UNCLASSIFIED

COVID-19 Palliative Care Toolkit:
Pandemic Use and Beyond

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Air Force Colonel Laurie Migliore, Ph.D., M.S.N., is the Director of Nursing Research and Center of Clinical Inquiry at the 59th Medical Wing, Office of the Chief Scientist, Science & Technology, Joint Base San Antonio, Lackland, AFB, Texas. Col Migliore's primary research endeavors focus on a variety of military health priorities in the domains of psychological health, deployment health and translational science. Her research passion is understanding and characterizing cognitive models of military identity and exploring relationships between core cognitive identity attributes, strength of military identity, and psychological well-being. Her work also includes studies exploring optimal mattress surfaces to reduce pressure injuries during aeromedical evacuation, long-term health outcomes of aeromedically evacuated patients, transport considerations for psychologically injured patients returned from war, and social network analysis of military researchers to identify collaborative trends to advance science.

Col Migliore leads teams in creating, translating, and implementing, evidence into military health care practices. She recently led several COVID-19 efforts, as a medical intelligence team lead; investigating the psychological impact of COVID-19 on coping strategies of deployed health care workers and the development of a COVID-19 palliative care toolkit for military facilities without palliative care staff. Col Migliore has collaborative relationships with investigators from Uniformed Services University, University of Michigan, Ohio State University, Tripler and Fort Bragg Army Medical Centers, and the TriService Nursing Research Program and 711th HPW. She is a member of the Association for Psychological Sciences since 2013. Col Migliore is an expert in agility and adapting to the needs of the military research community.

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Lt Col Sarah Huffman, Ph.D., C.C.N.S., A.C.N.P. is currently assigned to Travis Air Force Base (AFB), Calif. as the Director of Biobehavioral Research. Lt Col Huffman was previously assigned at Wright Patterson Air Force Base in Ohio as a nurse scientist in the Airman Biosciences Division, En Route Care Research at the 711th Human Performance Wing, and as Director of the Clinical Investigations Facility at the 88th Medical Group. Other former military assignments include Travis AFB, Calif. as a medical/surgical critical care nurse; Langley AFB, VA as the Emergency Department nurse manager; and Joint Base Elmendorf Richardson, AK as a critical care Clinical Nurse Specialist. Additionally, Lt Col Huffman completed two Air Force Institute of Technology (AFIT) student assignments and five deployments as a critical care nurse in support of Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)/Operation New Dawn (OND). Other recent deployments include Ground Surgical team nurse in support of Operation JUNIPER SHIELD and later as a pre-deployment site survey lead for ARNORTH Joint Task Force—civil authority during the COVID surge. Lt Col Huffman earned a Bachelor of Science Degree in nursing from the University of Texas, a master's degree with a focus on critical care nursing from the University of Virginia with certification as a critical care Clinical Nurse Specialist and Acute Care Nurse Practitioner, and in 2017 a Ph.D. in nursing from Uniformed Services University, Bethesda, MD. Lt Col Huffman's current active research studies include: "Adaptive Triage: A Prototype of Complex Military Medical-Decision-Making in Real Time Mass Casualty" and "Resilience in Special Operations Surgical Teams" which focus on performance improvement and readiness among combat casualty care teams in austere environments. Other research interests include social network analysis, communication and decision making in small medical teams, and the biopsychosocial-spiritual attributes of readiness and resilience that may enhance or degrade performance in En Route Combat Casualty Care (ERCCC) providers.

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Rebecca Heyne, Ph.D., D.N.P., M.B.A., C.P.N.P.-P.C. is an Evidence-Based Practice Facilitator with the TriService Nursing Research Program (TSNRP). She provides consultative services and mentorship for Evidence-Based Practice initiatives. Dr. Heyne is also an Executive Board Member of the Air Force Medical Service (AFMS) Centers of Clinical Inquiry. Dr. Heyne's evidence-based practice focuses on self-care, complementary and alternative medicine, mindfulness, palliative care and resiliency.

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LeAnne Lovett-Floom, D.N.P., M.S.N., T.N.S., P.H.N.,-B.C., L.S.S.G.B. currently serves the Navy, Air Force and Army in her role as Evidence -Based Practice (EBP) Facilitator under the TriService Nursing Research Program (TSNRP). Her multifaceted career spans over 27 years across a variety of clinical specialties with an emphasis in public and disaster health preparedness, pre-hospital and emergency medicine, health innovation technology, health care leadership, and quality outcomes. Previous roles in executive management, program development, medical-legal consulting, and academic curriculum development provide value added service to her current role. As the spouse of a combat veteran, and previous roles working with wounded ill and injured services members, Her research interests include operational and deployment health, disaster preparedness, precision medicine, patient and family advocacy, venous thromboembolism, health quality outcomes, and population health initiatives. Holding key leadership roles in many professional and community organizations, Dr. Lovett-Floom ignites innovation in an ever-changing world and welcomes opportunities to create a healthier world.

Disclosures

- The presenters have no relevant financial or non-financial relationships to disclose relating to the content of this activity.
- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of Defense, nor the U.S. Government.
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  - Respecting Choices
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  - Col Stephen Hernandez, PhD, RN
  - Kristin Callaghan, MSN, APRN, FNP-C, MBA
  - Linda Gowenlock, MSN, MPH, ACNS-BC, CCNS, ACHPN
  - Dr. Diane A. Faran, MD, FAAHPM, Palliative Medicine Consultant

Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Define the need for and importance of basic palliative care for hospitalized inpatients during the COVID-19 pandemic.
2. List three common themes derived from the COVID-19 palliative care literature reviews.
3. Summarize two lessons learned from the pilot implementation of a COVID-19 palliative care toolkit.
4. Identify two recommendations for utilizing the COVID-19 palliative care toolkit in future operations.

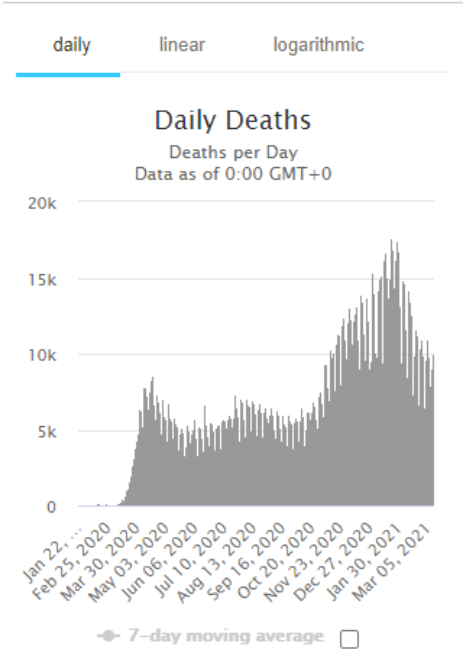
Overview

- Background
- Toolkit Development
- Toolkit Contents
- Pilot Implementation
- Evaluation: Lessons Learned
- Integration and Sustainment
- Military Relevance and Future Recommendations
- Key Takeaways

Background

COVID-19 Palliative Care Toolkit Background

- Early uncertainty of COVID-19 clinical impact on Military Treatment Facilities (MTFs)
- Travis Air Force Base is one of the earliest to be impacted in March of 2020
- Working on a rapid evidence-review for Crisis Standards of Care (CSC) the mortality rates in Italy were unprecedented
- Federal Emergency Management Agency (FEMA) Defense Support of Civil Authorities (DSCA) COVID-19 military deployer feedback (NY)
  - Staff unprepared for volume of death/dying
  - Crisis standards of care



