Approach to Care, Prognosis

ERIC BUSH MD, RPh, MBA

Program Details

- **Title:** Approach to Care, Prognosis
- **Dates/Term of offering:** This activity was released on May 31, 2022 and is valid for one year. Requests for credit must be made no later than May May 30,2023.
- **Joint Providership:** This activity is jointly provided by Global Education Group and Hospice and Palliative Board Review.com.

- **Target Audience:** The educational design of this activity addresses the needs of Physicians, NPs, Nurses, and health care professionals interested in learning more about hospice and palliative medicine and those who want to earn continuing education credits and/or prepare for board certification in hospice and palliative medicine.

Program Details

- **Program Overview:** Clinicians and health care professionals are unaware of best practices to be utilized to keep up with changing US hospice regulations and patient prognoses. As such, they do not know how to adequately counsel patients and families on appropriate hospice utilization, given the current regulations.
- **Faculty:** Eric Bush, MD, RPh, MBA
- **Physician Accreditation Statement:**

  This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Global Education Group (Global) and Hospice and Palliative Board Review.com. Global is accredited by the ACCME to provide continuing medical education for physicians.

Program Details

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- **Global Contact Information:** For information about the accreditation of this program, please contact Global at 303-395-1782 or cme@globaleducationgroup.com.
- **Fee Information:** There is a fee for this educational activity.

PROGRAM DETAILS

- **System Requirements:**
  - **PC:** Microsoft Windows 2000 SE or above, Flash Player Plugin (v7.0.1.9 or greater), Internet Explorer (11.0 or greater), Chrome, Firefox, Adobe Acrobat Reader*
  - **MAC:** MAC OS 10.2.8, Flash Player Plugin (v7.0.1.9 or greater,), Safari, Chrome, Adobe Acrobat Readers*, Internet Explorer is not supported on the Macintoch.

  *Required to view printable (PDF) version of the lesson.
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The ***faculty*** have the following relevant financial relationships with ineligible companies:

- **Eric Bush, MD, RPh, MBA:** Nothing to disclose

The ***planners and managers*** have the following relevant financial relationships with ineligible companies:

- **Lindsay Borvansky:** Nothing to disclose
- **Andrea Funk:** Nothing to disclose
- **Liddy Knight:** Nothing to disclose
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Program Details

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Learning Objectives

- Describe how to perform triage and referral of eligible patients for palliative and hospice services.
- Describe how to counsel patients and families on appropriate utilization of hospice and palliative care services.
- Describe how to perform discussions of US hospice regulations with patients and family.
- Describe how to counsel patients and caregivers on US hospice regulations and appropriate care for the patient and family given current regulations.
- Describe how to discuss utilization of appropriate personnel allocation in the hospice and palliative care setting.
- Describe how to counsel patients and families on appropriate personnel allocation in the hospice and palliative care setting and the benefits for patients and families undergoing this type of care.
- Describe appropriate treatments for patients who are critically ill due to Covid-19

When to ask about Hospice or Supportive (Palliative Care)

What People Want

- To die at home
- To be free from pain
- To be in the company of loved ones
- To retain control of the care we receive

