTERVIEW SHOW COMPLETION OF AN ADVANCE DIRECTIVE IS ASSOCIATED WITH IMPROVED SATISFACTION OF END OF LIFE CARE

Perception of Quality of Care and Satisfaction	Advance Directive Reported	No Advance Directive Reported	Adjusted Relative Risk (95% Confidence Interval)*
Assessment of quality within each domain of model of patient-centered, family-focused care			
Promoting shared decision-making, %			
One or more concerns with physician communication about decision-making among those who had contact with their physician	19.7	32.2	1.4 (1.1–1.6)
Respectful treatment, %			
Patient was not always treated with respect at last place of care	20.9	20.9	1.1 (0.8–1.3)
Attending to family needs for information, %			
One or more concerns with family needs for information about what to expect while dying	39.4	53.6	1.2 (1.0–1.3)
Attending to family needs for emotional support, %			
One or more concerns with family needs for emotional support	33.6	37.1	1.0 (0.7–1.3)
Overall quality of care			
Overall assessment of satisfaction with end-of-life care on 50-point scale (higher score implies higher satisfaction)	41.2	39.8	1.3 (−0.7–3.3)

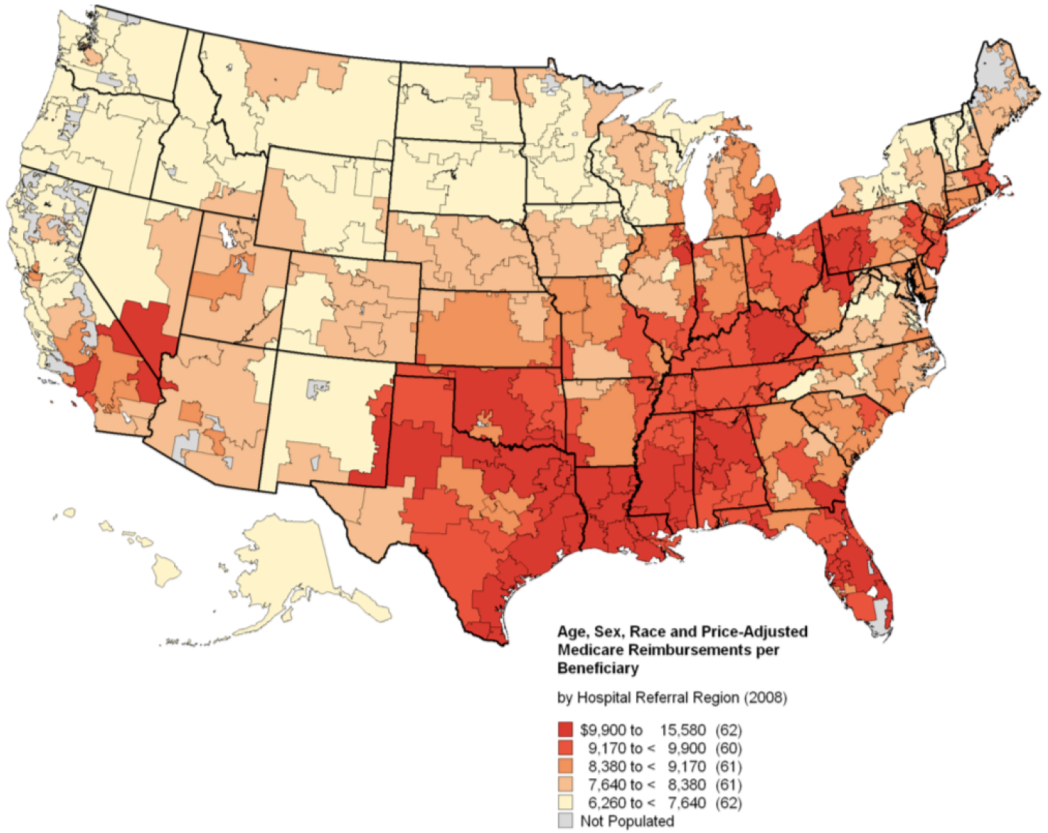
ADVANCE DIRECTIVES ARE ASSOCIATED WITH MEASUREABLE BENEFITS TO FAMILIES

- Eased burden of decision-making for families
- Better patient and family coping
- Family preparation on what to expect
- Improved bereavement outcomes - less risk of stress, anxiety and depression

DETERING BMJ 2010; ZHANG ANNALS 2009, WRIGHT 2008 JAMA
BLOCK, SUSAN CAPC

ADVANCE DIRECTIVES ARE ASSOCIATED WITH MEASUREABLE BENEFITS TO HEALTH SYSTEMS

- Reduced moral distress among health care providers
- Reduced cost of end of life care without increasing mo
- Specifically AD reduce costs of end of life care in high spending regions



ELPERN AM J CRIT CARE 2005; WRIGHT JAMA 2008; CHIARCHIARO AATS 2015; DETERING BMJ 2010; ZHANG ANNALS 2009
BLOCK, SUSAN CAPC

ADVANCE DIRECTIVE COMPLETION IS NOT ENOUGH TO IMPROVE END OF LIFE CARE

- 70 % of older adults have completed these, but only 37% of all adults
- Black and Latino patients are less likely than Whites to complete Advance Directives (regardless of desire for aggressive care)
- Older adults with lower levels of education, income, assets, and home ownership rates are less likely than their more advantaged counterparts to do formal directives
- Documented ACP discussions with health care providers lag behind rate of completions of AD

PATIENTS WITH HIV HAVE EVEN GREATER BARRIERS TO ADVANCED DIRECTIVE COMPLETION

- Prognostication has become more difficult as new therapies emerge and knowledge base grows
- HIV related stigma results in limited social support and isolation
- Support networks may shrink due to HIV related death and debility
- Emergent care decisions or end of life care decisions may fall to family members who may be unaware of serostatus or treatment wishes
- Decreased rates amongst patients with low income, lower illness severity, low education level, non white race, female sex, younger, IV drug use, social isolation

ERLANDSON KM, ALLSHOUSE AA, DUONG S, MAWHINNEY S, KOHRT WM, CAMPBELL TB. HIV, AGING, AND ADVANCE CARE PLANNING: ARE WE SUCCESSFULLY PLANNING FOR THE FUTURE? J PALLIAT MED. 2012;15(10): 1124-1129.

