The John A. Hartford Foundation
Tipping Point
CHALLENGE

# Mass Production of Compassionate Communication in the Era of COVID-19

Submitted by: Parkland Hospital and UT Southwestern Medical Center

Bronze Winner

Category: Building Skills Among Nonpalliative Care Specialties and Disciplines

## Overview

In March 2020, Parkland Hospital opened its COVID ICU ("ICU") for patients who required mechanical ventilation. Despite a high risk of mortality, patients were separated from their families due to necessary, but prohibitive, visitation policies. The ICU and palliative care teams (the latter, staffed primarily by UT Southwestern Medical Center physicians) created a novel care model, which facilitated daily communication with families of over 500 patients in the ICU (from March 2020-2021). The team assembled a network of physician volunteers to "adopt" ICU families and generated scripts to facilitate formation of a therapeutic alliance, counseling regarding prognosis and COVID-specific complications, exploration of values, delivery of recommendations regarding treatment options, and provision of emotional support. Members of the palliative care team rounded with the ICU team, assisted with symptom management, and coached volunteers. These strategies allowed the team to double the typical daily census of the palliative care team with no increase in staffing resources.

## Impact

For decades, our field has struggled with staffing shortages and bottlenecks in the trainee population. Our care model allowed for rapid upscaling of our Palliative Care team's reach with no increase in paid staffing resources. More than 500 families who were cut off from their loved ones in the COVID ICU received carefully crafted daily communication that promoted alignment between families and the medical team and that facilitated necessary conversations regarding prognosis, treatment options, treatment limitations, etc. These conversations happened with a degree of continuity that is rare in modern medicine, with many families interacting with the same 1-2 physicians volunteers on a daily basis for 2-3 months. In the absence of face-to-face interactions between families and the medical team, each of these physician volunteers became the "voice" of the ICU team for a particular family. The bond between these volunteers and their adopted families was unusually strong, and recommendations regarding treatment options and treatment limitations were almost universally accepted with a sense of trust and confidence. The impact of this system extended to hundreds of patients served by our safety net hospital and to thousands of their family members. We feel certain that our experience informs a new vision for the growth and evolution of Palliative Care services for the future.

## Evidence-Base

The mortality of patients with COVID-19 requiring invasive mechanical ventilation is exceedingly high, often topping 50% [Fried, Armstrong]. As our volumes surged, in addition to critical care beds and critical care staffing, access to subspecialty Palliative Care rapidly became one of our hospital's most urgent needs. This pandemic focused our hospital's attention on some preexisting challenges within the field of Palliative Care. In the face of growing demand for Palliative Care clinicians and with bottlenecks in the trainee pipeline, some have argued that Palliative Care consultations should be utilized only when absolutely necessary [Powell]. Others have claimed that the provision of specialist Palliative Care services for every dying patient is, in fact, impossible [Knights]. These perspectives reflect legitimate concerns about the ability to effectively scale the key competencies required for expert communication and complex symptom management. Already facing national staffing shortages and often working at or near capacity [Courtright], the current Palliative Care workforce – when conventionally structured – was unlikely to meet the titanic needs posed by this pandemic. Similar challenges will be faced, albeit with a gentler rate of rise, as our population continues to age. Novel solutions are called for. Organizations like VitalTalk have established that communication skills for serious illness can be learned. Our team built on the incredible work of organizations like VitalTalk by generating critical care-specific and COVID- specific scripts and communication tools. While simultaneously maintaining our typical non-COVID census, our team used the strategies and resources detailed above to extend Palliative Care services to an additional 500+ families of critically ill patients in our COVID ICU over the course of a year. We essentially doubling the census the team was able to carry on any given day of the past year with no increase in resources. We are currently in the process of generating scripts that are applicable to a number of other disease states that are typically encountered in the critical care setting, and our institution has asked that we expand the care model formulated for our COVID ICU to the remainder of our ICUs (targeting housestaff rotating on the unit as the key communicators rather than volunteer physicians). We are confident that these scripts and strategies are generalizable to other ICUs across the country. 1. Fried MW, Crawford JM, Mospan AR, et al. Patient characteristics and outcomes of 11 721 patients with Coronavirus Disease 2019 (COVID-19) hospitalized across the United States. Clinical Infectious Diseases. 2020;(ciaa1268). 2. Armstrong RA, Kane AD, Cook TM. Outcomes from intensive care in patients with COVID-19: a systematic review and meta-analysis of observational studies. Anesthesia. 2020;75(10):1340-1349. 3. Powell VD, Silveira MJ. What should palliative care's response be to the covid-19 pandemic? Journal of Pain and Symptom Management. 2020;60(1):e1-e3. 4. Knights D, Knights F, Lawrie I. Upside down solutions: palliative care and COVID-19. BMJ Supportive & Palliative Care. Published online July 17, 2020. 5. Courtright K., McMahon J., Yadav K. Excess consult volume for hospital-based palliative care teams in the U.S. (S774) Journal of Pain and Symptom Management. 2017;53:450–451.