(Worldometer, 2020)

COVID-19 Palliative Care Toolkit Background

- Bridge gap with limited Military Health System (MHS) resources

- MHS current Palliative Care Departments
  - Madigan Army Medical Center
  - Brooke Army Medical Center
  - Walter Reed National Military Medical Center

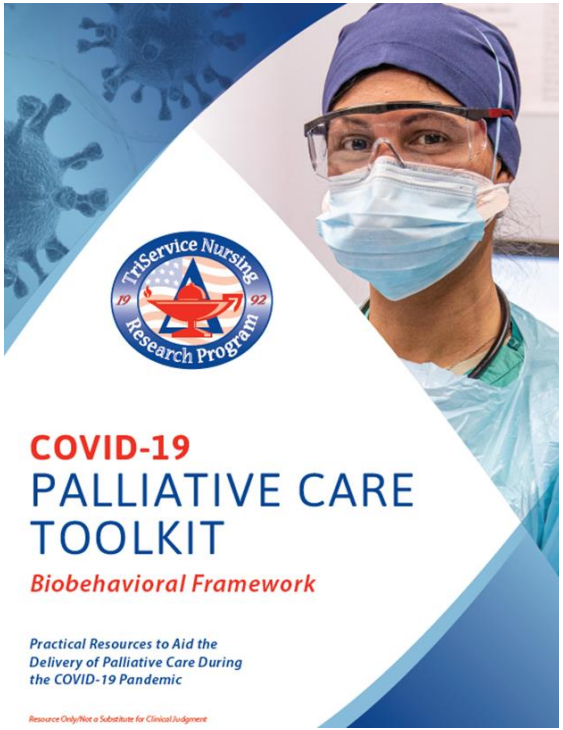
- TriService Nursing Research Program

  Evidence-based Practice (EBP) 2020 Mini-grant: $9K
  - Toolkit development + 10 iPads/stands/cases

(Migliore et al, 2021)

COVID-19 Palliative Care Toolkit Purpose

- Prepare/support frontline workers
- Unique COVID-19 palliative care challenges
  - Physical and social isolation
  - Limited access to in-person support (family, chaplains, social work, etc.)
  - Unpredictable rapid change of patient's clinical course
  - Complex decision-making conversations related to unanticipated death



(Migliore et al, 2021)

Toolkit Development

Literature Search: Show Me The Evidence!

PICOT Question

Population - Facilities caring for COVID-19 patients

Intervention - Palliative Care Team

Comparison - No Palliative Care Team

Outcomes - Management of COVID-specific care challenges

Time - During the COVID pandemic

In facilities caring for COVID-19 patients, how does having a palliative care team vs. having no palliative care team affect the management of COVID-specific care challenges?

Results: 2020 Rapid Review & Synthesis

- 17 publications were included for palliative care
- Nine publications included for iPad communication use
- Evidence ranged from Level V-VII
- Six central themes and high demand, high priority, high impact education needs and resources were identified

Level of Evidence	Reference	Key Elements
VI	Arya et al. (2020). Pandemic palliative care: Beyond ventilators and saving lives. *CMAJ, 2020*, 1-5.	- Symptom management and standard order sets - Staff education: palliative care principles, triage, telemedicine, critical communication regarding patient wishes and likelihood of survival - Leverage technology for patient/family communication
VII	Chidiac et al. (2020). Emergency palliative care planning and support in a -19 pandemic. *Journal of Palliative Medicine*, 23 (6), 1-2.	- Symptom management and standard order sets - Staff education: palliative care principles, critical communication - System for expedited discharge home with needed resources - Family/caregiver support for the provision of community-based palliative care
VII	Curtis et al. (2020). The importance of addressing advance care planning and decisions about do-not-resuscitate orders during novel coronavirus 2019 (COVID-19). *JAMA*, 323(18), 1771-1772.	- Importance of early discussion regarding patient's values, code status, goals for COVID-19 treatment - Avoiding non-beneficial or unwanted interventions to better allocate limited resources and reduce burden on healthcare workers
V	Etkind et al. (2020). The role and responses of palliative care and hospice services in epidemics and pandemics: A rapid review to inform practice during the COVID-19 pandemic. *Journal of Pain and Symptom Management*, S0885-3924 (20).	- Staff education: hospice/palliative care protocols, symptom management, psych support, bereavement counseling, personal protective equipment (PPE) - Need for palliative care and spiritual care experts, infrastructure for patient/family, support via phone - Shifting resources from inpatient to the community
VI	Fausto et al. (2020). Creating a palliative care inpatient response plan for COVID-19—The UW Medicine Experience. *Journal of Pain and Symptom Management*. DOI: 10.1016/j.jpainsymman.2020.03.025	- Inpatient response plan incorporates conventional, contingency, and crisis capacity. - Palliative care specialist consultation for inpatient providers - Train and coach staffing for crucial conversations - Encourage phone/video consultation to conserve PPE and limit exposure
VII	Ferguson et al. (2020). Palliative care pandemic pack: a specialist palliative care service response to planning the COVID-19 pandemic. *Journal of Pain and Symptom Management*, 60(1), e18-e20.	- 'Palliative Care Pandemic Pack' guide for non-palliative staff in **New Zealand** - Includes symptom management and other primary care provider resources - Empowers primary care teams to develop similar tools for their own communities
VII	Fusi-Schmidhauser et al. (2020). Conservative management of Covid-19 patients—emergency palliative care in action. *Journal of Pain and Symptom Management*, 60(1), e27-e30.	- Discussion regarding need for clear/concise treatment plan; rapid decision making - Focus **United Kingdom (UK)** and **Switzerland** during the COVID-19 pandemic - Developed a COVID-19 specific assessment tool to assist with quick assessment - Identification of key symptoms in an emergency setting when time is limited
VII	Hendin et al. (2020). End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection. *Canadian Journal of Emergency Medicine*, *22*(4), 414-417.	- Importance of reviewing patient's goals of care early in emergency department - Development of COVID-19 symptom management order sets - Importance of debriefing sessions for emergency department staff - Aid in decreasing risk of compassion fatigue/burnout
VII	Koh, M. Y. (2020). Palliative care in the time of COVID-19:	- Identified patient fears, isolation, need for spiritual/social connection

(Snapshot of one section of Evidence Table, Migliore et al., 2020)

Central Themes: 1 - 3

1. Critical need for frontline/primary care staff to have rapid palliative care training

2. Use existing palliative care specialists as consultants and subject matter experts

3. Primary education and training focuses:
    a) Immediate need to address goals of care
    b) Hard conversations
    c) Symptom management
    d) Communication (clear, direct, transparent)
    e) Mitigate social isolation through virtual/online/video calls
    f) Holistic approach body, mind, spiritual, social needs