ADVANCE DIRECTIVE COMPLETION IS NOT ENOUGH TO IMPROVE END OF LIFE CARE

- *Some patients complete written directives about care, but:*

  Directives often not accessible or need to be redone in some settings of care

  Directives vague, not applicable

  Preferences are unstable

  Patients often do not understand implications of choices

  HCPOA still struggle with substituted judgement

USE OF ADVANCED DIRECTIVES HAS INCREASED BUT HOSPITAL UTILIAZATION HAS NOT DECREASED NEAR END OF LIFE

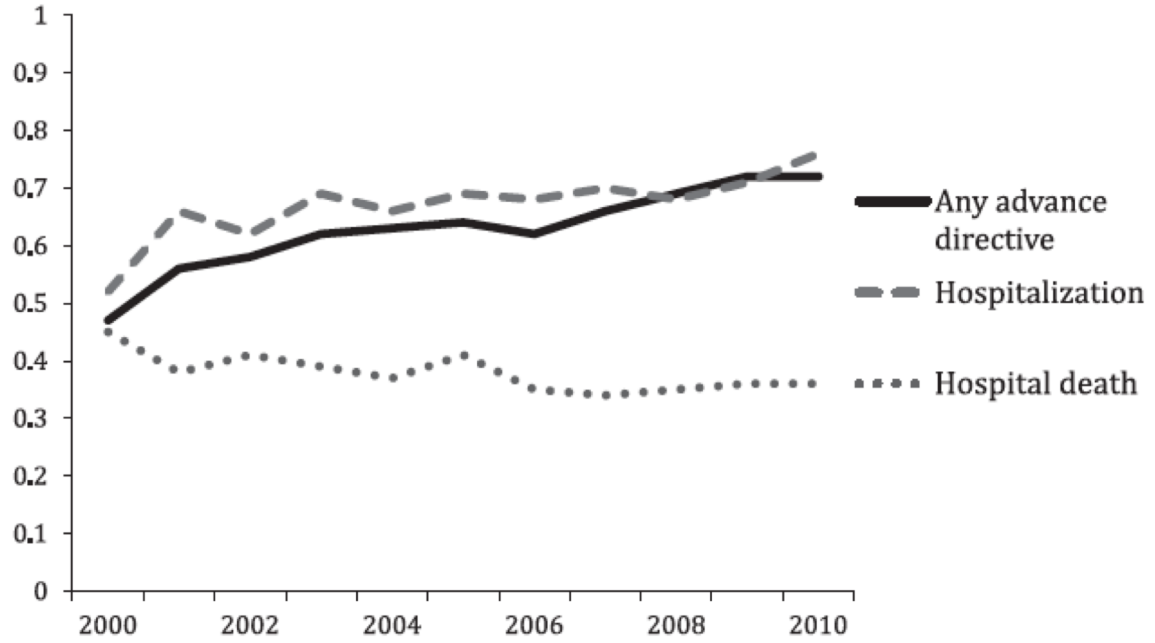
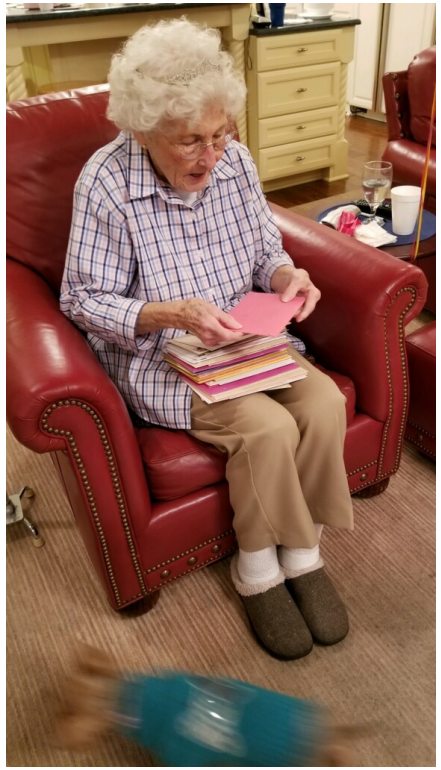


Figure 1. Population-weighted rates of advance directive completion, hospitalization, and hospital death in the United States (2000–2010).

ADVANCED DIRECTIVE COMPLETION BY ELDERLY AMERICANS: A DECADE OF CHANGE SILVERIA ET AL. JAGS APRIL 2014

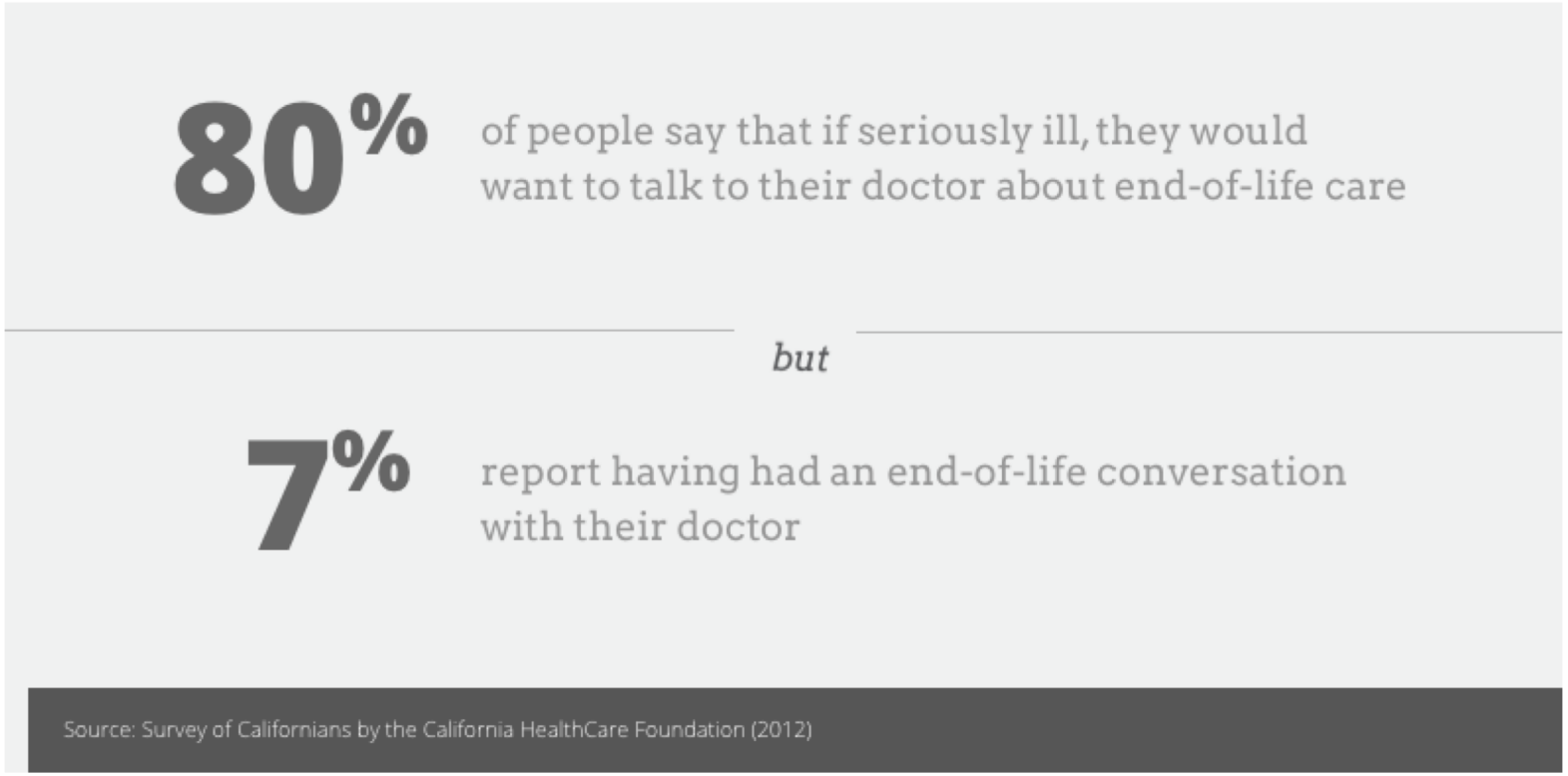
ADVANCE DIRECTIVE COMPLETION IS NOT ENOUGH TO IMPROVE END OF LIFE CARE

ADVANCED DIRECTIVES DON'T TELL WHAT IS MOST IMPORTANT TO THE PATIENT

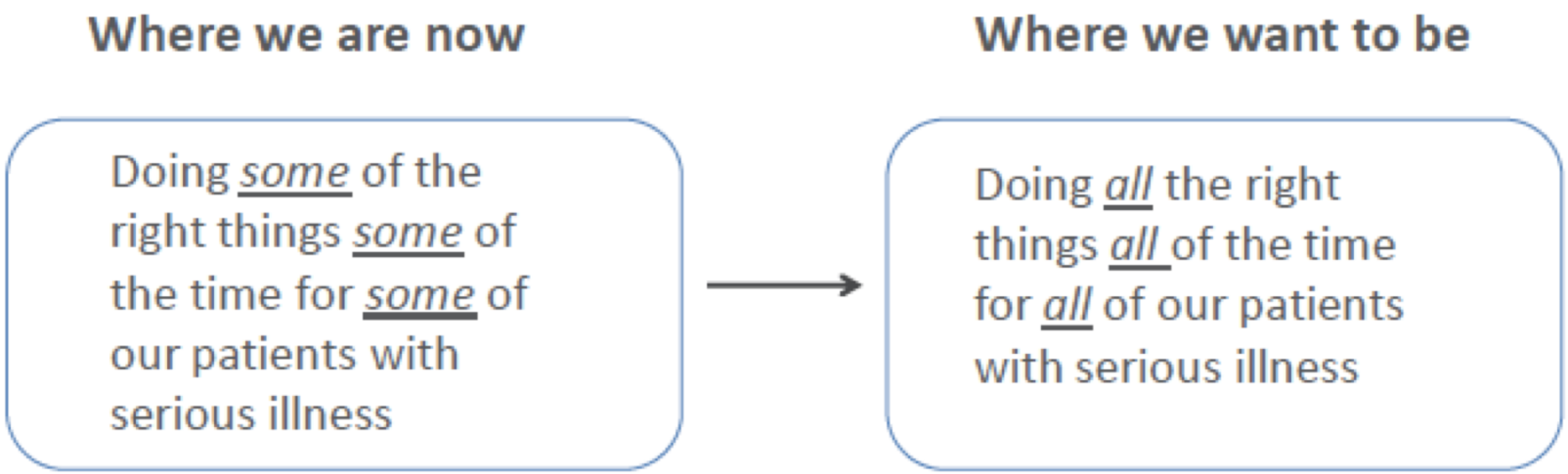


CHCF (California HealthCare Foundation). Final chapter: Californians' attitudes and experiences with death and dying. 2012. [August 7, 2013]