The Contrast of Reality

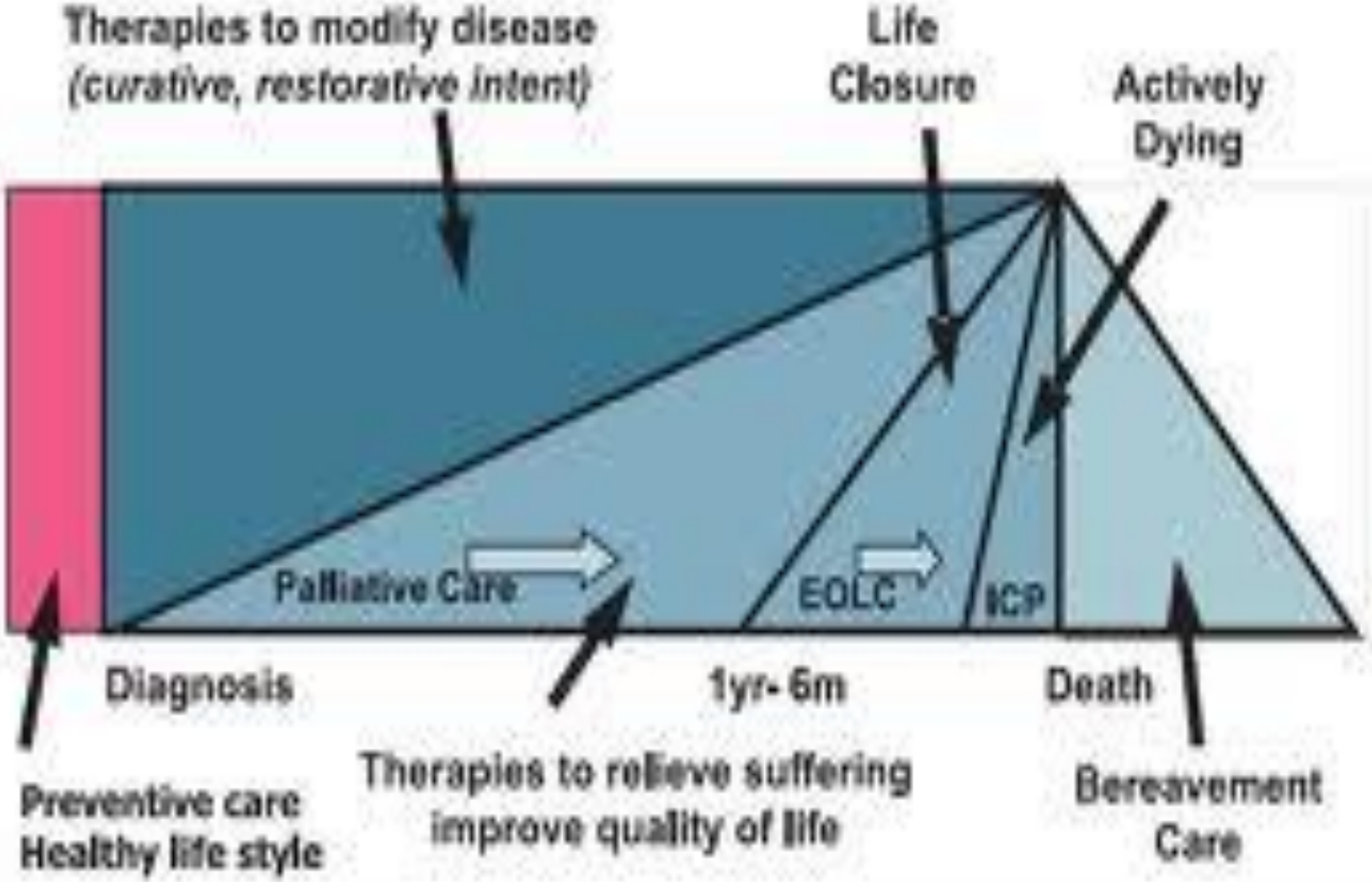
- Less than 25 percent of Americans die at home, although more than **70 percent** say that is their wish
- Only 20 to 30 percent of the population have completed an advanced directive
- Dying is often unnecessarily painful and isolating

The Reason for this Stark Reality

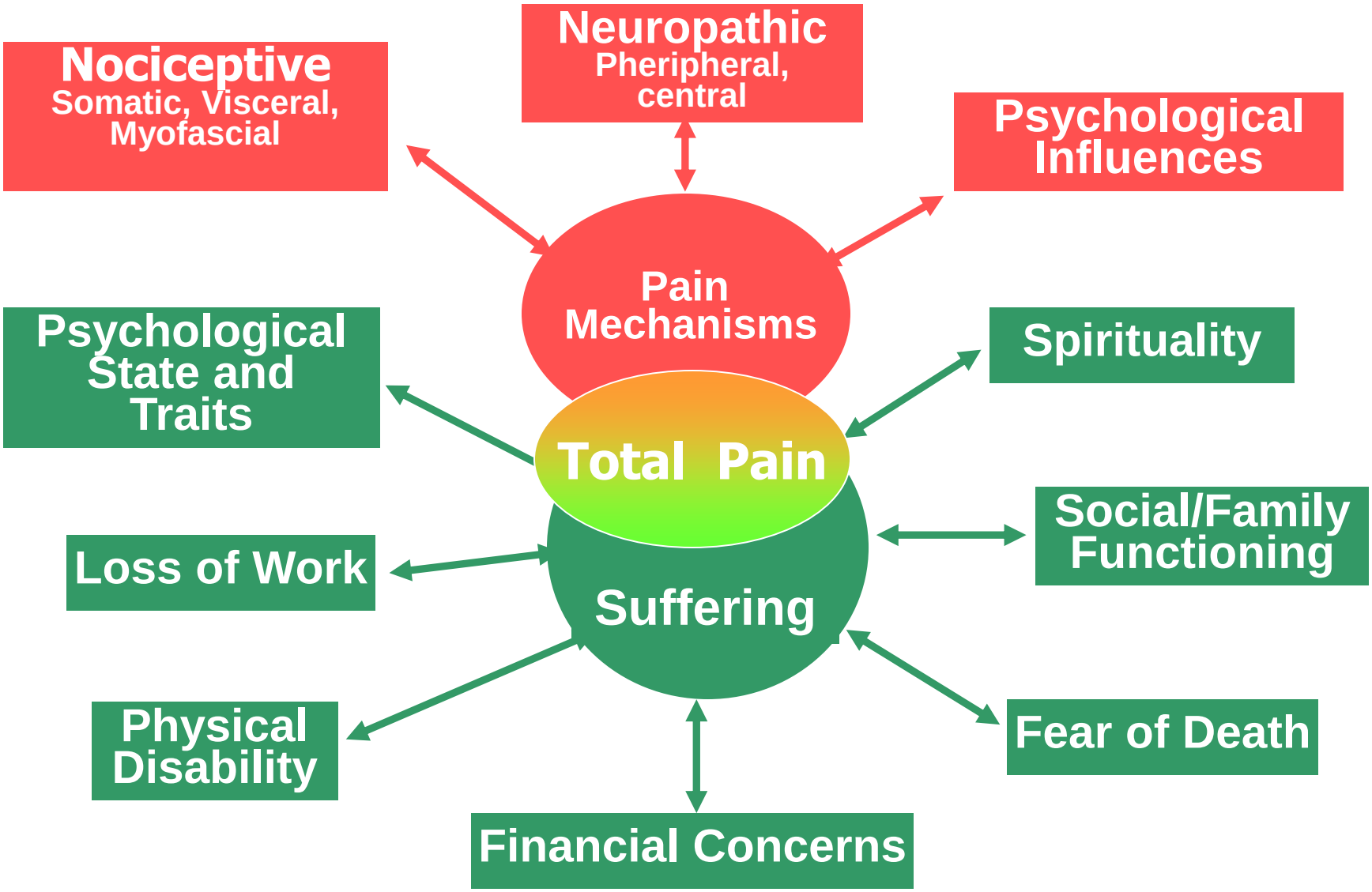
- Doctors aren't aware of their patients' wishes.
- A major 2007 study found that only 25% of physicians knew that their patients had advance directives on file.
- The end of life is often treated only as a medical moment.

