Providence St. Joseph Health

POWERED BY VITAL talk

Emergency Department and Inpatient COVID-19 Talking Maps

Connections Palliative Care, Oregon Region
Home and Community Care
Providence St. Joseph Health

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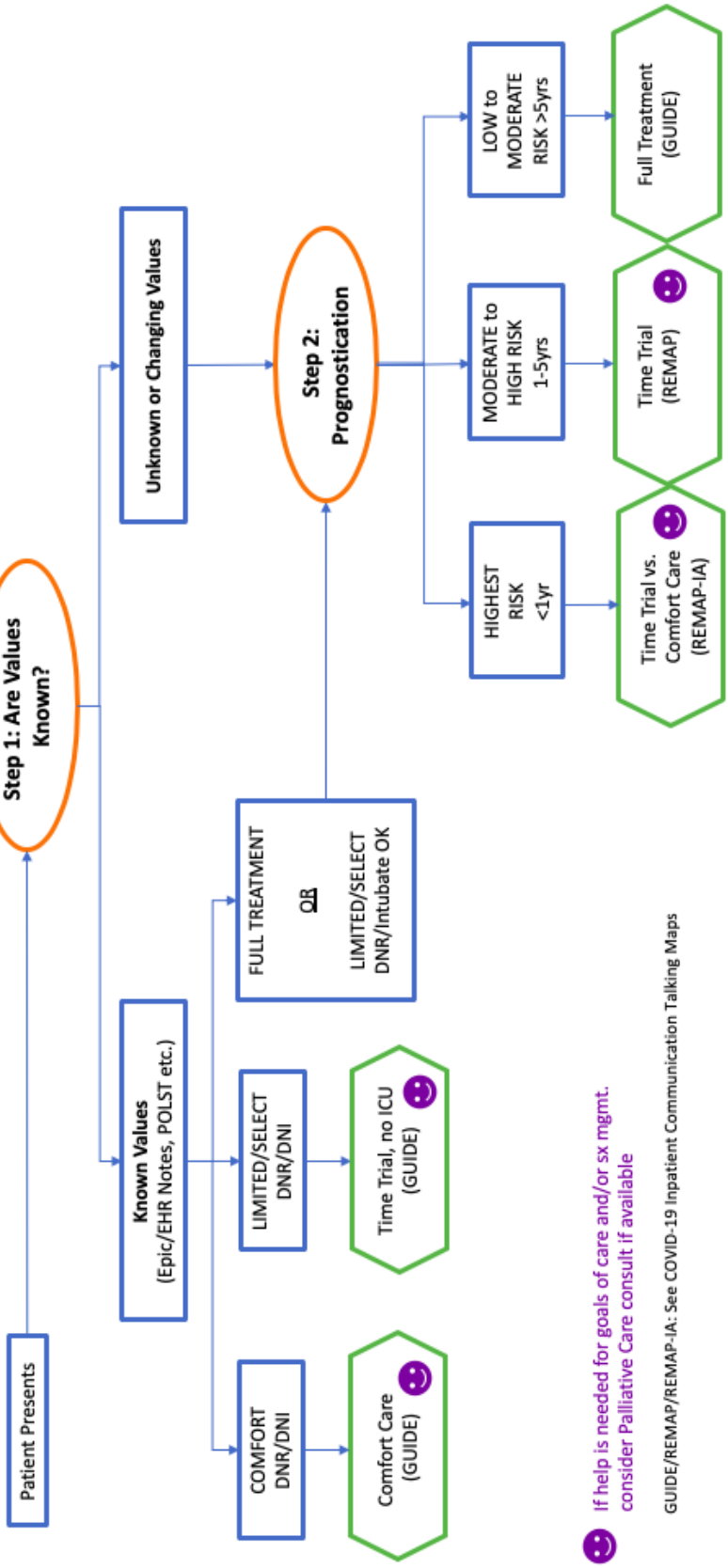
*These examples illustrate how VitalTalk frameworks, and associated communication skills, can be adapted to different situations and settings. Be aware these examples cannot address all situations.