PATIENTS WANT TO TALK TO HEALTH CARE PROFESSIONALS ABOUT WHAT MATTERS MOST



PATIENTS WANT TO TALK TO HEALTH CARE PROFESSIONALS ABOUT WHAT MATTERS MOST- ADVANCE CARE PLANNING CONVERSAITONS HELP



ADVANCE CARE PLANNING MAXIMIZES AUTONOMY

- ACP is the process of communication between individuals and their surrogates and their health care team to understand, reflect on , discuss and plan for a time when they may not be able to make their own health care decisions in order to help maximize patient autonomy

NTERNATIONAL SOCIETY OF ADVANCE CARE PLANNING AND END OF LIFE CARE. THE DEFINITION OF ADVANCE CARE PLANNING. HTTP://ACPELSOCIETY.COM/INDEX.PHP. ACCESSED ON JANUARY 18, 2016.

STRATEGIES TO SUPPORT ADULTS IN ACP

- Decisions about treatment plans should include a healthcare provider, follow local healthcare laws, and be based on a shared understanding of the person's changing health and prognosis
- Recording the person's values and choices for medical care is important and should be done after talking with individuals whom the person trusts to be included in decision making and healthcare providers
- Recorded preferences for medical care should be saved in such a way that they can be found when they are needed and updated over time

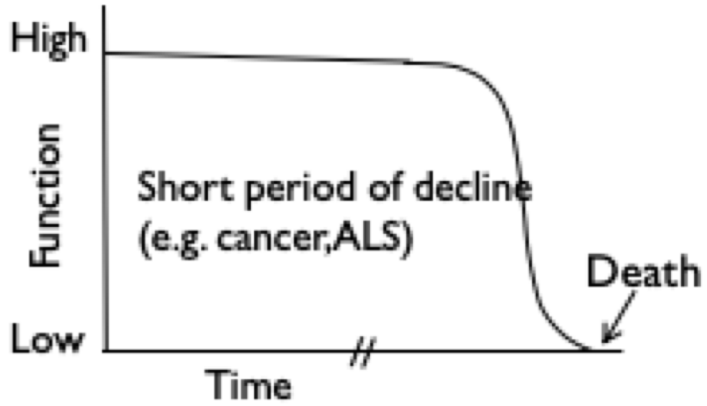
SUDORE AT AL. DEFINING ADVANCE CARE PLANNING FOR ADULTS. J PAIN AND SYMPTOM MANAG. 2017

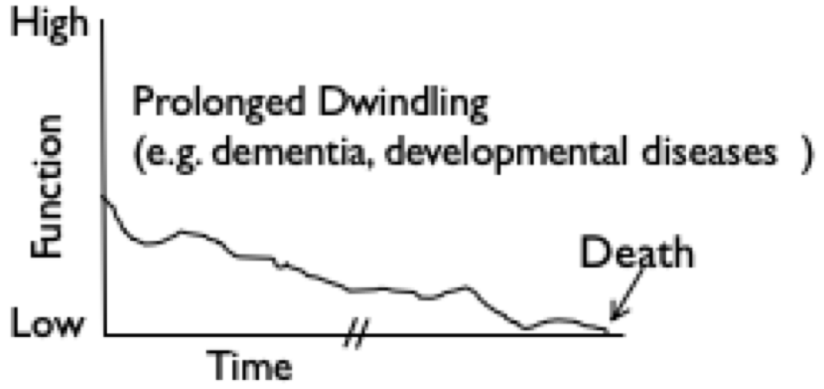
ADVANCED CARE PLANNING CONVERSATIONS RESULT IN CARE THAT MORE CONSISTENTLY REFLECTS A PATIENTS GOALS AND VALUES

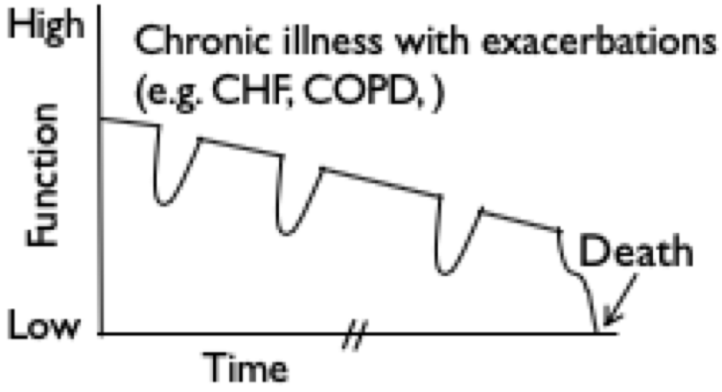
- Higher rates of completion of advanced directives
- Increased compliance with patient's end of life wishes
- Decrease in hospitalizations
- Decrease in hospital deaths and ICU deaths
- Increase in in home deaths

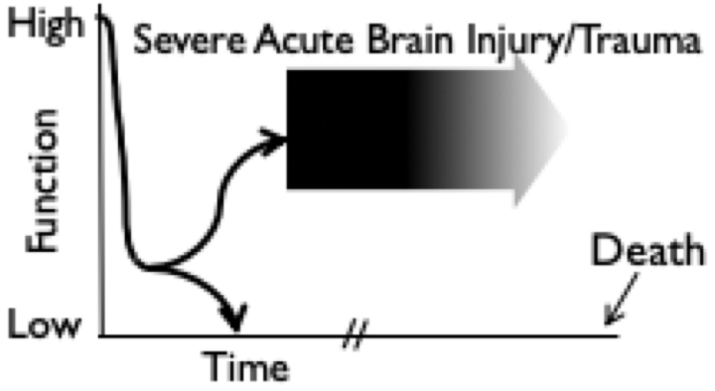
BRINKMAN-STOPPELENBERG, RIETJENS VAN DER HEIDE PALLIAT MED 2014

ILLNESSES HAVE VARYING TRAJECTORIES THAT INFLUENCE WHEN TO HAVE APC DISCUSSIONS









Creutzfeldt CJ, Longstreth WT, Holloway RG. BMJ 2015

RECOGNIZE THE TRIGGERS FOR THESE CONVERSATIONS IN OUR PATIENTS

- The US Department of Health and Human Services recommends ACP for all individuals with chronic, life-limiting illness OR those aged 55 years or older regardless of health status
- ACP was not addressed in ISA or DHHS HIV/AIDS practice guidelines at my last review
- There are not evidenced based recommendations on when we should discuss ACP with patients, especially those whose prognosis is driven by non – HIV related multimorbidity

RECOGNIZE THE TRIGGERS FOR THESE CONVERSATIONS IN OUR PATIENTS – NEAR TIME OF DIAGNOSIS OF HIV OR CO-MORBID CONDITIONS

- *"From the point of diagnosis you deal with depression... coming to grips with realizing that the virus is attacking your body...And how that changes your life completely." (INT-11)*

RECOGNIZE THE TRIGGERS FOR THESE CONVERSATIONS IN OUR PATIENTS – CHANGES IN FUNCTION

- *"For me, disabled is not being able to keep up, not being able to fully function, and feeling the guilt, and feeling the sadness and the emptiness, the loss. That's disability – just feeling exhausted and worn out" (INT-1)*

O'BRIEN ET AL. HEALTH AND QUALITY OF LIFE OUTCOMES 6:76, 2008

RECOGNIZE THE TRIGGERS FOR THESE CONVERSATIONS IN OUR PATIENTS – SOCIAL CHANGES

- *"it actually does cause me a bit of a dip when I notice a neighbor getting sick. I live in a building of all people with HIV and in the past few years 4 or 5 people died... and I went for a dip each death, even if I didn't know people...what happens to them matters and it actually affects me... I feel like my immune system is touched when that happens, I just get so down...that weighs on me." (INT-10-VCFG-1)*

RECOGNIZE THE TRIGGERS FOR THESE CONVERSATIONS

- GENERAL
  - THE SURPRISE QUESTION
  - PATIENT OR FAMILY RAISES CONCERNS ABOUT PROGNOSIS, APPROPRIATENESS, QUALTY, OR HASTENED DEATH
- DIAGNOSIS
  - NEAR THE TIME OF DIAGNOSIS, WHEN ADDITIONAL CO-MORBIDITIES OCCUR
- MEDICAL EVENTS
  - HOSPITALIZATIONS, > 7 DAYS, > 3 DAYS ICU, PROLONGED NEED FOR VENT OR ARTIFICIAL FEEDS, TRANSITION AWAY FROM HOME
- PROGRESSION
  - INCREASED DEPENDENCE, WEIGHT LOSS, ADL CHANGES, BEHAVIORAL CHANGES, >16 HOURS DAY OF SLEEP
- CARE GIVER DISTRESS/BURNOUT

WHO WAS RESPONSIBLE FOR DISCUSSING THE FUTURE WITH MRS. M?