Basic Concepts of Hospice & Supportive (Palliative Care)

Modified from-
http://depts.washington.edu/pallcare/training/ppt.shtml



Nature of Pain(or other symptom)



Supportive Care (Palliative Care)

- Supportive Care is given to improve the quality of life of patients who have a serious, chronic or life-threatening disease.
- The goal of Palliative Care is to prevent or treat as early as possible, the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social and spiritual problems related to a disease or its treatment.
- In short, symptom management, regardless of where the patient is in the disease process, is utilizing a biopsychosocial approach.

Supportive Care (Palliative Care)

- Primarily Inpt/office based
- Ongoing eval risk/benefit of interventions
- Chaplain and social work svcs available as outpt
- Helps to improve QOL and shown to improve lifespan in Stage 4 NSCLC
- No mechanism for reimbursement for multidisciplinary home based supportive care
- Pt/families often seen while enrolled in HHC

Hospice

- Provides support and care for those in the last phases of life-limiting illness(prognosis <6months)
- Recognizes dying as part of the normal process of living
- Affirms life and neither hastens nor postpones death
- Focuses on quality of life for individuals and their family caregivers

Differentiation

- Hospice - if the disease follows the expected course, a prognosis of six months or less (patients often referred late, NEJM NSCLC study)
- Supportive (Palliative) - symptom focused care anywhere throughout the disease spectrum, can be delivered in conjunction with curative care

Core Aspects of Hospice

- Patient/family focused
- Interdisciplinary
- Provides a range of services:
  - Interdisciplinary case management
  - Pharmaceuticals
  - Durable medical equipment
  - Supplies
  - Volunteers
  - Grief support

Additional Services

- Hospice offers additional services, including:
  - Hospice residential care (facility)
  - Inpatient hospice care
  - Complementary therapies
  - Specialized pediatric team
  - Caregiver training classes

Hospice Team Members

- The patient's personal physician
- Hospice physician (medical director)
- Nurses
- Home health aides
- Social workers
- Clergy or other counselors
- Trained volunteers
- Speech, physical, and occupational therapists

The Hospice Team

- Develops the plan of care
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for the patient and family
- Provides bereavement care and counseling

Where Hospice is Provided

- Home
- Nursing Facility
- Assisted Living Facility
- Hospital
- Hospice residence or unit
- Prison, homeless shelter – where ever the person is

Who Pays?

- Medicare
- Medicaid
- Insurance
- Private pay
- Sometimes a combination of these…

Admission Criteria

- General
  - Life-limiting illness, prognosis is 6 months or less if disease takes normal course
  - Live in service area
  - Consent to accept services

Physicians *Overestimate* Life Expectancy by What Percent?