**As time allows, clinicians should always try to elicit and understand the patient and family story; including what brings life meaning, where they draw strength, important people in their life, and how they spend their time. This knowledge builds trust, rapport, and fosters goal-concordant, whole person care.

ED/INPATIENT TALKING MAP WORKFLOW



PROGNOSTICATION

Note: These are general prognostication tools to help with rapid assessment and are not necessarily COVID-19 specific. No one tool can determine prognosis and many diseases processes are not included. These tools should be used together to create a general estimate to guide conversations.

COMPONENT	TOOL/QUESTION	LOW to MODERATE >5yrs	MODERATE to HIGH 1-5yrs	HIGHEST <1yr
Acute Illness (Inpatient/ED)	SOFA or MSOFA score[1, 2]	≤ 7 (Low potential for death)	8-11 (Intermediate potential for death)	≥ 12 (High potential for death)
Functional Status Functional Trajectory **(for estimates using multi-morbidity and function see the Lee Schonberg Index on www.eprognosis.com)**	Frailty Scale[3]	0 Criteria	1-2 Criteria	3+ Criteria
	Has the patient had any unplanned hospital admissions in the last 6 months?[4]	No Or Yes but age is <65y	Yes, and age is 65-85	Yes, and age is ≥ 85y
	2 yr "Surprise Question" "Would I be surprised if this patient died in the next 2 years?"[5]	Yes, I would be surprised	No, I would NOT be surprised	No, I would NOT be surprised
Disease Specific[6]	Does the patient have any of the following and what is the severity? Dementia, Malignancy, Heart Failure/CAD, Pulmonary Disease, Kidney Disease, Liver Disease, DM, Obesity	None OR Minor, well controlled, or earlier stage comorbidities	Examples: • Moderate dementia • Malignancy (<5yr expected survival) • NYHA Class III/IV CHF without frailty • Moderately severe lung disease • ESRD in patients <70y • Cirrhosis with history of decompensation	Examples • Severe dementia • Advanced cancer • NYHA Class IV CHF + frailty • Severe lung disease + frailty • ESRD ≥ 70y • Cirrhosis with MELD score ≥20, ineligible for transplant

1. MSOFA and SOFA: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3811929/
2. Adapted from: Executive Summary: Allocation of Scare Critical Care Resources During a Public Health Emergency, Doug White et. al. https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy_2020_04_15.pdf
3. Frailty Scale: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4515112/
4. Unplanned admissions: Quinn et. al. The risk of death within 5 years of first hospital admission in older adults. CMAJ. 2019 Dec 16;191(50):E1369-E1377.
5. 2 year "Surprise Question": Lakin et. al. Prioritizing Primary Care Patients for a Communication Intervention Using the "Surprise Question" J Gen Intern Med. 2019 Aug;34(8):1467-1474.
6. Fast Facts: mypcnow.org

Adapted by Caroline.Hurd@providence.org using work from VitalTalk, Ariadne Labs, Steve Berns, Elizabeth Lindenberger, Shoshana Helman, Lindsay Dow, Amy Kelley, Diane Meier, Elke Lowenkopf, J. Randall Curtis, Renee Stapleton, Erin Kross, and Rachelle Bernacki Version 5.6.20

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FRAILTY SCALE

FRAIL	SCORE = 0
Fatigue	*"Are you fatigued throughout the day?"* (yes=1pt)
Resistance	*"Can you walk up a flight of stairs?"* (no=1pt)
Ambulation	*"Can you walk a block?"* (no=1pt)
Illness	Does the patient have ≥ 5 of the following: HTN, DM, cancer (other than skin cancer), chronic lung disease, h/o MI/CAD/stent, CHF, angina, asthma, arthritis, h/o stroke/TIA, CKD? (yes=1pt)
Loss of weight	*"Have you lost weight unexpectedly in the past 6 months?"* OR: If weights are in Epic, have they lost more than 5% body weight (yes=1pt)
SCORE: 0 criteria = Robust | 1 or 2 criteria = pre-frail | 3+ criteria = frail	

Adapted from: Brigham and Women's Geriatric Resource for Front Line Clinicians Guide and
Ref: Morley et. al. www.ncbi.nlm.nih.gov/pmc/articles/PMC4515112/