Central Themes: 4 - 6

4. Support for caregivers (family members, staff)

5. Framework of stuff, staff, space, systems, separation

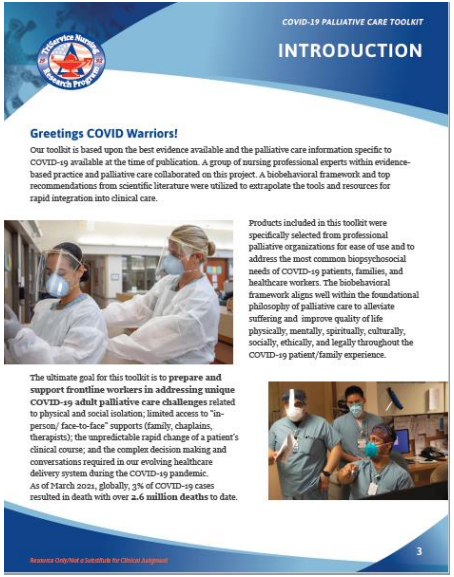
6. Need for quick use standardized resources (order sets, protocols, and guidelines)

(Brink, 2020)

Toolkit Contents

COVID-19 Palliative Care Toolkit Content

- Introduction
- About Toolkit Use
- Biobehavioral Framework
- Palliative Care 101
- Communication
- Pain & Symptom Management
- Support for Caregivers
- Mobile Apps
- Additional Resources



COVID-19 PALLIATIVE CARE TOOLKIT

INTRODUCTION

Greetings COVID Warriors!

Our toolkit is based upon the best evidence available and the palliative care information specific to COVID-19 available at the time of publication. A group of nursing professional experts within evidence-based practice and palliative care collaborated on this project. A biobehavioral framework and top recommendations from scientific literature were utilized to extrapolate the tools and resources for rapid integration into clinical care.

Products included in this toolkit were specifically selected from professional palliative organizations for ease of use and to address the most common biopsychosocial needs of COVID-19 patients, families, and healthcare workers. The biobehavioral framework aligns well within the foundational philosophy of palliative care to alleviate suffering and improve quality of life physically, mentally, spiritually, culturally, socially, ethically, and legally throughout the COVID-19 patient/family experience.

The ultimate goal for this toolkit is to **prepare and support frontline workers in addressing unique COVID-19 adult palliative care challenges** related to physical and social isolation; limited access to "in-person/ face-to-face" supports (family, chaplains, therapists); the unpredictable rapid change of a patient's clinical course; and the complex decision making and conversations required in our evolving healthcare delivery system during the COVID-19 pandemic. As of March 2021, globally, 3% of COVID-19 cases resulted in death with over **2.6 million deaths** to date.

Resource Only/Not a Substitute for Clinical Judgment

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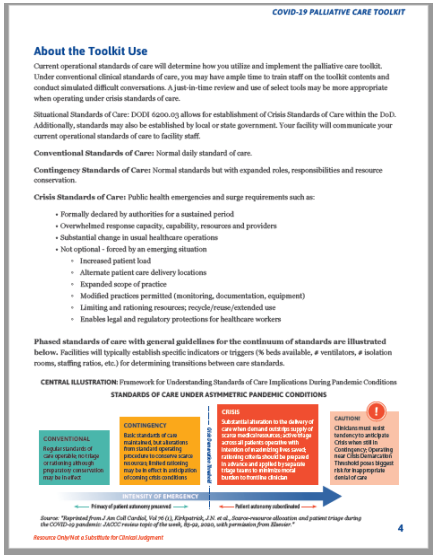
(Migliore et al, 2021)



COVID-19 PALLIATIVE CARE TOOLKIT

About the Toolkit Use

Current operational standards of care will determine how you utilize and implement the palliative care toolkit. Under conventional clinical standards of care, you may have ample time to train staff on the toolkit contents and conduct simulated difficult conversations. A just-in-time review and use of select tools may be more appropriate when operating under crisis standards of care.

Situational Standards of Care: DODI 6200.03 allows for establishment of Crisis Standards of Care within the DoD. Additionally, standards may also be established by local or state government. Your facility will communicate your current operational standards of care to facility staff.

Conventional Standards of Care: Normal daily standard of care.

Contingency Standards of Care: Normal standards but with expanded roles, responsibilities and resource conservation.

Crisis Standards of Care: Public health emergencies and surge requirements such as:

- Formally declared by authorities for a sustained period
- Overwhelmed response capacity, capability, resources and providers
- Substantial change in usual healthcare operations
- Not optional – forced by an emerging situation
  - Increased patient load
  - Alternate patient care delivery locations
  - Expanded scope of practice
  - Modified practices permitted (monitoring, documentation, equipment)
  - Limiting and rationing resources; recycle/reuse/extended use
  - Enables legal and regulatory protections for healthcare workers

Phased standards of care with general guidelines for the continuum of standards are illustrated below. Facilities will typically establish specific indicators or triggers (% beds available, # ventilators, # isolation rooms, staffing ratios, etc.) for determining transitions between care standards.

CENTRAL ILLUSTRATION: Framework for Understanding Standards of Care Implications During Pandemic Conditions

STANDARDS OF CARE UNDER ASYMMETRIC PANDEMIC CONDITIONS

CONVENTIONAL

CONTINGENCY

CRISIS

CAUTION

INTENSITY OF EMERGENCY

Primacy of patient autonomy preserved

Patient autonomy subordinated

Source: "Reprinted from J Am Coll Cardiol, Vol 76 (1), Kirkpatrick, J.N. et al., Scarce-resource allocation and patient triage during the COVID-19 pandemic: JACCS review topic of the week, 83-90, 2020, with permission from Elsevier."

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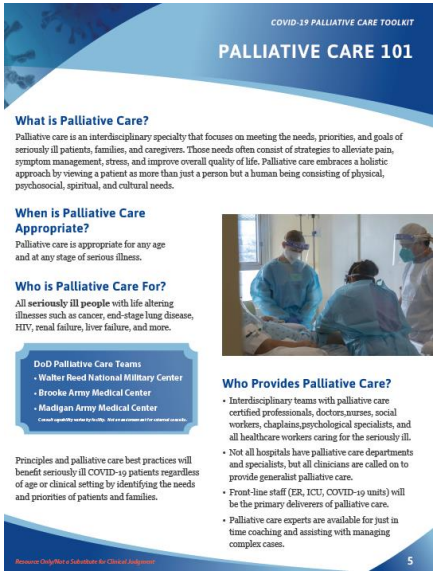
Biobehavioral Framework

- Integrates seven Domains of Palliative Care into Point of Care Toolkit

Palliative Care 101

- Who, what, when, where, why
- Care planning
- Goals
- Palliative Care vs Hospice vs End of Life care
- Referral considerations



COVID-19 PALLIATIVE CARE TOOLKIT

PALLIATIVE CARE 101

What is Palliative Care?

Palliative care is an interdisciplinary specialty that focuses on meeting the needs, priorities, and goals of seriously ill patients, families, and caregivers. Those needs often consist of strategies to alleviate pain, symptom management, stress, and improve overall quality of life. Palliative care embraces a holistic approach by viewing a patient as more than just a person but a human being consisting of physical, psychosocial, spiritual, and cultural needs.

When is Palliative Care Appropriate?

Palliative care is appropriate for any age and at any stage of serious illness.

Who is Palliative Care For?

All **seriously ill people** with life altering illnesses such as cancer, end-stage lung disease, HIV, renal failure, liver failure, and more.

DoD Palliative Care Teams
- Walter Reed National Military Center
- Brooke Army Medical Center
- Madigan Army Medical Center

Consult capability varies by facility. Visit an assessment for referral criteria.