a)10
b)50
c)70
d)90
e)Google

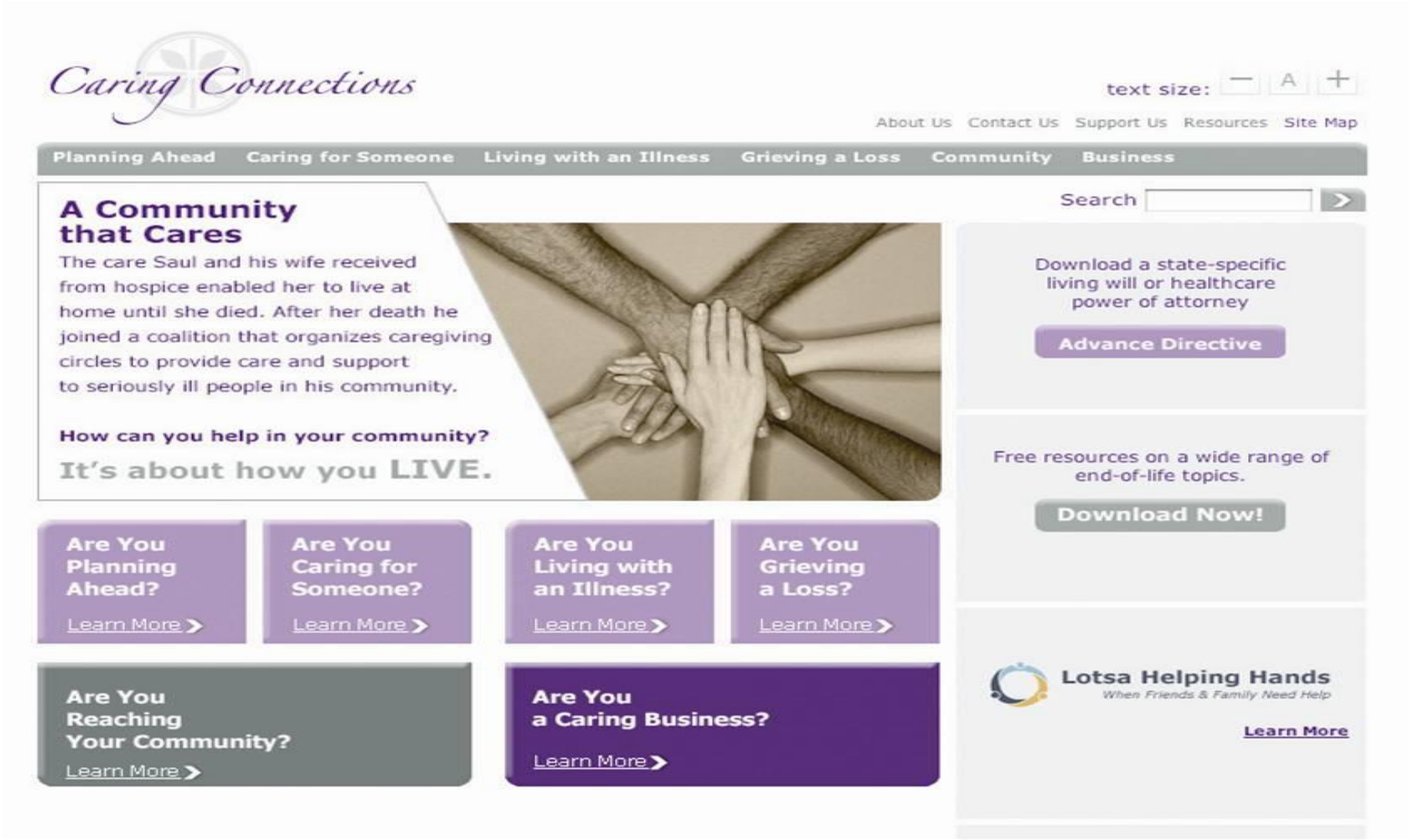
When to ask about Hospice or Supportive(Palliative) Care

- Poor quality of life
- Uncontrolled symptoms
- Treatment plan discordant with wishes
- Multiple hospitalizations but not getting “better”
- Prognosis 6months or less (based on diagnosis)
- Declining functional status/wt loss/overall decline
- Please d/w your family/physician/clergy/HC team

Summary

- Performance status important trigger for appropriate supportive/pall care/hospice referrals
- Patients/families/physicians often receive/refer patients late for palliative/hospice care
- We are there to support you and our patients/families throughout the spectrum of care
- Effort for true patient centered care must be united to be successful, resulting in better outcomes
- Complete your advanced directives, make your wishes known

www.caringinfo.org 800.658.8898



FREE Resources Available from *Caring Connections*

- More information about Hospice and Palliative Care
- State-specific advance directives
- Brochures to download or order:
  - What is Palliative Care?
  - Ask Tough Questions
  - Conversations Before the Crisis
  - Question and Answers: Artificial Nutrition
  - Question and Answers: Cardiopulmonary
  - Question and Answers: Dying at Home

It’s About How You LIVE!

- Learn about your options, choices and decisions
- Implement your advance directive plans
- Voice your decisions about hospice and palliative care
- Engage others to learn more about hospice and palliative care

Goals of Care and Approach

Why Talk About “It”

According to bioethicist Leon R. Kass, “At the time of life when there is perhaps the greatest need for human warmth and comfort, the dying patient is kept company by cardiac pacemakers and defibrillators, respirators, aspirators, oxygenators, catheters and his intravenous drip. Ties to the community of men are replaced by attachments to an assemblage of machines.”