COVID-19: NURSE(S) RESPONDING TO EMOTIONS

STEP	WHAT YOU SAY OR DO	TIPS/SKILLS
NAME	*"You sound concerned."*	**Acknowledges** the emotion. Be careful to suggest only; most people don't want to be told how they feel but appreciate the acknowledgement. In general, turn down the intensity (e.g. scared→concerned).
UNDERSTAND	*"I can imagine this is difficult news to hear."* *"Many people in your situation might feel…"*	**Normalizes** the emotion or situation. Avoid suggesting you understand their experience, because we often can't.
RESPECT	*"I can see you really care about your mother."*	Expression of praise or **gratitude** about the things they are doing. This can be especially helpful when there is conflict.
SUPPORT	*"We will do everything we can to support you during this illness."*	Expression of what you can do for them and a good way to express **non-abandonment**. Making this kind of commitment can be a powerful statement.
EXPLORE	*"Can you **tell me more** about…?"*	Emotion cues can be expressions of underlying concerns or meaning. Combining this with another NURSE(S) skills can be very effective and help you understand their reasoning or actions. Make sure to avoid judgment and come from a place of **curiosity**.
(S)ILENCE	Can be used in many situations, but often effective after delivering serious news	It is often more therapeutic for family members to provide emotional support to each other. Using silence allows room for this opportunity. Silence can also make **space** for the person to share more. Use silence intentionally; too much can leave people feeling uncomfortable.
BONUS: "I wish" statements	*"**I wish** … [we had more testing ability….the situation were different…that your father wasn't so sick…etc.]"*	I wish statements allow you to **affirm** your commitment even when you don't have the ability to achieve the desired outcome.

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COVID-19: REMAP Goals of Care

ED FOCUS: Rapid assessment of health care representative + code status

PATIENT SELECTION: Used to rapidly assess code status in MODERATE to HIGH risk patients in the ED who are suspected of having COVID-19 and are potentially unstable.

INTRODUCE the idea

[provide context] *I'm **worried** you are very sick with the coronavirus. Because things can change quickly with this illness, we want to give you information about what to **expect** for **your situation** and learn **what matters** most to you in case you become critically ill and you can't communicate.*

[ask permission] *Is that okay?*

ASK about a Health Care Representative

[normalize] *To start, is there someone you **trust** to make medical decisions for you in case you become too sick to communicate? Not everyone has someone they can trust. How about you?*

[YES: Get their name(s) + phone # - if legally designated, work with your team to get any existing paperwork]
[NO: Normalize this is common and emphasize the importance of creating a plan now]

REFRAME we are in a different place

[context] *I want to make sure you get the best care possible and know how to care for you in case you become critically ill.*

[assess understanding] *What do you **already know** about what could happen when people are sick with the coronavirus?*

[respect + ask permission] *Thank you, that's helpful. Would it **be okay** if I share what I know?*

[affirm first] *If this is the coronavirus, many people recover with a short hospital stay. We **hope** this is the case for you.*

[headline = information + meaning]

Information: *We also know that people who [are older/have **serious medical conditions like yours**] are at risk of becoming critically ill from the coronavirus.*

Meaning: *This **means** that if you become critically ill, **I'm worried,** because of your [medical conditions/age] there is a **high chance** you would **not survive**, even with maximal medical treatments like CPR or a ventilator machine that breathes for you.*

STOP! Emotions means they heard the reframe. Respond to emotions (see below) before giving more medical information.

EXPECT EMOTION

[use the **NURSE(S)** and **I wish** tools to explicitly empathize before giving more information]

Name: *I can see this is hard to hear.*
Understand: *I can only imagine how difficult this is to think about.*
Respect: *Thank you for sharing your concerns with me.*
Support: *We are here to support you through this.*
Explore: *Tell me more about what you are thinking.*
Silence: Intentional act of holding space.
I wish: *I wish the situation were different.*

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MAP out values

[context + ask permission] *While we **hope** for the best, I want to be sure we understand what is important to you in case you become critically ill and you cannot breathe on your own. **Is it okay** if we talk about that?*