Principles and palliative care best practices will benefit seriously ill COVID-19 patients regardless of age or clinical setting by identifying the needs and priorities of patients and families.

Who Provides Palliative Care?

- Interdisciplinary teams with palliative care certified professionals, doctors,nurses, social workers, chaplains,psychological specialists, and all healthcare workers caring for the seriously ill.
- Not all hospitals have palliative care departments and specialists, but all clinicians are called on to provide generalist palliative care.
- Front-line staff (ER, ICU, COVID-19 units) will be the primary deliverers of palliative care.
- Palliative care experts are available for just in time coaching and assisting with managing complex cases.

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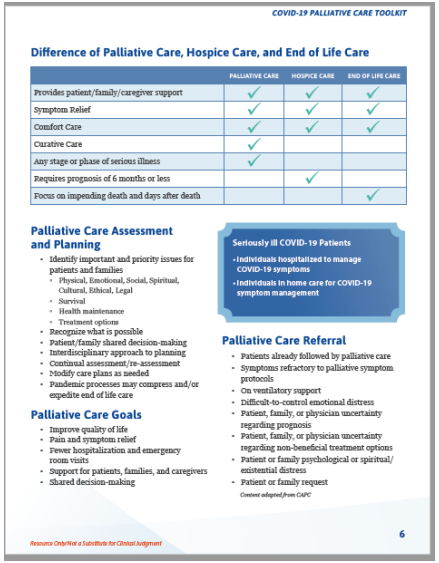

COVID-19 PALLIATIVE CARE TOOLKIT

Difference of Palliative Care, Hospice Care, and End of Life Care

	PALLIATIVE CARE	HOSPICE CARE	END OF LIFE CARE
Provides patient/family/caregiver support	✓	✓	✓
Symptom Relief	✓	✓	✓
Comfort Care	✓	✓	✓
Curative Care	✓		
Any stage or phase of serious illness	✓		
Requires prognosis of 6 months or less		✓	
Focus on impending death and days after death			✓

Palliative Care Assessment and Planning
- Identify important and priority issues for patients and families
  - Physical, Emotional, Social, Spiritual, Cultural, Ethical, Legal
  - Survival
  - Health maintenance
  - Treatment options
- Recognize what is possible
- Patient/family shared decision-making
- Interdisciplinary approach to planning
- Continual assessment/re-assessment
- Modify care plans as needed
- Pandemic processes may compress and/or expedite end of life care

Palliative Care Goals
- Improve quality of life
- Pain and symptom relief
- Fewer hospitalization and emergency room visits
- Support for patients, families, and caregivers
- Shared decision-making

Seriously ill COVID-19 Patients
- Individuals hospitalized to manage COVID-19 symptoms
- Individuals in home care for COVID-19 symptom management

Palliative Care Referral
- Patients already followed by palliative care
- Symptoms refractory to palliative symptom protocols
- On ventilatory support
- Difficult-to-control emotional distress
- Patient, family, or physician uncertainty regarding prognosis
- Patient, family, or physician uncertainty regarding non-beneficial treatment options
- Patient or family psychological or spiritual/existential distress
- Patient or family request

Content adapted from CAPC

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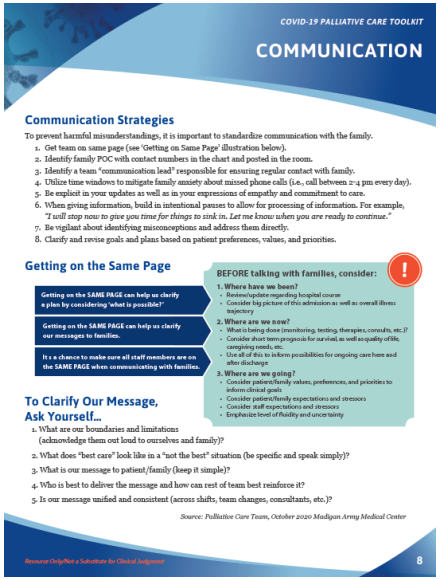
(Migliore et al, 2021)

Communication

- Strategies
- Getting on the same page
- Scripts



COVID-19 PALLIATIVE CARE TOOLKIT

COMMUNICATION

Communication Strategies

To prevent harmful misunderstandings, it is important to standardize communication with the family.

1. Get team on same page (see 'Getting on Same Page' illustration below).
2. Identify family POC with contact numbers in the chart and posted in the room.
3. Identify a team "communication lead" responsible for ensuring regular contact with family.
4. Utilize time windows to mitigate family anxiety about missed phone calls (i.e., call between 2-4 pm every day).
5. Be explicit in your updates as well as in your expressions of empathy and commitment to care.
6. When giving information, build in intentional pauses to allow for processing of information. For example, *"I will stop now to give you time for things to sink in. Let me know when you are ready to continue."*
7. Be vigilant about identifying misconceptions and address them directly.
8. Clarify and revise goals and plans based on patient preferences, values, and priorities.

Getting on the Same Page

Getting on the SAME PAGE can help us clarify a plan by considering 'what is possible?'

Getting on the SAME PAGE can help us clarify our messages to families.

It's a chance to make sure all staff members are on the SAME PAGE when communicating with families.

BEFORE talking with families, consider:

1. Where have we been?
   - Review/update regarding hospital course
   - Consider big picture of this admission as well as overall illness trajectory
2. Where are we now?
   - What is being done (monitoring, testing, therapies, consults, etc.)?
   - Consider short term prognosis for survival, as well as quality of life, caregiving needs, etc.
   - Use all of this to inform possibilities for ongoing care here and after discharge
3. Where are we going?
   - Consider patient/family values, preferences, and priorities to inform clinical goals
   - Consider patient/family expectations and stressors
   - Consider staff expectations and stressors
   - Emphasize level of fluidity and uncertainty

To Clarify Our Message, Ask Yourself...

1. What are our boundaries and limitations (acknowledge them out loud to ourselves and family)?
2. What does "best care" look like in a "not the best" situation (be specific and speak simply)?
3. What is our message to patient/family (keep it simple)?
4. Who is best to deliver the message and how can rest of team best reinforce it?
5. Is our message unified and consistent (across shifts, team changes, consultants, etc.)?

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

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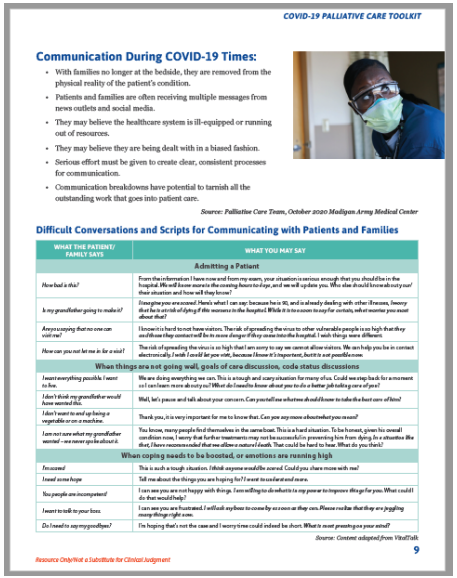

COVID-19 PALLIATIVE CARE TOOLKIT

Communication During COVID-19 Times:

- With families no longer at the bedside, they are removed from the physical reality of the patient's condition.
- Patients and families are often receiving multiple messages from news outlets and social media.
- They may believe the healthcare system is ill-equipped or running out of resources.
- They may believe they are being dealt with in a biased fashion.
- Serious effort must be given to create clear, consistent processes for communication.
- Communication breakdowns have potential to tarnish all the outstanding work that goes into patient care.