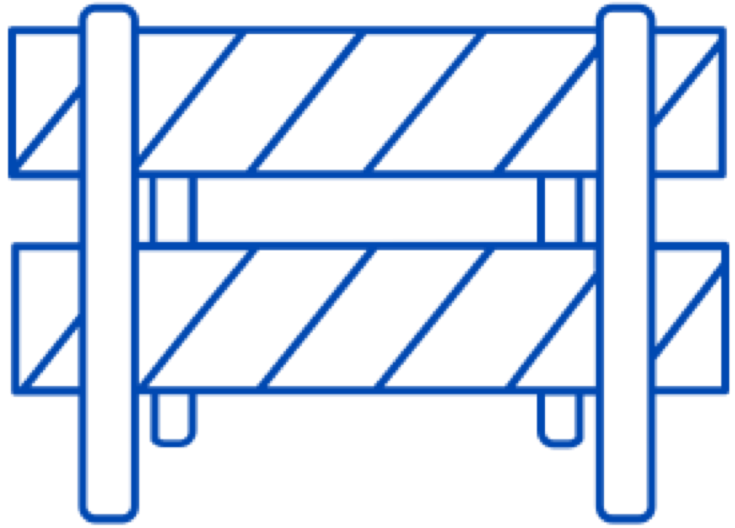
- The primary care physician?
- The pulmonologist?
- The social worker in ID clinic?
- Her husband?
- The palliative care team?
- The patient should lead this?

- Patients prefer to have these discussions with the providers that know them best
- Communication-priming before the visit may increase the number of conversations, increase documentation and improve patient rated physician communication
- The COVID pandemic provides a unique opportunity to have these conversations

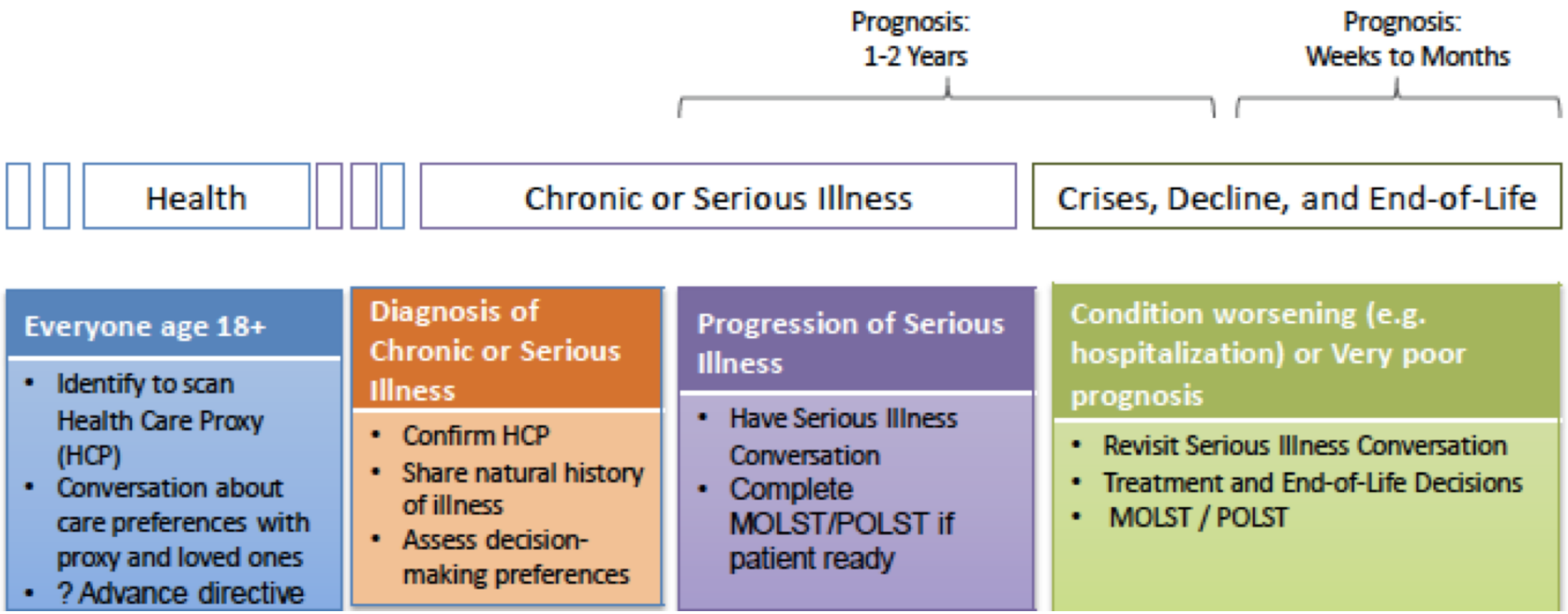
CURTIS ET AL. JAMA INT MED 2018

WHAT ARE BARRIERS YOU FACE TO EFFECTIVE ACP CONVERSATIONS?

- Competing demands of other work
- Small "window of opportunity"
- Uncertainty around prognosis
- Billing remains mysterious
- Too many patients already!
- No system is in place to facilitate these discussions
- Lack of communication skills specific to exploring values
- Lack of communication skills specific to emotional encounters
- Cultural differences



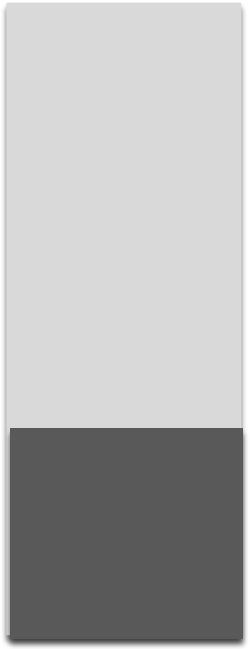
A HEALTH-SYSTEM-BASED APPROACH TO ADVANCE CARE PLANNING CAN HELP REDUCE THE BARRIERS



HOW DO WE GET COMPENSATED FOR THE WORK?

- Face-to-face or telemedicine service between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing AD, with or without completing relevant legal forms.'
- Don't forget to documents your minutes (16-45 min, 46-75 min,etc) "separate from and in addition to" other services.
- Can be billed the same day as E and M
- Can be billed subsequent days
- Co-pays do apply unless part of Annual Wellness Visit for Medicare (modifier 33)

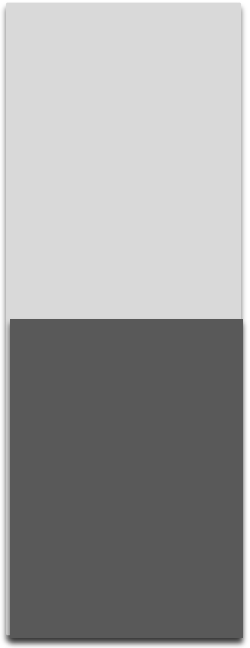
PATIENTS ASSUME CLINICIANS HAVE BEEN TRAINED BUT…



only

29%

had formal training



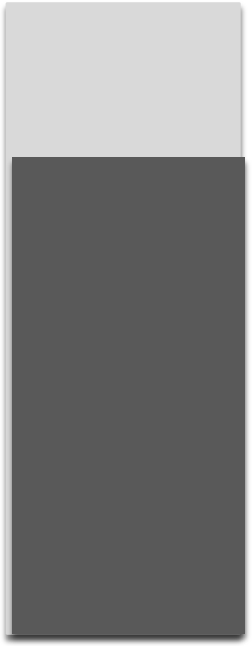
and

46%

were ‘unsure’ of what to say

National survey of primary care and specialist physicians. Cambia Health Foundation; California Healthcare Foundation; John A. Hartford Foundation. 2016.