[use the values triad to elicit their primary value]
Some people, if they got sicker:

> *[longevity] would want all treatments to **live as long** as possible; including CPR and a ventilator, even if this means living on machines permanently, or dying in the critical care unit.*
>
> *[function] Other people would not want CPR, but they would want a **trial of a ventilator** to see if they could recover. However, if the machines weren't helping, and were only causing suffering, they would want them stopped.*
>
> *[comfort] Other people would not want CPR or a ventilator if there was only a small chance they would work. Instead, they would want treatments that focus on **comfort and a natural death.***
>
> *How about you?*

[for surrogates-empty chair] *If [patient] **could understand** this situation and tell us what is important, what would they say?*

ALIGN

[reflect/respect values] *As I listen, it **sounds** like what matters most is…* [summarize values]. *Did I miss anything?*

PLAN next steps

[ask permission + recommend] *Given what I know about your **medical situation** and what you said is **most important**, would it be okay if I make a **recommendation** about next steps?* [if yes proceed]

*We are committed to giving you the best care possible in hopes that you recover from this illness. If you become critically ill, despite our best efforts, and you cannot breathe on your own, I would **recommend…***

[**choose ONE response** below based on the clinical conditions and the patient's values]

> [RESPONSE 1 - LONGEVITY] *…**all available** medical treatments to help you **live as long as possible**, including a ventilator and CPR.*
> [anticipatory guidance] *I also want you to be prepared that even with maximal medical treatments you may become so sick that you are dying and we may no longer recommend CPR, because it would not help you survive.*
>
> [RESPONSE 2 - FUNCTION] *…medical treatments that could help you **recover**, including a **trial** of a ventilator machine. If it became clear that you would not improve, we would stop or avoid treatments that aren't helping, like the ventilator and CPR, and focus on your comfort to allow a natural death.*
>
> [RESPONSE 3 - COMFORT] …we **stop or *avoid*** *treatments that cause **discomfort,** like CPR and ventilators and focus your care on treating symptoms to ensure your **comfort** during the dying process.*

[check-in] *How does this plan seem to you?*
[affirm + close] *Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare team knows what's important to you. Know that our team will do everything we can to help you through this.*

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (green Goals of Care tile in some Epic builds], if the patient does not have an Advance Directive, health care representative and/or POLST, recommend inpatient team complete as appropriate.

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COVID-19: REMAP Goals of Care

ACUTE CARE FOCUS: Elicit values to create a plan of care

PATIENT SELECTION: Used to elicit values and create a plan of care for MODERATE to HIGH risk patients on acute care who have COVID-19 and could get sicker.

INTRODUCE the idea

[provide context] *Because things can change quickly with the coronavirus, we are talking with **every patient** who has the virus about what they might **expect** for their situation and what is **important** to them so that we can provide the best care possible.*

[ask permission] *Is that okay?*

ASK about a Health Care Representative

[normalize] *To start, is there someone you **trust** to make medical decisions for you in case you become too sick to communicate? Not everyone has someone they can trust. How about you?*

[YES: Get their name(s) + phone # - if legally designated, work with your team to help get any existing paperwork]
[NO: Normalize this is common and emphasize the importance of creating a plan now]

REFRAME we are in a different place

[context] *The next thing I want to do is provide you with information about what to expect when you have the coronavirus.*

[assess understanding] *So I know where to begin, what do you **already know** about what could happen when people are sick with the coronavirus?*

[respect + ask permission] *Thank you, that's helpful. Would it **be okay** if I share what I know?*

[affirm first] *We are committed to doing everything we can to help you recover. Many people only need a short hospital stay and we **hope** this is the case for you.*

[headline = information + meaning]

Information: *We also know that people who [are older/have **serious medical conditions like yours**] are at risk of becoming critically ill.*

Meaning: *This **means** that if you become critically ill, **I'm worried**, because of your [medical conditions/age] there is a **high chance** you would **not survive**, even with maximal medical treatments like CPR or a ventilator machine that breathes for you.*

STOP! Emotions means they heard the reframe. Respond to emotions (see below) before giving more medical information.