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

Difficult Conversations and Scripts for Communicating with Patients and Families

WHAT THE PATIENT/ FAMILY SAYS	WHAT YOU MAY SAY
Admitting a Patient	
How bad is this?	From this information I have now and from my exam, your situation is serious enough that you should be in the hospital. *We will know more in the coming hours to days*, and we will update you. Who else should I know about my care/ their situation and how will they know?
Is my grandfather going to make it?	*Imagine you are assessed.* Here's what I can say: because he is 90, and is already dealing with other illnesses, I worry that he is at risk of *dying if this worsens in the hospital.* While it is too soon to say for certain, what matters you most about that?
Are you saying that no one can visit me?	I know it is hard to not have visitors. The risk of spreading the virus to other vulnerable people is so high that *they will lose* their contact will be *is more benign if they come into the hospital.* I wish things were different.
How can you not let me in for a visit?	The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. We can help you be in contact electronically. *I wish I could let you visit, because I know it's important, but it is not possible now.*
When things are not going well, goals of care discussion, code status discussions	
I want everything possible. I want to live.	We are doing everything we can. This is a tough and scary situation for many of us. Could we step back for a moment so I can learn more about you? *What do I need to know about you to do a better job taking care of you?*
I don't think my grandfather would have wanted this.	Well, let's pause and talk about your concern. Can you tell me what we *should* know to take the best care of him?
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. *Can you say more about what you mean?*
I am not sure what my grandfather wanted – we never spoke about it.	You know, many people find themselves in the same boat. This is a hard situation. To be honest, given his overall condition now, I worry that further treatments may not be successful in preventing him from dying. In a situation like that, I have recommended that we allow a *natural death.* That could be hard to hear. What do you think?
When coping needs to be boosted, or emotions are running high	
I'm scared	This is such a tough situation. *I think anyone would be scared.* Could you share more with me?
I need some hope	Tell me about the things you are hoping for? *I want to understand more.*
You people are incompetent!	I can see you are not happy with things. *I am willing to do what is in my power to improve things for you.* What could I do that would help?
I want to talk to your boss.	I can see you are frustrated. *I will ask my boss to come by as soon as they can. Please realize that they are juggling many things right now.*
Do I need to say my goodbyes?	I'm hoping that's not the case and I worry time could indeed be short. *What is most pressing on your mind?*

Source: Content adapted from VitalTalk

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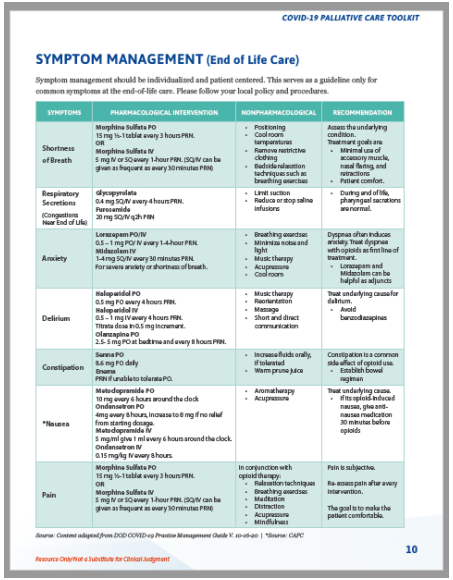
(Migliore et al, 2021)

Pain & Symptom Management

- End of life medication dosages and indications from DoD COVID-19 Practice Management Guide
- Evidence-based nonpharmacological strategies



COVID-19 PALLIATIVE CARE TOOLKIT

SYMPTOM MANAGEMENT (End of Life Care)

Symptom management should be individualized and patient centered. This serves as a guideline only for common symptoms at the end-of-life care. Please follow your local policy and procedures.

SYMPTOMS	PHARMACOLOGICAL INTERVENTION	NONPHARMACOLOGICAL	RECOMMENDATION
Shortness of Breath	Morphina Sulfate PO 15 mg ½-1 tablet every 3 hours PRN. OR Morphina Sulfate IV 5 mg IV or SQ every 1-hour PRN. (SQ/IV can be given as frequent as every 30 minutes PRN)	• Positioning • Cool room temperatures • Remove restrictive clothing • Bedside relaxation techniques such as breathing exercises	Assess the underlying condition. Treatment goals are: • Minimal use of accessory muscle, nasal flaring, and retractions • Patient comfort.
Respiratory Secretions (Congestions Near End of Life)	Glycopyrrolata 0.4 mg SQ/IV every 4 hours PRN. Peroxamida 20 mg SQ/IV q2h PRN	• Limit suction • Reduce or stop saline infusions	• During end of life, pharyngeal secretions are normal.
Anxiety	Lorazepam PO/IV 0.5 – 1 mg PO/ IV every 1-4-hour PRN. Midazolam IV 1-4 mg SQ/IV every 30 minutes PRN. For severe anxiety or shortness of breath.	• Breathing exercises • Minimize noise and light • Music therapy • Acupressure • Cool room	Dyspnea often induces anxiety. Treat dyspnea with opioids as first line of treatment. • Lorazepam and Midazolam can be helpful as adjuncts
Delirium	Haloperidol PO 0.5 mg PO every 4 hours PRN. Haloperidol IV 0.5 – 1 mg IV every 4 hours PRN. Titrate dose in 0.5 mg increment. Olanzapine PO 2.5- 5 mg PO at bedtime and every 8 hours PRN.	• Music therapy • Reorientation • Massage • Short and direct communication	Treat underlying cause for delirium. • Avoid benzodiazepines
Constipation	Sunna PO 8.6 mg PO daily Enema PRN if unable to tolerate PO.	• Increase fluids orally, if tolerated • Warm prune juice	Constipation is a common side-effect of opioid use. • Establish bowel regimen
*Nausea	Meto-Dopramide PO 10 mg every 6 hours around the clock Ondansetron PO 4mg every 8 hours, increase to 8 mg if no relief from starting dosage. Meto-Dopramide IV 5 mg/ml give 1 ml every 6 hours around the clock. Ondansetron IV 0.15 mg/kg IV every 8 hours.	• Aromatherapy • Acupressure	Treat underlying cause. • If its opioid-induced nausea, give anti-nausea medication 30 minutes before opioids
Pain	Morphina Sulfate PO 15 mg ½-1 tablet every 3 hours PRN. OR Morphina Sulfate IV 5 mg IV or SQ every 1-hour PRN. (SQ/IV can be given as frequent as every 30 minutes PRN)	In conjunction with opioid therapy: • Relaxation techniques • Breathing exercises • Meditation • Distraction • Acupressure • Mindfulness	Pain is subjective. Re-assess pain after every intervention. The goal is to make the patient comfortable.