What People Want

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- To be free from pain
- To be in the company of loved ones
- To retain control of the care we receive

The Contrast of Reality

- Less than 25 percent of Americans die at home, although more than **70 percent** say that is their wish
- Dying is often unnecessarily painful and isolating
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Barriers to Palliative Care & Hospice

- Lack of knowledge
- Culture
- Religion
- Limited trained providers
- Fractionated health system
- Communication
- Perception

When Should We Have the Talk -

Patients with a serious, life-threatening illness &

- Not Surprised if the patient died in the next 12 months
- Bounce-Backs more than one ED visit or hospital admission for the same condition within several months
- Uncontrolled Symptoms prompted by difficult-to-control physical or emotional symptoms
- Functional Decline or worsening of feeding intolerance, unintentional weight loss, or caregiver distress
- Increasingly Complicated-complex long-term care needs

Goals of Care

- Talking with patients about resuscitation preferences can be challenging.
- Patients tend to overestimate their chances of surviving arrest by, on average, 60.4%.
- The average survival-to-discharge rate for adults who suffer in-hospital arrest is 17% to 20% (has not changed in decades).
- Advanced age, malignancy, cirrhosis, AIDS, and renal failure are associated with poorer outcomes.

We all die. The goal isn't to live forever, the goal is to create something that will.

Chuck Palahniuk

(American transgressional fiction novelist and freelance journalist)

Physicians *Overestimate* Life Expectancy by What Percent?

a) 10

b) 50

c) 70

d) 90

e) Google

A Profound Thought…..

"The bad news about breaking bad news is that bad news is bad news."

Definition

Bad news is any news that seriously and adversely affects the patient's view of his or her future.

Background

Many patients with cancer, for example, can recall in detail how their diagnosis was disclosed, even if they remember little of the conversation that followed, and they report that physician competence in these situations is critical to establishing trust.

Separate MESSAGE from MESSENGER

Even though the message is bad, the messenger can be seen as part of the support system. Attitude is extremely important.

Myth- Breaking Bad News is an Innate Skill

- Physicians who are good at discussing bad news with their patients usually report that breaking bad news is a skill that they have worked hard to learn.
- Furthermore, studies of physician education demonstrate that communication skills can be learned and have effects that persist long after the training is finished.

SPIKES Method

- **S** Getting the **SETTING** right
- **P** What the patient **PERCEIVES**
- **I** An **INVITATION** to share the news
- **K** Giving the **KNOWLEDGE**
- **E** **EMPATHISING & EXPLORING** the patient's emotions and
- **S** **STRATEGY** and **SUMMARY**

S - SETTING

- Privacy
  - Family members
- Eye contact
- Body language and positioning
- Psychotherapy neutral position

Getting Started

- The physical setting ought to be private, with both physician and patient comfortably seated.
- You should ask the patient who else ought to be present and let the patient decide -- studies show that different patients have widely varying views on what they would want.
- It is helpful to start with a question like, "How are you feeling right now?" to indicate to the patient that this conversation will be a two-way affair.

Starting off

“BEFORE YOU TELL, ASK”

P - PERCEPTION

Different ways of asking

- Assess vocabulary and comprehension

Note denial

Listening Skills:

- Silence
- Repetition
- ‘’Listening mode”
- Touch (as appropriate)
- Avoid office interruptions

Find Out Patient Perception

- By asking a question such as, "What have you already been told about your illness?"
- Begin to understand what the patient has already been told ("*I have lung cancer, and I need surgery*").
- How much the patient understood about what's been said ("*the doctor said something about a spot on my chest x-ray*").
- Patient level of technical sophistication ("*I've got a T2N0 adenocarcinoma*").
- Patient emotional state ("*I've been so worried I might have cancer that I haven't slept for a week*").

I - INVITATION by the Patient to Share the Information

- Different ways of asking
- Level of information to provide
- Aim to get a clear invitation - often indicated by patient query such as “what else should I know?”

K - Giving the KNOWLEDGE and Medical Facts

Align starting at a point compatible with the patient's current comprehension and terminology:

- Small chunks check reception
- Avoid "medspeak"
- Adjust pace according to patient's response

Sharing the Information

- Decide on the agenda before you sit down with the patient so that you have the relevant information at hand.
- The topics to consider in planning an agenda are: Diagnosis, treatment, prognosis, and support or coping. However, an appropriate agenda will usually focus on one or two topics.
- For a patient on a medicine service whose biopsy just showed lung cancer, the agenda might be: a) disclose diagnosis of lung cancer; b) discuss the process of workup and formulation of treatment options.

Info Sharing Pointers

- Give the information in small chunks and be sure to stop between each chunk to ask the patient if he or she understands; ("*I'm going to stop for a minute to see if you have questions*").
- Long lectures are overwhelming and confusing.
- Remember to translate medical terms into English and don't try to teach pathophysiology. Avoid “medicalese.”