EXPECT EMOTION

[use the **NURSE(S) and I wish** tools to explicitly empathize before giving more information]

Name: *I can see this is hard to hear.*
Understand: *I can only imagine how difficult this is to think about.*
Respect: *Thank you for sharing your concerns with me.*
Support: *We are here to support you through this.*
Explore: *Tell me more about what you are thinking.*
Silence: Intentional act of holding space.
I wish: ***I wish** the situation were different.*

MAP out values

[elicit values] ***Given this situation**, what is most **important** for us to know if you were to get sicker?*

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MAP out values cont.

[concerns] *In hearing you could get sicker, what **concerns** you most?*
[abilities] *What **abilities** are so important to you that you can't imagine living without them?*
[strengths] *What gives you **strength** as you think about the days ahead?*
[optional - experience w/ illness] *Has **anyone** you've known been **seriously ill**? How does this **impact** your thinking?*
[optional - personal beliefs] *Are there important spiritual or cultural beliefs that impact how you think about these things?*

[values triad] ***Given this situation**, people have different ideas about how they would want to be cared for if they become sicker. Some people, if they know there is only a small chance of survival:*

> *[longevity] would want all treatments to **live as long** as possible; including CPR and a ventilator, even if this meant living on machines permanently, or dying in the critical care unit.*
>
> *[function] Other people would not want CPR, but they would want a **trial of a ventilator** to see if they could recover. However, if the machines weren't helping, or were only causing suffering, they would want them stopped.*
>
> *[comfort] Other people would not want CPR or a ventilator. Instead, they would only want treatments that focus on **comfort** and a **natural death**.*
>
> *How about you?*

ALIGN

[reflect/respect values] *As I listen, it **sounds** like what matters most is…* [summarize values]. *Did I miss anything?*

PLAN next steps

[ask permission] *Given what I know about your **medical situation** and what you said is **most important**, would it be okay if I make a **recommendation** about next steps?* [if yes, proceed]

[recommend] *We are committed to giving you the best care possible. If you become critically ill, despite our best efforts, and you cannot breathe on your own, I would **recommend…***

[**choose ONE response** below based on the clinical conditions and the patient's values]

> [RESPONSE 1 - LONGEVITY] *…**all available** medical treatments to help you **live as long as possible**, including a ventilator and CPR.*
> [anticipatory guidance] *I also want you to be prepared that even with these treatments you may become so sick that you are dying and we may no longer recommend CPR, because it would not help you survive.*
>
> [RESPONSE 2 - FUNCTION]*…medical treatments that could help you **recover,** including a **trial** of a ventilator machine. If it became clear that you would not regain a life you found meaningful, we would stop or avoid treatments that aren't helping, like the ventilator and CPR, and focus on your comfort to allow a natural death.*
>
> [RESPONSE 3 - COMFORT] *…we **stop or avoid** treatments that cause **discomfort,** like CPR and ventilators, and focus your care on treating symptoms to ensure your **comfort** during the dying process.*

[check-in] *How does this plan seem to you?*

[affirm + close] *Thank you for talking with me about this today. I will write down our discussion in your medical record, so everyone on your healthcare team knows what is important to you. Know that our team will do everything we can to help you through this.*

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (green Goals of Care tile in some Epic builds), if the patient does not have an Advance Directive, health care representative and/or POLST, complete as appropriate.

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COVID-19: REMAP-IA Informed Assent

ICU FOCUS: Using informed assent to make decisions with surrogates about CPR

PATIENT SELECTION: To make informed assent decisions with a surrogate about CPR in HIGHEST risk patients with COVID-19 who are full code, intubated and dying despite critical care.

- Informed Assent should always be tailored to the patient's values and only be used when clinicians are in consensus that CPR is exceedingly unlikely to return a patient to their defined acceptable quality of life (Curtis et. al. JAMA March 2020). When prognosis is uncertain use the acute care REMAP talking map (pg9).
- Ideally, this conversation builds on prior conversations eliciting the patient's personal story and values.