*Source: Content adapted from DOD COVID-19 Practice Management Guide V. 10-16-20 | *Source: CAPC*

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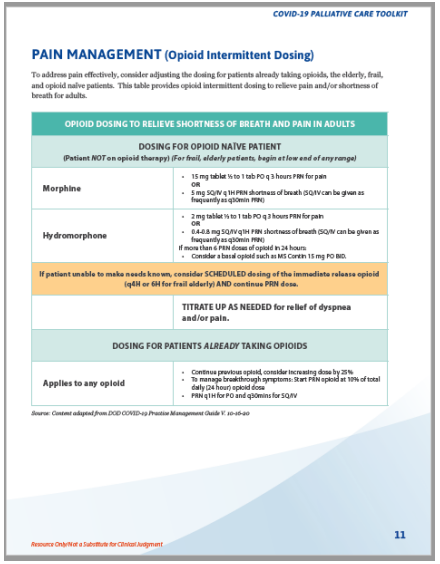

COVID-19 PALLIATIVE CARE TOOLKIT

PAIN MANAGEMENT (Opioid Intermittent Dosing)

To address pain effectively, consider adjusting the dosing for patients already taking opioids, the elderly, frail, and opioid naïve patients. This table provides opioid intermittent dosing to relieve pain and/or shortness of breath for adults.

OPIOID DOSING TO RELIEVE SHORTNESS OF BREATH AND PAIN IN ADULTS	
DOSING FOR OPIOID NAÏVE PATIENT **(Patient *NOT* on opioid therapy) *(For frail, elderly patients, begin at low end of any range)***	
Morphine	• 15 mg tablet ½ to 1 tab PO q 3 hours PRN for pain OR • 5 mg SQ/IV q 1H PRN shortness of breath (SQ/IV can be given as frequently as q30min PRN)
Hydromorphone	• 2 mg tablet ½ to 1 tab PO q 3 hours PRN for pain OR • 0.4-0.8 mg SQ/IV q1H PRN shortness of breath (SQ/IV can be given as frequently as q30min PRN) If more than 6 PRN dose of opioid in 24 hours: • Consider a basal opioid such as MS Contin 15 mg PO BID.
If patient unable to make needs known, consider SCHEDULED dosing of the immediate release opioid (q4H or 6H for frail elderly) AND continue PRN dose.	
	TITRATE UP AS NEEDED for relief of dyspnea and/or pain.
DOSING FOR PATIENTS *ALREADY* TAKING OPIOIDS	
Applies to any opioid	• Continue previous opioid, consider increasing dose by 25% • To manage breakthrough symptoms: Start PRN opioid at 10% of total daily (24 hour) opioid dose • PRN q1H for PO and q30mins for SQ/IV

Source: Content adapted from DOD COVID-19 Practice Management Guide V. 10-16-20

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(Migliore et al, 2021)

Spirituality

- Spirituality
- Faith and beliefs
- Grief
- Cultural considerations
- Bereavement

COVID-19 PALLIATIVE CARE TOOLKIT

SPIRITUALITY

North American Definition of Spirituality:

"Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience connectedness to the moment, to self, to others, to nature and to the significant or sacred." (Puchalski et. al, 2009)

Spirituality allows individuals to find purpose, meaning, transcendence and relationship and is typically rooted in beliefs, doctrine, and practices.

Helpful Tips in Addressing Patient's Spiritual Needs:

1. Assess spiritual need with the understanding that the spiritual dimension of a person's life is an avenue for compassionate caregiving.
2. Provide basic spiritual support
   - Empathic listening
   - Compassionate presence
   - Inquiry about spiritual beliefs, values, & practices
   - Reflective listening, query about important life events
   - Life review, listening to the patient's story
   - Breathing practice or contemplation
   - Support patient's sources of spiritual strength
   - Continued presence and follow-up
   - Open-ended questions to elicit feelings
3. Refer to spiritual care provider when appropriate.

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

Spirituality is Described in Terms of:
- Indicator of our humanity
- Our core, beliefs, values
- Our inner being
- The divine, Holy One, Spirit
- Found within or beyond

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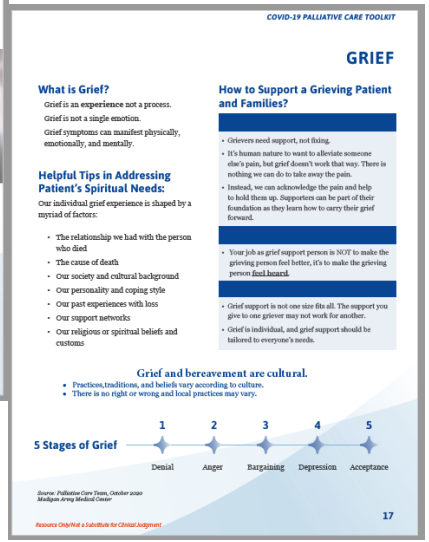

COVID-19 PALLIATIVE CARE TOOLKIT

GRIEF

What is Grief?

Grief is an **experience** not a process.

Grief is not a single emotion.

Grief symptoms can manifest physically, emotionally, and mentally.

Helpful Tips in Addressing Patient's Spiritual Needs:

Our individual grief experience is shaped by a myriad of factors:

- The relationship we had with the person who died
- The cause of death
- Our society and cultural background
- Our personality and coping style
- Our past experiences with loss
- Our support networks
- Our religious or spiritual beliefs and customs

How to Support a Grieving Patient and Families?

- Grievers need support, not fixing.
- It's human nature to want to alleviate someone else's pain, but grief doesn't work that way. There is nothing we can do to take away the pain.
- Instead, we can acknowledge the pain and help to hold them up. Supporters can be part of their foundation as they learn how to carry their grief forward.
- Your job as grief support person is NOT to make the grieving person feel better, it's to make the grieving person feel heard.
- Grief support is not one size fits all. The support you give to one griever may not work for another.
- Grief is individual, and grief support should be tailored to everyone's needs.

Grief and bereavement are cultural.
- Practices,traditions, and beliefs vary according to culture.
- There is no right or wrong and local practices may vary.

5 Stages of Grief

1 Denial, 2 Anger, 3 Bargaining, 4 Depression, 5 Acceptance

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

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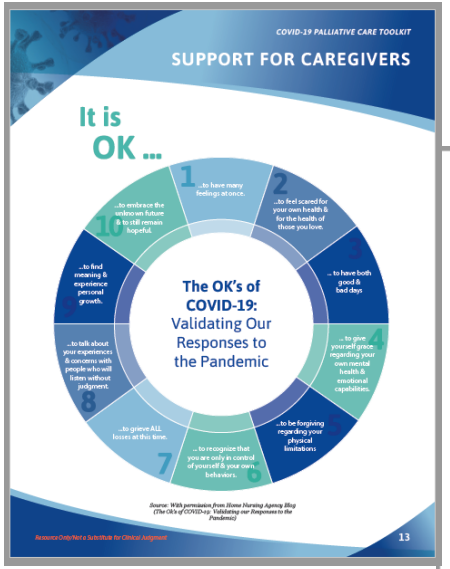
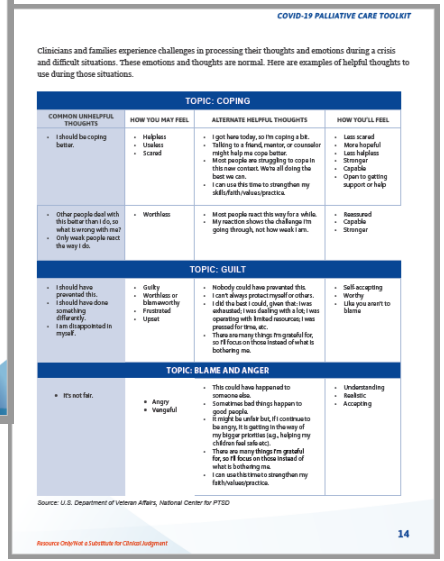
(Migliore et al, 2021)

Support for Caregivers

- Validating responses
- Transforming unhelpful thoughts into helpful thoughts for
  - Coping
  - Guilt
  - Blame
  - Anger





(Migliore et al, 2021)

Mobile Apps

- Department of Defense (DoD) mobile IOS and Android apps
  - COVID Coach
  - Insomnia Coach
  - Mindfulness Coach
  - Posttraumatic Stress Disorder (PTSD) Coach

COVID-19 PALLIATIVE CARE TOOLKIT

MOBILE APPLICATIONS

COVID Coach

For managing the stressors associated to the COVID-19 pandemic.