EVEN THOUGH CLINICIANS AGREE THAT THESE CONVERSATIONS MATTER…



71%

don't have a system in place to routinely ask about goals

National survey of primary care and specialist physicians. Cambia Health Foundation; California Healthcare Foundation; John A. Hartford Foundation. 2016.

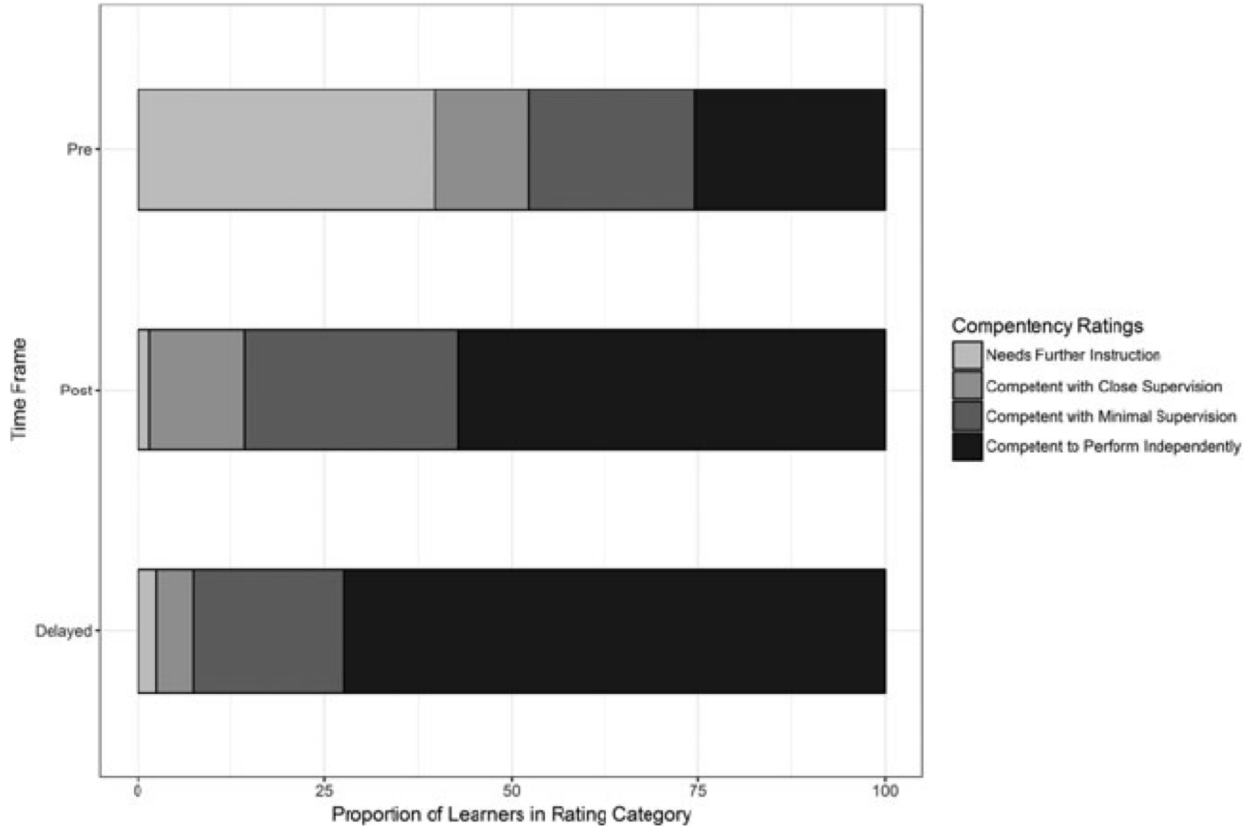
No training + no system

No communication or
Very late communication.

Poor outcomes,
Avoidable suffering

PRACTICE IMPROVES SELF RATING OF SKILLS IN DISCUSSING ADVANCE DIRECTIVES AND ELICITING GOALS AND VALUES

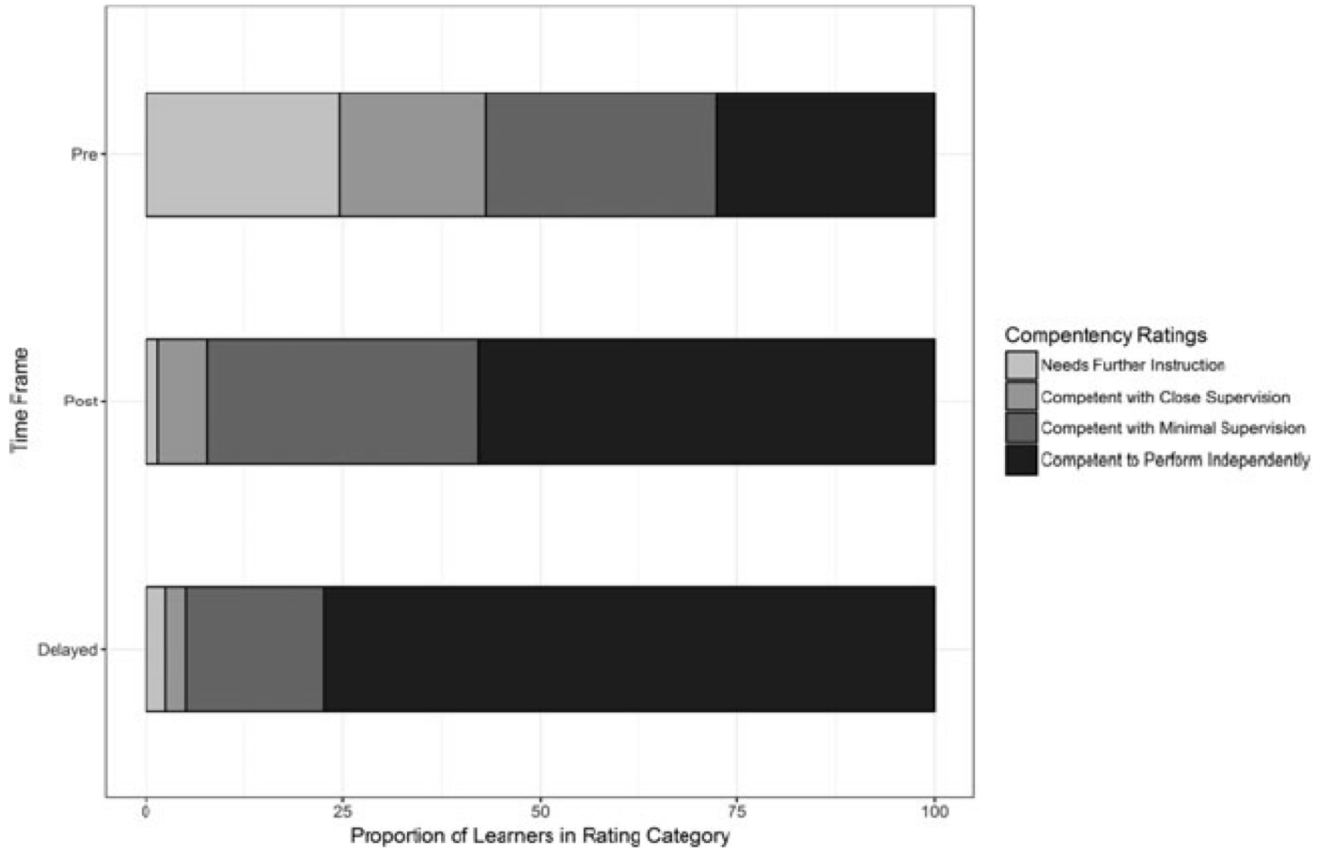
PRACTICE IMPROVES SELF RATING OF SKILLS IN DISCUSSING ADVANCE DIRECTIVES



BOND ET AL. J PALL MED 2017

FIG. 3. Self-ratings of competence in having discussions about advance directives. Delayed rating was at 30–90 days postcourse. $N = 65$, 65, and 40 learners at pre, post, and delayed time points.

PRACTICE IMPROVES SELF RATING OF SKILLS IN ELICITING VALUES AND GOALS



BOND ET AL. J PALL MED 2017

FIG. 2. Self-ratings of competence in having discussions about values and goals over time. Delayed rating was at 30–90 days postcourse. $N = 65$, 65, and 40 learners at pre, post, and delayed time points.