INTRODUCE the idea

[heads up + provide context] *We have some **serious news** to talk about today. [Patient's] condition has changed in the last few [hrs/days], and I want to give you a **medical update** and then **plan together** for next steps.*

[ask permission] *Is that okay?*

REFRAME we are in a different place

[assess understanding] *So I know where to begin, what do you **already know** about [patient's] current condition?*

[respect + ask permission] *Thank you, that's helpful. Would it **be okay** if I share what I know?*

[affirm first] *We were all **hoping** that [patient] would recover from this virus.*

[HEADLINE: information + meaning]

[Information] *We are doing **everything possible** to help [patient] live and despite maximal medical treatment, [patient] has become sicker in the past few [hours/days].*

[Meaning] *This **means** that the infection, and damage it's caused, is so severe that we think [patient] **is dying**, and may even die in the coming [hrs/days].*

STOP! Emotions means they heard the reframe. Respond to emotions (see below) before giving more medical information.

EXPECT EMOTION

[use the **NURSE(S) and I wish** tools to explicitly empathize before giving more information]

Name: *I can see this is hard to hear.*

Understand: *I can only imagine how difficult this is to think about.*

Respect: *I can see how much you care about [patient].*

Support: *We are here to support you through this.*

Explore: *Tell me more about what you are thinking.*

Silence: Intentional act of holding space.

I wish: ***I wish** we had better treatments for this infection.*

MAP out values

[Ask Permission] ***Given this situation**, I want to know how best to care for [patient]. Is it okay if we talk about that?*

[**Yes**: proceed]

[**No**: explore and address emotions/concerns]

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MAP out values cont.

[determine if longevity is primary value] *In hearing **this news**, some people would want to **live as long as possible** regardless of their quality of life. They believe every minute counts, even if they die on machines or after an attempt of CPR. Is that the case for [patient]?*

[**Yes**: skip to ALIGN below]
[**No**: elicit the patient's primary value by describing the two options below]:

> [time trial] *Other people would want a **trial of current treatments** for a short time to see if there is any improvement, but they don't want CPR if it won't help.*
>
> [comfort focused] *Other people, in hearing this news, would only want treatments that help with **comfort** to allow a **natural death** and would want all life support stopped, including the ventilator.*

[Empty Chair] *If [patient] could **sit here with us** and understand the situation, what would [patient] say is **most important**?*

ALIGN

[reflect/respect values] *As I listen, it **sounds** like what matters most to [patient] is…* [summarize values]. *Did I miss anything?*

PLAN next steps

*Given what I know about the **medical situation** and what you said is **most important** to [patient], we will…*
[note that informed assent language DOES NOT include making a "recommendation" like the other talking maps]

[**choose ONE response** below based on the patient's values]

> [RESPONSE 1 – LONGEVITY – Informed Assent Not Appropriate]*…continue all maximal medical treatments to help [patient] live as long as possible, including CPR if [patient's] heart stops. [anticipatory guidance] If you want to change this plan at any time, let our team know. We will also update you if we see any signs that [patient] is improving, or getting worse.*
> [maintain alignment and consider consulting palliative care to help with ongoing conversations]
>
> [RESPONSE 2 - TIME TRIAL – Informed Assent for DNR] *…do a **trial of the current treatments for [specific time]**. Together, we will watch for signs of improvement, including [list signs]. We will also look for any signs that [patient] is getting worse, including [list signs]. If [patient] does get worse and is actively dying, we will shift our entire focus to comfort during the dying process and stop the ventilator to allow a natural death. If [patient's] heart stops and [patient] dies, we will not do CPR because it will not help [patient] survive or reach [patient's] goals.*
>
> [RESPONSE 3 – COMFORT – Informed Assent for Comfort Care] *…focus **all our care on comfort**. We call this 'comfort care.' This means **avoiding** treatments that cause **discomfort,** like CPR, and **stopping** treatments that aren't helping, like the ventilator. We will monitor [patient's] comfort closely and start additional treatments or medications, if needed, to improve comfort during the dying process.*

[check in] *What questions do you have?*

[affirm+ close] *Thank you for talking with me about this today. I will write down our discussion in the medical record, so everyone on your healthcare team knows the plan. No matter what happens, our team will be here to support you through this.*

[**Optional - All Patients:** Offer spiritual/psychosocial/bereavement services from the interprofessional team as appropriate]
[**Optional - Comfort Care:** Ask if they want information about the dying process/expected survival (i.e. min to hrs, sometimes days)]

DOCUMENT your conversation

Document your conversation in the EHR (green Goals of Care tile in some Epic builds).

