A TRIAL OF PALLIATIVE MEDICINE IN THE ER DURING COVID-19: A HENRY FORD EXPERIENCE

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Objectives

- **Primary objective:** Assess the impact on code status change by having an early Goals of Care (GOC) conversation by the Palliative Medicine (PM) team in the Henry Ford Hospital (HFH)- Detroit Campus Emergency Room (ER), during the COVID-19 Pandemic.
- **Secondary objective:** Validate the severity of illness in those chosen for consult by looking at the overall mortality.

Background

HFH is a major tertiary/quaternary academic hospital in Detroit, Michigan, serving a demographic that is 78.6% African Americans and where over a third of the overall population live in poverty.

As one of the worst affected areas in the country early in the COVID-19 Pandemic, we noticed that PM was being consulted later in the course of illness. Many times it was after patients were already intubated or just before death when the patient could not be involved in the GOC conversation. Hospital admissions in the consult population may lead to decreased quality of life, unnecessary procedures, use of scarce resources, and increased health care costs. By seeing select high risk patients at arrival to the ER, our study aimed to increase patient participation in the discussions and get their wishes on the record before being admitted or requiring any form of life support.

This study is unique as there have not been many studies looking at the impact of an embedded PM team in the ER during this Pandemic in an underserved population.

Methods

This retrospective descriptive observational study was conducted at the HFH ER between 3/31/20 and 4/30/20. PM physicians spent 8 hours/day during the busiest hours in the ER, triaging patients ≥18 years old for consults based on their mSOFA scores, high risk comorbidities (end-stage renal disease, heart failure, pulmonary disease, hepatic failure, dementia), older age and frailty by chart review.

GOC conversations occurred in person with the patient and over the phone with representatives. An End-of-Life note was completed in the electronic medical record (EPIC) noting the desired code status and wishes. Patient data was obtained per HFH IRB protocol.

56 patients in the ER were consulted by PM for GOC conversation. For the purpose of this study, Do Not Attempt Resuscitation (DNAR) was defined as No Cardiopulmonary Resuscitation (CPR)/Attempt Intubation, and also as Do Not attempt CPR/Do Not Attempt Intubation.

Results

The average age was 78.6 years (55-100 years), with 41/56 (73%) being over 70 years. 34/56 (61%) were male, and 41 (73%) patients were Black, 5 (9%) White, 3 (5%) Hispanic, and 7 (13%) other race. 23/41 of the Black patients were male. 38 (68%) patients presented from home, and 18 (32%) presented from Nursing Home (NH). 25/56 (45%) patients were admitted to the ICU vs 31/56 (55%) who were not.

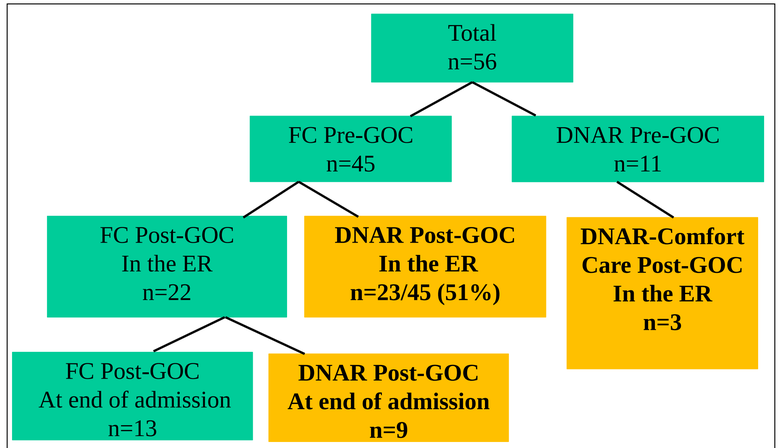

Figure 1. Outcomes

(FC = Full Code; DNAR = Do Not Attempt Resuscitation)

32/56 (57%) of all patients PM consulted, changed from Full Code to DNAR that admission - 17 of whom died, 53%

Code Status	Patient no. Pre-GOC n=56	Post-GOC In the ER n=56	Post-GOC At end of admission n=56
Full Code	45 (80%)	22 (39%)	13 (23%)
DNAR	11 (20%)	34 (61%)	43 (77%)

Table 2. Code Status pre- and post-GOC

Results

Deaths	Home	Nursing Home	Total
Total	19	10	29
Died as Full Code	2	0	2
Died as DNAR	17	10	27

Table 1. Deaths, by Code Status and Residence

Discussion

There was a 14-fold increase in the number of PM GOC consults in the ER during the study compared to the 2 prior months before the pandemic (4 vs 56 consults), hence allowing earlier identification of patients who could benefit from a PM GOC consult. 51% of patients changed their code status to DNAR in the ER, while a total of 71% had changed at some point during their admission. Having these conversations earlier allowed patients and families more time to discuss and think about their goals prior to a crisis point. 17/29 (59%) patients who died, changed their code status and only 2 patients died as a Full Code, suggesting that GOC conversation succeeded in educating patients and families on their severity, and families who chose Full code had a reasonable chance of discharge. Despite the concern for the number of COVID-19 deaths in NH patients documented in the USA, we did not obtain a significant difference between deaths from Home vs NH residents in this study

Conclusion

- With the hope of a COVID-19 vaccine as we move into the Influenza season, there could be a benefit in the addition of a Palliative Medicine team in the ER as this Pandemic continues.
- Discussing GOC and code status as early as in the ER could support providers, increase patient autonomy to allow allocation of resources to those patients for whom life-sustaining treatments are in line with their wishes and prognosis and decrease maleficence.

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