E - Acknowledging EMOTIONS

- The “Empathic Response”
  - Identify the emotion (theirs or yours)
  - Identify the source of the emotion
  - Respond in a way that shows you have made that connection
  - You don’t have to agree with the viewpoint
- Avoid downplaying severity of situation
- You don’t have to feel the emotion yourself

Responding to patient feelings

- If you don't understand the patient's reaction, you will leave a lot of unfinished business, and you will miss an opportunity to be a caring physician.
- Learning to identify and acknowledge a patient's reaction is something that definitely improves with experience, if you're attentive, but you can also simply ask ("*Could you tell me a bit about what you are feeling?*").

S - STRATEGY & SUMMARY

- Develop plan collaboratively
- Summarize main areas
- Any questions for now?
- Clear plan for next steps

Planning and Follow-Through

- At this point you need to synthesize the patient's concerns and the medical issues into a concrete plan that can be carried out in the patient's system of health care.
- Outline a step-by-step plan, explain it to the patient, and contract about the next step.
- Be explicit about your next contact with the patient ("*I'll see you in clinic in 2 weeks*") or the fact that you won't see the patient ("*I'm going to be rotating off service, so you will see Dr. Back in clinic*").
- Give the patient a phone number or a way to contact the relevant medical caregiver if something arises before the next planned contact.

What If the Patient Starts to Cry While I am Talking?

What if the patient starts to cry while I am talking?

- In general, it is better simply to wait for the person to stop crying.
- If it seems appropriate, you can acknowledge it ("*Let's just take a break now until you're ready to start again*") but do not assume you know the reason for the tears (you may want to explore the reasons now or later).
- Most patients are somewhat embarrassed if they begin to cry and will not continue for long. It is nice to offer kleenex if they are readily available (something to plan ahead); but try not to act as if tears are an emergency that must be stopped, and don't run out of the room--you want to show that you're willing to deal with anything that comes up.

The best laid plans of mice and men often go astray……

I had a long talk with the patient yesterday, and today the nurse took me aside to say that the patient doesn't understand what's going on! What's the problem?

- Sometimes patients ask the same question of different caregivers, sometimes they just didn't remember it all, and sometimes they need to go over something more than once because of their emotional distress, the technical nature of the medical interventions involved, or their concerns were not recognized and addressed.

Its not you its me, well maybe it really is you…..

I just saw another caregiver tell something to my patient in a really insensitive way. What should I do?

- First, examine what happened and ask yourself why the encounter went badly. If you see the patient later, you might consider acknowledging it to the patient in a way that doesn't slander the insensitive caregiver ("*I thought you looked upset when we were talking earlier and I just thought I should follow up on that--was something bothering you?*").

S-P-I-K-E-S Method

- Easy to remember steps
- Physicians can separate themselves from the “bad news”
- A quality and fair approach for good patient care

Perspective

Breaking bad news is never easy or pleasant: but at least having some plan or approach increases the professional's feeling of confidence and that is often perceived as increased competence.

Case - Sometimes You Have to Take What the Defense Gives You

- 74 yo F with NSCLC
- Stage IV at diagnosis
- Never smoked, drank, etc
- Scapular and abd pain
- Consulted for “pain mgmt”
- Family wants hospice, pt angry - not agreeable

Steps

- Day 1 - Address pain
- Day 2 - Address code status (more important than macro goals discussion)
- Day 3 - Pt agreeable to hospice
- Day 6 - Peaceful death in Hospice

What if I Just Can’t Have “The Talk”

- Think about patients co-morbidities
- Add current trajectory
- Discuss risk/benefit given this milieu

Self Care-for MD's, NP's, RN's, Everyone!

- Epidemic of physician/caregiver burnout
- Optimize admin support, efficiencies in the workplace
- Find healthy coping that works for you
- Establish boundaries (given the interpersonal nature of hospice and palliative care boundaries can be difficult to enforce)
- Establish supportive network
- Know the signs of burnout and address them in a timely manner (lack of empathy, disengagement, etc)
- There is only one you! Care for yourself like you care for your patients!

Final Thought

Do not undertake anything beyond your capacity and at the same time do not harbor the wish to do less than you can. One who takes up tasks beyond his powers is proud and attached. On the other hand, one who done less than he can is a thief---- *Mohandas Gandhi*

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Covid-19

Background

- Coronavirus disease 2019 (COVID-19) illness caused by a novel coronavirus now called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; formerly called 2019-nCoV),
- First identified amid an outbreak of respiratory illness cases in Wuhan City, Hubei Province, China. Initially reported to the WHO on December 31, 2019. On January 30, 2020, the WHO declared the COVID-19 outbreak a global health emergency. March 11, 2020, the WHO declared COVID-19 a global pandemic
- According to the CDC, individuals at high risk of infection include persons in areas with ongoing local transmission, healthcare workers caring for patients with COVID-19, close contacts of infected persons, and travelers returning from locations where local spread has been reported.
- Person-to-person spread of SARS-CoV-2 has occurred in the United States. Individuals who believe they may have been exposed to SARS-CoV-2 should immediately contact their healthcare provider.