COVID-19: GUIDE Delivering Serious News/Anticipatory Guidance

CONFIRMED DNR/DNI

PATIENT SELECTION: For delivery of information and anticipatory guidance to patients with a new diagnosis of COVID-19 who are DNR/DNI/Select Treatments or DNR/DNI/Comfort Care

GET READY

[key information] Make sure you have the key **information** (COVID-19 test results, prognosis, POLST etc.)

[key people] Make sure you have the key **people** (patient/family/surrogate, team, virtually if necessary)

[key space] If possible, find a **private**, quiet space and allow adequate time

UNDERSTAND what they know

[heads up] *I have some serious news to talk about today.*

[assess prior knowledge] *So I know where to begin, what do you **already know** about [your test results for the coronavirus, how coronavirus affects your lungs, what to expect with a coronavirus infection, etc.]?*

INFORM using a headline

[ask permission] *Thank you, that's helpful. Would it **be okay** if I share what I know?*

[headline = information + meaning]

Information:

Example 1: *"The test results show that you have the coronavirus."*

Example 2: *"The CT scan shows that the coronavirus has caused serious damage to your lungs."*

Meaning:

*This **means** that while we **hope** you will improve, we are **worried** that because of your [age/medical conditions] you could get sick quickly and die from this virus.*

STOP! Emotions means they heard the headline. Respond to emotions before giving more medical information.

DEMONSTRATE EMPATHY

[use the **NURSE(S)** tool to explicitly empathize before giving more information]

Name: *I can see this is hard to hear.*

Understand: *I can only imagine how difficult this is to think about.*

Respect: *Thank you for sharing your concerns with me.*

Support: *We are here to support you through this.*

Explore: *Tell me more about what you are thinking.*

Silence: Intentional act of holding space.

I wish: ***I wish** the situation were different.*

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EQUIP for next steps

[affirm] *I want you to know that our team will do everything we can to support you.*

[anticipatory guidance] [Provide a spectrum of potential outcomes and signpost potential challenges]

*I also want you to be **prepared** for what's to come. Our plan right now is to…*

[**choose ONE response** below based on the clinical conditions and the patient's values]

> [Option 1: DNR/DNI Select Treatments] *…admit you to the hospital for a **trial** of medications and treatments to help you **recover**. We will monitor you closely on our acute care floor. We **hope** you improve quickly, and we can get you home as soon as possible. Given your prior wishes to avoid burdensome treatments like CPR and ventilator breathing machines, if you worsen and become critically ill, despite our best efforts, we would **shift our focus** to ensuring your comfort during the dying process.*
>
> [Option 2: DNR/DNI Comfort Care] *…admit you to the hospital and start medications and treatments to help you **feel better**. Because of the severity of this illness, your other medical conditions, and your previously expressed wishes, we will focus our care on treating symptoms to ensure your **comfort**. We will avoid treatments that cause discomfort, like CPR and ventilator breathing machines. We hope you will recover from this illness and return home. However, even if you become sicker, we will pay close attention to shortness of breath, or any other signs of discomfort, and we will give medications and other treatments that will help you feel more comfortable during the dying process.*

[Remember you will likely need to respond to emotions again after this recommendation]

[check-in] *How does this plan seem to you?*

[affirm and close] *Thank you for talking with me about this today. I will write our discussion down in your chart, so everyone on our healthcare teams knows the plan. We are committed to making sure you get the best care possible.*

DOCUMENT your conversation

In addition to documenting your conversation in the EHR (green Goals of Care tile in Epic], if the patient does not have a health care representative and/or POLST, complete/recommend as appropriate.

COVID-19 COMMUNICATION RESOURCES

- VitalTalk
  - https://www.vitaltalk.org/guides/covid-19-communication-skills/
- Ariadne: Serious Illness Care Program
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