NUMEROUS GUIDES EXIST TO HELP PRACTICE THE CONVERSATION

THE SERIOUS ILLNESS CARE PROGRAM

- SET UP THE CONVERSATION
- ASSESS UNDERSTANDING AND PREFERENCES
- SHARE PROGNOSIS
- EXPLORE KEY VALUES
- CLOSE THE CONVERSATION

SERIOUS ILLNESS CONVERSATION GUIDE-
SET UP THE CONVERSATION

I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

We want you to have control over your medical care so that you get the best care possible. Because of the coronavirus, we are talking to all our patients about what is important to them if something unexpected happens and they became very sick. **- is it okay if we talk about this**?

SERIOUS ILLNESS CONVERSATION GUIDE-
ASSESS UNDERSTANDING AND PREFERENCES

"What is **your understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

SERIOUS ILLNESS CONVERSATION GUIDE
SHARE PROGNOSIS

"I want to share with you **my understanding** of where things are with your illness and what could happen if you were to get very sick from COVID." (pick one that fits needs of patient)

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."
OR

Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR

Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

SERIOUS ILLNESS CONVERSATION GUIDE
EXPLORE KEY VALUES

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

SERIOUS ILLNESS CONVERSATION GUIDE
CLOSE THE CONVERSATION

I've heard you say that ____ is really 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."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

SERIOUS ILLNESS CONVERSATION GUIDE

DOCUMENT THE CONVERSATION

COMMUNICATE WITH KEY CLINICIANS

HOW TO RESPOND TO THE 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" statemen	*"**I wish** we had better treatments… [more testing ability….that we in a different situation…that father wasn't so sick… etc.]"*	I wish statements allow you to affirm your commitment even when you don't have the ability to achieve the desired outcome.

Screenshot

HOW DID OUR ADVANCE CARE PLANNING CONVERSATION HELP MRS. M?

- Discussed what she wanted to know about her prognosis
- Conversation about goals and values documented
- DNR/I order placed and home DNR/I paper work completed
- Decision maker on paper
- Opioids for dyspnea
- Brochures on hospice in the home

CONVERSATION GUIDES DURING COVID FOR PATIENTS THAT ARE LOW RISK, MODERATE RISK AND HIGH RISK OF SERIOUS DECLINE

COVID-19: ADVANCE CARE PLANNING

Outpatient: Low Risk Patients

1. INTRODUCE the idea

[Set Agenda, Normalize] *"We want you to have control over your medical care so that you get the best care possible. Because of the coronavirus, we are talking to all our patients about what is important to them if something unexpected happens and they became very sick."*

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

YES: Go to Step 2
NO: [Explore Concerns] Address concerns first, if concerns cannot be addressed, offer written material and revisit at another encounter.

[Name Emotion if present, Respect Statement] *"It can be hard to talk about these things, thank you for talking with me."*

2. ELICIT questions

[Set Agenda] *"Are there things you want to make sure we cover today?"*

YES: Elicit/address quick questions, bracket longer questions, then go to Step 3.
NO: Go to Step 3

3. EXPLORE prior plans

[Assess] *"Many people already have plans, or a legal document that outlines their wishes, called an advance directive. What about you?"*

YES: Review prior preferences (use rest of map if needed) and obtain documents.
NO: Go to Step 4

4. CHOOSE a healthcare representative

[Context, Normalize] *"A good first step can be choosing someone who could make medical decisions for you if you were 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, and if they have a legal form designating this person. If they have form, ask for a copy, if they don't, offer to complete one at the end.
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."*

5. ASK what matters

[Elicit Values] *"The next step is to think about key things that matter most to you in your life. Everyone defines quality of life differently, what does a 'good day' look like for you?* [pause and listen]*…"What activities or experiences are most important to you?"*

[Reflect Back Values] *"It sounds like [value] is most important…."*
[Respect Contributions] *"Thank you for sharing, it really helps me understand better."*

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6. ASK about serious illness

[Context] *"Now that I have a better understanding of what is most important in your life now, it can be helpful to think about what would be important to you if you unexpectedly got very sick."*

[Past Experiences] *"Have you seen or experienced a serious medical illness or accident? ["Has anyone you know had the coronavirus?"]*

"What did you take away from that experience? What went well? What did not go well? Why?" "If you were in these situations, what would be important to you?"

[Respect Contributions] *"Thank you, that is really helpful."*

7. ASK about tradeoffs

[What If] *"Something else, that can be hard to think about is, if you got the coronavirus, or another serious illness, and became so critically ill that the doctors thought you were unlikely to survive, what would be important to you?"*

[Values Triad]

- *"Some people would want to try all life support treatments to **live as long** as possible, even if this meant living on machines for the rest of their life or not being aware of their surroundings."*

-*"Other people would want a **trial** of life support treatments, but if they weren't working and were only causing suffering they would want them stopped."*

-*"Other people would not want artificial life support treatments and would want to focus on **comfort and a natural death**."*

"How about you?"

8. DOCUMENT preferences

[Align and Plan] *"We've had a really important talk today and I want you to know that if you get sick, our team will do everything we can to help you recover. I will document our conversation in the medical record, so everyone knows your wishes. You can also complete an advance directive, which is a legal document that can assign a health care representative and can provide written instructions."*

[Ask Permission] *"Would it be okay if we complete one today?"*

YES: Complete [State] advance directive and make recommendations based on your conversation and thank them for the discussion.
NO: *"Let us know if you change your mind. Thank you for talking with me about this today."*

9. SHARE preferences

If they have someone they trust to make medical decisions:

"I encourage you to talk with your healthcare representative about your wishes. It can really help people when they are in stressful situations and have to make medical decisions for someone else. If you want help talking with them, let us know."

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COVID-19: Serious Illness Conversation Guide

Outpatient: Moderate Risk Patients

1. INTRODUCE the idea

[Set Agenda, Normalize] *"Given the situation with the coronavirus, I am asking **all my patients** about **what matters** most and what they might **expect** for their situation. This way, we can prepare for the future, so you get the best care possible.*

[Ask Permission] *"Would it be okay if we talk about that 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.

"I am going to use this guide, so I don't miss anything…"

2. ELICIT agenda

[Elicit Agenda] *"Are there things you want to make sure we cover today?"*

YES: Elicit/address quick questions, bracket longer questions, then go to Step 3.
NO: Go to Step 3

3. DISCUSS prognosis

[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 situation?"*
[Assess Information Preferences] *"How much **information,** about what to expect in the future, would be **helpful**?"*
[Ask Permission] *"Would it **be okay** if I share what I know?"*

[Headline] *"Based on your medical conditions, you are at increased risk for serious complications from coronavirus"* [Then pick ONE of the following strategies]

Uncertainty: *"While it can be difficult to predict, **some people** with similar medical conditions get the coronavirus and do very well with mild symptoms and **other people** get very sick quickly, and even die."* [Can also use best/worst/most likely case]

Time: *"I **wish** we were not in this situation. I'm **worried** that if you got coronavirus and became very sick, even with medical support, time could be as short as [days to weeks, weeks to mths]…."*

Function: *"I **hope** you do well for a long time, I **worry** if you got the coronavirus, you would not be able to [function]…"*

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]

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5. MAP out values

[Context, Elicit Values] *"In order to provide you with the best care if you were to get sick, it helps me to know what are some things that **matter most** to you **now**? . . .If you got the coronavirus and your health situation **worsened**, then what would **matter most**?"*

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

[Strengths] *"What gives you **strength** as you think about the future?"*

[Abilities] *"What **abilities** are so critical that you can't imagine living without them?"*

[Experience with Illness] *"Has **anyone** you know been **seriously ill**? How does this experience **impact** your own decisions? Do you have any spiritual or cultural beliefs that impact how you think about these decisions?*

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

*-"Some people would want to try all life support treatments to **live as long** as possible, even if this meant living on machines for the rest of their life or not being aware of their surroundings."*

*-"Other people would want a **trial** of life support treatments, but if they weren't working and were only causing suffering they would want them stopped."*

*-"Other people would not want artificial life support treatments and would want to focus on **comfort and a natural death**."*

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?"*

[Plan should be based on the values you elicited, consider the POLST framework for potential plans] [Check-In] *"How does this plan seem to you?" "Did I miss anything?"*

[Affirm] *"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 will do everything we can to help you through this."*

8. 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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COVID-19: Vital Talk REMAP Goals of Care

Outpatient: High Risk Patients

1. INTRODUCE the idea

[Set Agenda, Normalize] *"Given the situation with the coronavirus, I am asking **all my patients** about **what matters** most and what they might **expect** for their situation. This way, we can prepare for the future, so you get the best care possible."*

[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 cover today?"*

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 situation?"*

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

[Deliver Headline = Information + Meaning]

Info: *"Because of your other medical conditions [and your age], you are in the highest risk group for serious complications if the coronavirus makes you very sick."*

Meaning: *"This **means** that if you got the coronavirus and became so sick that you needed intensive care, I **worry** that you would 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: *"This must be hard news to hear."*
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 you got the coronavirus and your health situation **worsened**. Is that okay?"* [If yes, proceed, if not, explore emotions first]

[Hopes] *"What are you **hoping** for in the coming days, weeks, mths…? What/who else is important to you?...What does a 'good day' look like?...Anything else that is important that we should know?..."*
[Concerns] *"When you think about the future with your health, what are your biggest **concerns** or **worries**?"*

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MAP out values (cont.)