- Learn ways to improve your well-being during this global pandemic
- Use trackers for mental health and personal goals
- Find tools for coping and self-care

https://www.ptsd.va.gov/appvid/mobile/COVID_coach_app.asp

Insomnia Coach

- Guided, 5-week training plan to help you track and improve sleep
- Sleep coach with tips for sleeping and personal feedback about your sleep
- Interactive sleep diary to help you keep track of daily changes
- 17 tools to help you get your sleep back on track

https://mobile.va.gov/app/insomnia-coach

Mindfulness Coach

Designed to support independent mindfulness practice.

- Mindfulness Training: A stepped training plan that ties together features from each section
- Practice Now: Library of mindfulness exercises
- Track Progress: Assessments and goal tracker
- Build Expertise: Short readings to increase understanding of how mindfulness works

https://mobile.va.gov/app/mindfulness-coach

Covid Coach IOS | Covid Coach Android | Mindfulness Coach IOS | Mindfulness Coach Android

PTSD Coach IOS | PTSD Coach Android | Insomnia Coach IOS | Insomnia Coach Android

Use the above codes to open a link for each app in your preferred app store. Open your smartphone camera and focus on the corresponding code. Alternatively, visit the App Store or Google Play and type the name of the app in the search bar.

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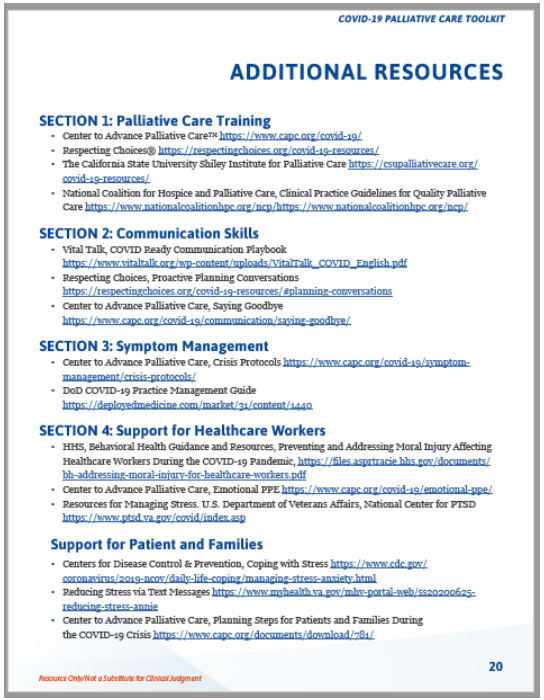
(Migliore et al, 2021)

Additional Resources

- Helpful resources to provide more in-depth information and support



COVID-19 PALLIATIVE CARE TOOLKIT

ADDITIONAL RESOURCES

SECTION 1: Palliative Care Training

- Center to Advance Palliative Care™ https://www.capc.org/covid-19/
- Respecting Choices® https://respectingchoices.org/covid-19-resources/
- The California State University Shiley Institute for Palliative Care https://csupalliativecare.org/covid-19-resources/
- National Coalition for Hospice and Palliative Care, Clinical Practice Guidelines for Quality Palliative Care https://www.nationalcoalitionhpc.org/ncp/https://www.nationalcoalitionhpc.org/ncp/

SECTION 2: Communication Skills

- Vital Talk, COVID Ready Communication Playbook https://www.vitaltalk.org/wp-content/uploads/VitalTalk_COVID_English.pdf
- Respecting Choices, Proactive Planning Conversations https://respectingchoices.org/covid-19-resources/#planning-conversations
- Center to Advance Palliative Care, Saying Goodbye https://www.capc.org/covid-19/communication/saying-goodbye/

SECTION 3: Symptom Management

- Center to Advance Palliative Care, Crisis Protocols https://www.capc.org/covid-19/symptom-management/crisis-protocols/
- DoD COVID-19 Practice Management Guide https://deployedmedicine.com/market/21/content/1440

SECTION 4: Support for Healthcare Workers

- HHS, Behavioral Health Guidance and Resources, Preventing and Addressing Moral Injury Affecting Healthcare Workers During the COVID-19 Pandemic, https://files.asprtracie.hhs.gov/documents/bh-addressing-moral-injury-for-healthcare-workers.pdf
- Center to Advance Palliative Care, Emotional PPE https://www.capc.org/covid-19/emotional-ppe/
- Resources for Managing Stress. U.S. Department of Veterans Affairs, National Center for PTSD https://www.ptsd.va.gov/covid/index.asp

Support for Patient and Families

- Centers for Disease Control & Prevention, Coping with Stress https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html
- Reducing Stress via Text Messages https://www.myhealth.va.gov/mhv-portal-web/ss20200625-reducing-stress-annie
- Center to Advance Palliative Care, Planning Steps for Patients and Families During the COVID-19 Crisis https://www.capc.org/documents/download/781/

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(Migliore et al, 2021)

Toolkit Pilot Implementation

Pilot Implementation

- Toolkit development Jun-Dec 2020
- 60 MDG, David Grant USAF Medical Center, Travis AFB, CA
- Pilot rollout on Med/Surg unit, COVID unit, Intensive Care Unit (ICU)
- Incorporated 10 iPads for patient communication
  - Loaded with self-care apps (COVID/Insomnia/Mindfulness Coach)

Implementation Phases

Phase I: Develop the toolkit content and format; engage palliative care consultants; identify stakeholders; recruit unit Implementation Champions; assess Systems capability for supporting iPads

Phase II: Educate Implementation Champions using draft toolkit; test iPads on pilot unit; consultant review and revisions of draft toolkit; brief implementation efforts locally; feedback from patient and staff end-users

Phase III: Final draft of toolkit for PAO review; re-educate Implementation Champions; troubleshoot IT issues with iPads; provide final toolkit for sustained implementation; feedback from patient and staff end-users

*PAO – Public Affairs Office

Evaluation: Lessons Learned

Lessons Learned: Implementation Phase

- Assess environmental challenges PRIOR to and CONTINUALLY during implementation (IT, staffing, room configuration, emergency department (ed) needs
- When possible, have Systems Department purchase, maintain, and sustain devices (iPad/tablets) to ensure consistent management, integration, and sustainment
- Anticipate delays and disaster impacts
- Develop a contingency plan--triple redundancy for all Implementation Champions (DSCA FEMA deployments, illness, quarantines)
- Know bed expansion/surge plans to prep for staffing/structural changes (consolidated units; dedicated COVID unit; expanded unit)
- Implementation teams for palliative care, when possible, should include multidisciplinary representation and engagement