Symptoms

- Presentations of COVID-19 have ranged from asymptomatic/mild symptoms to severe illness and mortality. Symptoms may develop 2 days to 2 weeks following exposure to the virus. A pooled analysis of 181 confirmed cases of COVID-19 outside Wuhan, China, found the mean incubation period to be 5.1 days and that 97.5% of individuals who developed symptoms did so within 11.5 days of infection.
- Wu and McGoogan reported that, among 72,314 COVID-19 cases reported to the Chinese Center for disease Control and Prevention (CCDC), 81% were mild (absent or mild pneumonia), 14% were severe (hypoxia, dyspnea, >50% lung involvement within 24-48 hours), 5% were critical (shock, respiratory failure, multiorgan dysfunction), and 2.3% were fatal. [15]
- Common symptoms have included the following: Fever, Cough, Myalgia, Fatigue, Shortness of breath/dyspnea
- Less-common symptoms have included the following: Headache, Sputum production, Diarrhea, Malaise, Respiratory distress
- The most common serious manifestation of COVID-19 appears to be pneumonia.
- A complete or partial loss of the sense of smell (anosmia) has been reported as a potential history finding in patients eventually diagnosed with COVID-19, but this has not been a distinguishing feature in published studies, so its clinical importance is questionable.
- Symptoms in children with infection appear to be uncommon, although some children with severe COVID-19 have been reported.

Diagnosis and Management

- COVID-19 should be considered a possibility in patients with respiratory tract symptoms and newly onset fever or in patients with severe lower respiratory tract symptoms with no clear cause.
- Suspicion is increased if such patients have been in an area with community transmission of SARS-CoV-2 or have been in close contact with an individual with confirmed or suspected COVID-19 in the preceding 14 days.
- Microbiologic testing is required for definitive diagnosis(RT-PCR).
- Patients who do not require emergency care are encouraged to contact their healthcare provider over the phone. Patients with suspected COVID-19 who present to a healthcare facility should prompt infection-control measures. They should be evaluated in a private room with the door closed (an airborne infection isolation room is ideal) and asked to wear a surgical mask. All other standard contact and airborne precautions should be observed, and treating healthcare personnel should wear eye protection.

Management

- No specific antiviral treatment is recommended for COVID-19. Infected patients should receive supportive care to help alleviate symptoms. Vital organ function should be supported in severe cases. [20]
- No vaccine is currently available for SARS-CoV-2. Avoidance is the principal method of deterrence.
- Numerous collaborative efforts to discover and evaluate effectiveness of antivirals (e.g. remdesivir), immunotherapies (e.g. hydroxychloroquine, sarilumab), monoclonal antibodies, and vaccines have rapidly emerged.

Virology and Transmission

- Coronaviruses are a vast family of viruses, 7 of which are known to cause disease in humans. SARS-CoV-2 is likely one such virus, postulated to have originated in an animal and seafood market, now with person to person transmission.
- Severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome(MERS) are also caused by coronaviruses that "jumped" from animals to humans (mortality rate of approximately 10%), before it was controlled in 2003. MERS continues to resurface in sporadic cases. A total of 2,465 laboratory-confirmed cases of MERS have been reported since 2012, resulting in 850 deaths (mortality rate of 34.5%).

Route of Transmission

- Transmission is believed to occur via respiratory droplets from coughing and sneezing, as with other respiratory pathogens, including influenza and rhinovirus. Virus released in respiratory secretions can infect other individuals via direct contact with mucous membranes. Droplets usually cannot travel more than 6 feet. The virus can also persist on surfaces to varying durations and degrees of infectivity. Importance of social distancing to inhibit transmission.
- The duration of viral shedding varies significantly and may depend on severity.
- Data have suggested that asymptomatic patients are still able to transmit infection.

Epidemiology and Prognosis

Coronavirus outbreak and pandemic

- More than 1million persons afflicted globally with greater than 60,000 deaths as of early April 2020. More than 180 countries have reported laboratory-confirmed cases of COVID-19 on all continents except Antarctica.