[Values Triad] *"If you become sicker, how much are you **willing to go through** for the possibility of gaining more time?"*
*- "Some people would want to try all life support treatments to **live as long** as possible, even if this meant living on machines for the rest of their life, or not being aware of their surroundings, they would even want CPR if their heart stops and they die."*

*-"Other people would want a **trial** of medical treatments, but if they weren't working, and they weren't going to get back to **doing** important things, they would want them stopped. They would not want to be on a ventilator that breathes for them and they would not want CPR."*

*-"Other people, if they got the coronavirus and got very sick, would want to avoid the hospital all together, focus on **comfort and have a natural death**. They would want to start hospice to manage their symptoms and try to stay at home."*

"How about you?"

[For Surrogates-Empty Chair] *"If your father **could understand** the situation and talk to us, what would he say?"*

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]: "*If you were to get the coronavirus, or some other serious illness and you needed to go to the hospital. I would **recommend** all available medical treatments to help you live as long possible.* [Affirm] *I want you to know that, if this happens, 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]: "*If you were to get the coronavirus, or some other serious illness and you needed to go to the hospital. I would **recommend** all available medical treatments that would help you get back to doing things that are important to you. If you get sicker, 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 at the end of life 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 this happens, we will do everything that we think will help you recover."*

[Response 3-Comfort]: "*If you were to become seriously ill with the coronavirus, or another serious illness. I would **recommend** avoiding the hospital and not using breathing machines or CPR. We could arrange hospice care to help manage your symptoms at home, focus on your comfort, and allow a natural and peaceful death.* [Pause and Check-in] *"How does this plan seem to you?" "Did I miss anything?"* [Affirm] *I want you to know that, if this happens, 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 is important to you. Our team will do everything we can to help you through this."*

8. 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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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.

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Telehealth and Advance Care Planning (ACP): Documentation and Billing

What's Included in ACP*?* An ACP conversation happens any time providers help patients understand their medical options and plans for their future.

CPT 99497*:* Advance care planning, including the explanation and discussion of advance directives such as professional standards forms (with completion of forms, when performed) by the physician or other qualified health care professional; first 16-30 minutes, face-to-face (or telehealth as described in 1135 waiver) with patient and/or family member(s) and/or surrogate.

CPT 99498: Each additional 30 minutes; if the ACP conversation is 46 minutes or more both codes apply. (List separately in addition to code for primary procedure.)

These two codes are based on time spent offering ACP conversation. The following are possible cases and documentation examples:

Time Track Example: A 72-year-old patient has a telehealth wellness visit and tells you, "My friend has a Do Not Resuscitate (DNR) order in place even though he's not sick. Should I have one?" You complete the wellness visit and then spend an additional 32 minutes discussing a DNR document with the patient, which the patient agrees to. Your ACP notes and coding for this service should look something like this:

"In addition to the time spent conducting his annual wellness visit, I spent 32 minutes (starting at 1:10 p.m. and ending at 1:42 p.m.) reviewing several ACP options with the patient, who agreed to a DNR during our discussion."

99497-Periodic comprehensive preventive medicine; established patient 65 years or older.

99497-33-Advance care planning including the explanation and discussion of advance directives for the first 30 minutes. (Modifier 33 is to indicate preventive care services.)

Note: The completion of an advance directive is NOT a requirement for billing the service. The service is the explanation and discussion of the form.

Total Time Example: An 82-year-old male with mild dementia has a telehealth visit with his son to discuss his future care. You spend 25 minutes with the patient and his son, performing a history, exam, and medical decision-making related to the patient's medications. You also spend another 46 minutes discussing ACP. During this discussion, the patient states that he doesn't want a feeding tube, and that he's willing to go to a nursing home. You suggest he complete a Five Wishes that conveys his goals of care. Documentation might look like:

"In addition to the time spent evaluating and managing the patient's end-stage Parkinson's disease and mild dementia, we also spent 46 minutes (starting at 2:14
p.m. and ending at 3:00 p.m.) discussing the fact that he doesn't want a feeding tube, and that he is open to nursing home care. Finally, I suggested he complete a Five Wishes document which his son will obtain."

99214-Office visit, 25minutes spent taking history, performing exam and making decisions about medication.

99497-First 30 minutes of ACP services

+99498-Additional 16 minutes of ACP service.

Key Points to Remember:

- ➔ The billing codes are not limited to particular specialties, and can be billed by any physician or non-physician authorized to independently bill Medicare. Note: LCSWs cannot bill for this service.
- ➔ These codes are not limited to any specific diagnosis.
- ➔ These codes can be billed when conversations are had with the legally appropriate decision maker, even if the patient is not in the room.
- ➔ These codes can be billed on the same date of service (or different date) as most other E/M codes, as well as transitional care management services (TCM) or chronic care management services (CCM). It is important to indicate that the time spent on advance care planning was "separate from and in addition to" other services.
- ➔ The usual Part B deductible and coinsurance apply, except when advance care planning discussions occur as part of the Annual Wellness Visit.
- ➔ Advance care planning forms can include things like Health Care Proxy, MOST(Medical Orders for Scope of Treatment), a Living Will, DNR, Five Wishes and Medical Durable Power of Attorney.

University of Kentucky Palliative Care Medicine
Outpatient Symptom Management for COVID-19 + Patients

Before enacting any of the following recommendations, **PLEASE clarify patient's GOALS OF CARE**. These recommendations are consistent with comfort-focused, supportive care for patients with serious illness who are at or approaching end-of-life

Dyspnea

Opioids are the mainstay of dyspnea management; May also help in relieving pain, agitation and anxiety.
Dyspnea is evidenced by a RR > 24 and/or use of accessory muscles to breath.

***ALL** patients on opioids need an **appropriate** bowel regmen. Constipation is a predictable and preventable side effect of opioid therapy and can increase pain/discomfort when not managed. Start with Senna 2 tabs PO QHS, escalate to BID or add suppository if no BM in >72 hours.

1. Optimize underlying disease treatments first; utilize supplemental oxygen as needed and titrate based on patient needs and comfort. Additional general measures to be recommended include: *positioning* (elevate head as needed), *bedside fan*, *diuretics* for fluid management.

2. **Opioid Naïve**
   - Begin at low end of range for frail or elderly patients, or those with organ dysfunction
   - Start with PRN short acting opioids **Q4H or more frequently** based on severity of disease
     - Extended-release formulations and Q6H frequency are NOT appropriate
   - If using greater than 6 PRN doses per 24 hours, consider scheduling the dose Q4H
     AND
   - Continue with PRN dosing at equal or increased doses/intervals
   - Doses should be titrated up as needed for optimal patient response

For assistance with selecting appropriate agents or starting doses please reference the **attached pocket guide**

3. **Opioid Tolerant**
   - Continue patient's pre-existing opioid regimen
   - May need additional PRN opioids for acute management
   - Increase their existing short acting opioid dose by 25-50% (Ex: Oxycodone 10 mg PO Q4H PRN at home may be increased to Oxycodone 12.5 mg -15 mg PO Q3-4H PRN)
     OR
   - If not using any short acting at home, start short acting opioid (PO/SL) PRN at 10-20% of patients total daily opioid dose (Ex: MS Contin 45 mg PO Q8H at home, start IR Morphine liquid PO 15-20 mg Q3-4H PRN)

3. Severe/Refractory Symptoms or Imminent Death
   - In home hospice services will provide the most hands on support for these patients including nursing assistance, medication adjustments, aids, social work/chaplain support for caregivers and family and more.
   - Opioid dosing may be increased to as frequent as Q1H for oral medications
   - Additional non-opioid medications may be needed to improve patient comfort

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Respiratory Secretions/Congestion

Advise familyand caregivers thatwhenpatientsexperience thisat end-of-life it isnotusually uncomfortable for the patient. This symptom results due to weakness/inability to clear secretions manually. It can be extremely distressing to loved ones and caregivers.