Lessons Learned: Sustainment Phase

- Implementation of any toolkit requires stakeholder engagement, dedicated Champions, firm commitment from Systems Department (iPad/tablet integration) and inpatient clinical and administrative leaders
- Establish sustainment Champions (facility and unit level) to own toolkit maintenance, sustainment (new staff a refresher training)
- Engage consultants and SME's early and continuously in processes
- Pre-determine targeted/intentional dissemination plan
- Secure permission on variety of platforms for toolkit implementation education (Virtual Grand Rounds, DHA Toolkit site, DHA Knowledge Exchange (KX), link to Clinical Practice Guideline (CPG), NTP, MTF Newcomers orientation, ProStaff)

Integration & Sustainment

Results: 2021 Rapid Review & Synthesis

- 10 COVID-19 publications
- Evidence ranged from Level I-VII
- Four central themes consistent with initial 2020 Rapid Review
  - Critical need for staff to have rapid palliative care training
  - Palliative care delivery methods
  - Symptom management
  - Support for caregivers (family members, staff)

Level of Evidence	Reference	Key Elements
VI	DeLima et al. (2020). Development of a palliative care toolkit for the COVID-19 pandemic. Journal of Pain and Symptom Management, 60(2), e22–e25.	- Products included: online resources, mobile and desktop web applications, one-page guides, pocket cards, and communication skills training videos. - Education resources: expert and evidence-based guidance regarding symptom management, conversations about goals of care, code status, and end of life. - Established nurse hotline and virtual palliative consult service.
VI	Fadul et al. (2021). Integration of palliative care into COVID-19 pandemic planning. *BMJ Supportive & Palliative Care, 11*(1), 40-44.	- Primary planning considerations for palliative care during the pandemic. - Decision algorithms for rationing care. - Training on effective symptoms management. - Alternative delivery methods of palliative care services. - Death and bereavement support for surviving family members.
IV	Hernandez, S. (2021). A case report of Air Force Reserve nurses deployed to New York City for COVID-19 support. *Military Medicine, 186* (12 Suppl 2), 56–60.	- Improve competency with Crisis Standards of Care. - Focused training on providing effective nursing care during the surge of COVID-19-positive patients. - Need to develop a higher level of resilience & mitigate moral distress.
VI	Janssen, D. J. (2021). Palliative care in COVID-19. *Current Opinion in Supportive and Palliative Care, 15*(4), 199-204.	- Highlighted the needs, challenges, and development of COVID-19 palliative care.
I	Lieneck et al. (2021). Provision of palliative care during the COVID-19 Pandemic: A Systematic review of Ambulatory Care Organizations in the United States. *Medicine, 57*(10).	- Barriers and Facilitators identified. - Need for additional resources, training, and policy development within palliative care planning and outcomes.
VI	Mitchell et al. (2020). The role and responsibilities of primary healthcare services in delivering palliative care in epidemics and pandemics: A rapid review to inform practice and service delivery during the COVID-19 pandemic. *Palliative Medicine, 34*(9), 1182-1192.	- Key factors for successful primary healthcare palliative care response. - Communication between policymakers and healthcare providers. - Education, training, and debriefing the workforce. - Support for family/caregivers. - Continued delivery of equipment and access to support services.
VI	Mitchinson et al. (2021). Missing the human connection: A rapid appraisal of healthcare workers' perceptions and experiences of providing palliative care during the COVID-19 pandemic. *Palliative Medicine, 35*(5), 852-861.	- Healthcare workers struggle to connect with patients due to increased work pressures and limited opportunities for human interaction. - Designated teams and processes for communication should be established early. - Policies on care delivery should support forming human connections with patients and retain the fundamentals of palliative care.

(Snapshot of one section of Evidence Table, Migliore et al., 2021)

Dissemination Efforts

DHA

- Chief Medical & Nursing Officers brief May 2021
- J-7 CEPO Nurse Week Recording May-Nov 2021

JTS

- Link added Joint Trauma System COVID Resources Oct 2021
- https://www.triservicenurse.org/resources

TSNRP

- Link added to TriService Nursing Research Program (TSNRP) website Jun 2021
- Plenary brief to TSNRP audience Sep 2021
- Manuscript submitted for TSNRP Supplement: Nursing Outlook Journal Mar 2022

Integration & Sustainment: A Call to Action

- Identify Enterprise Key Personnel and Stakeholders
  - Strategic Planning
  - Target appropriate working groups, clinical communities, clinical champions
- Education and Training
  - Stakeholder focused vs. Key Personnel
  - Decision-maker/Policy-maker
  - Clinical skills training; new staff orientation, residency programs, nurse transition program
  - Deployment training platforms
- Clinical Integration
  - Bedded facilities
  - Exercise scenarios

Next Steps

- Consider TriService implementation science grant
  - Clear implementation plan
  - Documented stakeholder support (letters of support required for grant submission)
  - Controlled, systematic implementation
  - Standardized outcomes, tracking, reporting
  - Funding for program manager, support staff
- Target roll-out at Joint MTFs/DHA Large Markets
- Partner with/consult experts
  - Joint Trauma System Process Improvement
  - Implementation Science consultant
  - Marketing & strategic communications

Military Relevance & Future Recommendations

Military Relevance

- Standardized enterprise-level DHA palliative care resources such as the COVID-19 Palliative Care Toolkit may benefit DHA **inpatient settings without palliative care departments** BEYOND THE PANDEMIC for broad implementation **in garrison** MTFs and in **austere battlefields experiencing prolonged field care.**

- **Toolkit link: https://www.triservicenurse.org/resources**

Recommendation: Universal Palliative Care Strategy

American Academy of Nursing on Policy

International consensus-based policy recommendations to advance universal palliative care access from the American Academy of Nursing Expert Panels

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*Palliative Care & End-of-Life Expert Panel
[b]Global Nursing & Health Expert Panel
[c]Expert Panel on Aging
[d]Bioethics Expert Panel

- Fundamental competency
- Generalist palliative care
- Consistent with nursing philosophy: whole person
- Vital for all disciplines
- Aligns with American Academy of Nursing 2021 international policy recommendations

Recommendation: Disaster Preparedness Resource

- Future pandemics
- Disaster response
- Humanitarian crises

Recommendation: Prolonged Field Care Resource

- Think: stuff, staff, space, systems, separation
- Environment
  - Limited resources
  - Contested, Aerial denial
- Clinical
  - Lack of specialty care, medications, supplies, equipment, manpower
  - Ruthless prioritization & triage
  - Focus: alleviate suffering, manage symptoms, have tough conversations

Key Takeaways

- Literature reviews in 2020 & 2021 provided compelling evidence of the need for universal palliative care basic training and resources.
- A COVID-19 palliative care toolkit was developed to empower frontline workers and to bridge the gap in palliative care needs focusing on four components: palliative care, communication, symptom management during the end of life, and support for caregivers.
- Palliative care is a fundamental clinical competency, is consistent with nursing's whole person philosophy, and has practical utility for all disciplines beyond the pandemic.
- The COVID-19 Palliative Care Toolkit is a point of care nursing resource for pandemic care, basic palliative care, humanitarian and disaster care, and military prolonged field care.

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