United States data

- On February 26, 2020, the first case of COVID-19 not associated with travel from China or known contact with an infected traveler was reported in California. Community spread of the virus has now been reported in multiple states. Local clusters "hotspots" have occurred (i.e. NY City).
- "Surge" of acute Covid-19 patients has resulted in strained health systems throughout the US (inadequate PPE-personal protective equipment, hospital beds, personnel, ventilators, ICU beds etc.).
- Guidelines for PPE use in public, for healthcare providers see CDC website:https://www.cdc.gov/hai/prevent/ppe.html

China

- Few cases recently, marked concern for underreporting and lack of transparency.
- **Prognosis-overall mortality to date ~2%(markedly worse than influenza, less deadly than SARS,MERS). Those most at risk are older with multiple co-morbidities. Eighty percent of those with Covid-19 have mild symptoms/can be treated at home.**

References

- https://www.esicm.org/wp-content/uploads/2020/03/SSC-COVID19-GUIDELINES.pdf
- https://emedicine.medscape.com/article/2500114-overview#showall
- *Michael Stuart Bronze. Fast Five Quiz: COVID-19 - Medscape - Mar 20, 2020.*
- https://reference.medscape.com/viewarticle/924616_2

APPENDIX

What People Want – Page 11: Notes

Citations:

- Item 1:
- Institutes of Medicine Report *Dying in America*, 2014: http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- As reported by PBS Frontline, *Facing Death* (sourcing a Time/CNN Poll from 2000: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/)

- Items 3 and 4:
- Institute of Medicine (IOM) Report *Dying in America*, 2014: http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- The Journal of the American Medical Association, *SUPPORT Study* , 1995: http://jama.jamanetwork.com/article.aspx?articleid=391724

The Contrast of Reality – Pg 12: Notes

- People often don't receive the care they want – almost everyone has a "horror story" of a loved one dying in pain or isolation that could have been avoided.

- Citations in Order
- 1.a Reported by PBS Frontline, sourcing the Centers for Disease Control, 2005: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/
- 1.b Harvard Business Review *Tackling Social Problems*, 2012: https://hbr.org/2012/01/tackling-social-problems/
- 2. IOM, Dying in America, 2014
- 3. Reported by PBS Frontline, sourcing The Associated Press, 2010: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/
- 3. Reported by National Health Care Decisions Day (NHDD) sourcing The Pew Research Center, *More Americans Discussing – and Planning – End-of-Life Treatment,* 2006: http://www.people-press.org/files/legacy-pdf/266.pdf

The Reason for this Stark Reality – Pg 13: Notes

- Reported by PBS Frontline sourcing Critical Case Journal, 2007: http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/
- Reported by National Health Care Decisions Day (NHDD): http://www.nhdd.org/facts/

Core Aspects of Hospice – Pg 21: Notes

- As defined by HMB

Additional Services – Pg 22: Notes

Not all programs offer these – based on needs in community, mission, resources, skills

Hospice Team Members – Pg 23: Notes

Also from the HMB – palliative care programs don’t need to include all these disciplines

The Hospice Team – Pg 24: Notes

- These are primary services offered by hospice. Not all patients/families avail themselves of these services.
- Develops the plan of care with the family
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for care needs of patient and family
- Provides bereavement care and counseling to surviving family and friends

Where Hospice is Provided – Pg 25: Notes

- Delivered across care setting
- Man on the porch

www.caringinfo.org 800.658.8898 – Pg 31: Notes

- www.caringinfo.org is a national consumer website, sponsored by NHPCO, with specific information on:
  - Advance care planning
  - Caregiving
  - Pain
  - Financial Planning
  - Hospice and palliative care
  - Grief
- Plus a consumer helpline number is available to answer your questions. Will mail advance directives for FREE

FREE Resources Available from *Caring Connections* – Pg 32: Notes

- The FREE resources available from Caring Connections are:
- State-specific advance directives
- Advance Care Planning information
- Some of the brochure topics available to download or order:
  - *Advance Directives and End-of-Life Decisions*
  - *Health Care Agents: Appointing One & Being One*
  - *Conversations Before the Crisis*
  - *You Have Filled Out Your Advance Directive…Now What?*
  - *Ask Tough Questions*

It's About How You LIVE! Pg 33: Notes

- Overall – IT"S ABOUT HOW YOU LIVE!
- Think about how you want it to be for yourself, your loved ones and your community and decide what actions you need and want to take when you walk out the door
- You can **Learn** more about your options and choices about hospice and palliative care
- You can **Implement** a plan to ensure your wishes are honored by completing your advance directives and other plans for future health care. FREE advance directive forms are available at www.caringinfo.org
- You can **Voice** your decisions about hospice and palliative care by talking to your loved ones and doctor
- You can **Engage** in personal or community efforts to improve end-of-life care by helpng others to learn more about hospice and palliative care
- We are here to help you take that next step with whatever you decide. To contact us……
- Thank you for your time.

What People Want – Pg 36: Notes

Citations:

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- The Journal of the American Medical Association, *SUPPORT Study* , 1995: http://jama.jamanetwork.com/article.aspx?articleid=391724

The Contrast of Reality – Pg 37: Notes

Citations:

- Item 1:
- Institutes of Medicine Report *Dying in America*, 2014: http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
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- The Journal of the American Medical Association, *SUPPORT Study* , 1995: http://jama.jamanetwork.com/article.aspx?articleid=391724

POSTTEST/QUIZ

Please click on the link below to be taken to this activity's quiz. After successful completion, you can then fill out an evaluation and application for CME credit.

Approach to Care, Prognosis