1. **Atropine** 1% (ophthalamic drops) 1-2 drops SL Q4H PRN
   OR
2. **Hyoscyamine** 0.125 mg SL Q4H PRN
   OR
3. **Glycopyrrolate** 1 mg PO Q4H PRN
   OR
4. **Scopolamine Patch** apply 1.5 mg patch Q72H

Agitation/Delirium/Restlessness

Lookfor**sources of reversible distress FIRST** thismayincludethingssuchasuncontrolled pain, constipation, urinary retention, pressure ulcers; Initiate appropriate treatments are immediately.

1. Reviewmedication listandremoveallnon-essentialmedicationsormedicationsthatmaybe contributing to worsening delirium/mental status. Please reference American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults: https://onlinelibrary-wiley-com.ezproxy.uky.edu/doi/full/10.1111/jgs.15767

2. **Lorazepam** oral tablets or solution, start with 0.5 mg - 1 mg Q4H PRN, may consider increasing dose by 0.5 mg increments to a max of 2 mg per dose.
   - May also be utilized for management of severe/refractory dyspnea

3. **Haloperidol** oral tablets or solution, start with 0.5 mg - 1 mg Q6H PRN, may consider increasing dose by 1 mg increments to a max of 5 mg per dose.

For questions related to available dosage forms, utilize your clinic pharmacists or retail pharmacists in the community. Highly concentrated oral solutions may be more appropriate for patients who have an impaired ability to swallow or non-functioning GI tract, as they can be absorbed sublingually.

These recommendations are generalized and for reference. They may not be appropriate for every patient and should not be supersede clinical judgement. This protocol has been simplified to allow for use in multiple settings. This protocol is intended for use in patients whose primary goals are comfort and supportive care.

Evidence supports that appropriate doses of opioids do NOT hasten death. Dosing of any of the above medications should be reassessed as patient's condition changes or if goals of care change.

Feedback/Questions should be sent to Palliative Care Pharmacist at meg.mitchell@uky.edu

UKHC Opioid Analgesia Pocket Pearls

Practice Pearls:

- For **ACUTE** or **BREAKTHROUGH** pain, use immediate release formulations on a PRN basis
- For appropriate **CHRONIC** pain syndromes, consider using a **scheduled** regimen reflective of the patient's previous PRN opioid needs
- Adjusting scheduled and/or PRN opioids:
  - For moderate pain without dose-limiting side effects, ↑ dose by 25-50%
  - For severe pain without dose-limiting side effects, ↑ dose by 50-100%
- Switching opioids:
  - Use appropriate equianalgesic doses (See Table 1)
  - **Reduce calculated dose 25-50%**
- Begin a bowel regimen when opioid therapy is initiated (stimulant laxative)
- If dose increases do **not** improve pain, do **not** continue to escalate opioids
- Check KASPER before writing any discharge opioid prescription

Table 1: Equianalgesic Starting Doses in Opioid Naïve Patients

Drug	SC/IV Dose	Oral Dose
Morphine	2 mg	5 mg
Hydrocodone	---	5 mg
Oxycodone	---	2.5 – 5 mg[1]
Hydromorphone	0.25 mg	1-2 mg[1]
Fentanyl	0.01 mg (10 mcg)	---

[1] When converting higher doses, consider contacting palliative medicine/pharmacy for assistance

Table 2: Medication Selection in Renal/Hepatic Dysfunction[1,2]

Renal Dysfunction			**Hepatic** Dysfunction		
Preferred	**Consider**	**Avoid**	**Preferred**	**Consider**	**Avoid**
Oxycodone	Hydromorphone	Morphine	Hydromorphone	Oxycodone	Tramadol
Fentanyl[4]	Hydrocodone	Tramadol	Morphine	Fentanyl[3,4]	Hydrocodone
		Codeine			Codeine

[1] Start with lower doses and/or extend dosing intervals, especially in elderly or opioid naïve patients.
[2] Patients with renal or hepatic dysfunction are at higher risk for adverse effects/toxicity.
[3] Avoid continuous infusions and transdermal fentanyl in severe hepatic dysfunction.
[4] See reverse side of card for contraindications to transdermal fentanyl use

Naloxone (Narcan®) For suspected opioid overdose
- **RR < 8 bpm AND difficult to arouse** in a patient **receiving** opioids
  1. Contact primary provider
  2. Administer naloxone **0.08 mg** IVP every 2 minutes until RR≥9/min
     ** Dilute one vial (0.4 mg) with 9 mL NS and give 2 mL (0.08 mg) every 2 minutes*
  3. If patient **APNEIC**, give **0.4 mg** (full vial, undiluted) every 2 minutes until respiratory rate improves, RR≥9/min **AND** call a "code blue"

- Onset: ~1-2 minutes. Duration of effect: 20-60 min
- If no response is noted after **2 doses**, consider other causes of respiratory depression
- Naloxone in excess can precipitate acute opioid withdrawal (e.g., severe pain, seizures, tachycardia, and hypertension)

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UKHC Opioid Analgesia Pocket Pearls

Fentanyl Transdermal System (Duragesic®):

Only for use in **CHRONIC, STABLE PAIN** in **OPIOID TOLERANT** patients[1]

- Takes **>12 hours** to become therapeutic and effects last 12 hours after removal
- **Avoid** in those with sustained fever and **caution** with CYP 3A4 inhibitors
- **Avoid** in patients who are frail, cachectic, or malnourished as absorption is minimized

Table 3: Equianalgesic Conversion to Transdermal Fentanyl[2]

Oral Morphine Equivalent (OME)	Transdermal Fentanyl Dose[3]
60-119 mg/day	25 mcg/hr patch
120-179 mg/day	50 mcg/hr patch
180-239 mg/day	75 mcg/hr patch
240-300 mg/day	100 mcg/hr patch
> 300 mg/day	*Contact Palliative Medicine*

[1] Opioid tolerant = around-the-clock opioid at ≥ 60 OME per day for longer than a week. Fentanyl patches should not ever be used for acute pain or in opioid naïve patients.
[2] When converting OME → patch, only reduce for cross tolerance if patient specifics warrant. When converting patch → OME, reduce 25 – 50% for cross tolerance.
[3] Significant interpatient and intrapatient variability exists in absorption from transdermal fentanyl.

Buprenorphine & Methadone:

- Indications: opioid use disorder & pain management
- Pharmacology and pharmacokinetics are very different than other opioids
- Outpatient use (for OUD or analgesia) should be continued on admission unless there are acute contraindications to use
- **Converting** to or from these medications is highly nuanced, patient specific, and should be done only by experienced clinicians
- Please contact ***addiction medicine*** or ***palliative medicine*** for assistance

Methadone	Buprenorphine
PO:IV methadone ratio = 2:1	Inappropriate initiation in an opioid tolerant patient may precipitate acute withdrawal
Do NOT titrate more frequently than every 5 days	"Ceiling effects" for pain and respiratory depression
Known risk of QT prolongation (Torsades de Pointes)	

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COVID-19 COMMUNICATION RESOURCES

- VitalTalk
  - https://www.vitaltalk.org/guides/covid-19-communication-skills/
- Ariadne: Serious Illness Care Program
  - https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
- Center to Advance Palliative Care (CAPC)
  - https://www.capc.org/toolkits/covid-19-response-resources/
- Respecting Choices
  - https://respectingchoices.org/covid-19-resources/
- Prepare for your Care
  - https://prepareforyourcare.org/covid-19
- The Conversation Project
  - https://theconversationproject.org/wp-content/uploads/2020/04/tcpcovid19guide.pdf
- ELNEC: COVID-19 Resources for Nursing
  - https://www.aacnnursing.org/ELNEC/COVID-19
- National POLST
  - https://polst.org/covid/
- Providence St. Joseph Health/Institute for Human Caring
  - https://coronavirus.providence.org/#tabcontent-38-pane-2/
- California State University Palliative Care Courses
  - https://csupalliativecare.org/covid-19-resources-announced/