## Feasibility

Our initiative is perhaps unusual in that it required no additional financial resources. The key resource we required was tight collaboration and trust between the Palliative Care team, our colleagues in critical care, and other members of the interdisciplinary team. Open, bidirectional communication between the Palliative Care team and our colleagues in critical care allowed for the generation of high quality scripts with relative rapidity and ease. In non-COVID settings within our institution, any number of different team members -- physicians, advanced practice providers (APPs), consultants, bedside nursing, chaplain services, or a combination of these – provide updates to the families of critically ill patients. The content and tone of these updates may vary considerably. The frequency

of communication may also vary; some teams may commit to updating families every 1 to 2 days, while others may update families only regarding major clinical events or when prompted by a family calling the hospital for information. Team turnover may derail the communication routine that a family has learned to expect. Variability impairs the delivery of consistent, cohesive messages to the family. Unfortunately, inconsistencies can foster distrust and significantly damage the team-family relationship. The biggest challenge we faced was obtaining buy in for a completely new system of communication from other members of the interdisciplinary COVID ICU team, one that prioritized message discipline and continuity. This gap was bridged successfully via extensive education of bedside staff and the extension of invitations to various team members to participate in key family meetings, many of which were conducted via Zoom or conference call.

## Scalability

Across the country, health systems have nimbly adapted to the growing need for specialist Palliative Care expertise during the COVID-19 pandemic [Fausto]. Some have relied on the remarkable generosity of clinician volunteers to support the families of critically ill patients and offload overworked ICU teams [Israilov, Lipworth]. Others have developed battlefield-ready "Toolkits" to educate and empower non-palliative care clinicians, who all too often find themselves delivering Palliative Care services to patients facing the end of life [DeLima Thomas]. The rapidly deployed, interdisciplinary model developed at Parkland Hospital similarly relies on the efforts of volunteers and the creation of communication guides and scripts. Other health systems may use this model to offload critical care teams and expand the scope of Palliative Care services during times of increased clinical need due to the pandemic. Similar models could be adapted and deployed to meet the well-documented, ever-growing need for Palliative Care expertise in other disease states [Lupu, Kamal]. Our team is already in the process of generating these resources for critically ill patients with end stage liver disease. Rather than volunteers, these scripts and our methods will be directed towards physicians rotating through the ICU in addition to ICU staff. Should our COVID ICU census surge once more, remote technologies will again be used to expand our pool of communicators to include volunteers. 6. Lipworth AD, Collins EJ, Keitz SA, et al. Development of a novel communication liaison program to support covid-19 patients and their families. Journal of Pain and Symptom Management. 2021;61(1):e1-e10. 7. Fausto J, Hirano L, Lam D, et al. Creating a palliative care inpatient response plan for covid-19—the uw medicine experience. Journal of Pain and Symptom Management. 2020;60(1):e21-e26. 8. Israilov S, Krouss M, Zaurova M, et al. National outreach of telepalliative medicine volunteers for a new york city safety net system covid-19 pandemic response. Journal of Pain and Symptom Management. 2020;60(2):e14-e17. 9. DeLima Thomas J, Leiter RE, Abrahm JL, et al. Development of a palliative care toolkit for the covid-19 pandemic. Journal of Pain and Symptom Management. 2020;60(2):e22-e25. 10. Lupu D, Quigley L, Mehfoud N, Salsberg ES. The growing demand for hospice and palliative medicine physicians: will the supply keep up? Journal of Pain and Symptom Management. 2018;55(4):1216-1223. 11. Kamal AH, Wolf SP, Troy J, et al. Policy changes key to promoting sustainability and growth of the specialty palliative care workforce. Health Affairs. 2019;38(6):910-918.

## Sustainability

The successes of this model are four-fold. First, each critically ill COVID-positive patient benefited from multidisciplinary care and daily assessment by Palliative Care faculty. To our knowledge, no other high-volume health system has been able to ensure Palliative Care consultation for all COVID-positive patients requiring

mechanical ventilation. Second, the families of these critically ill patients benefited from daily contact with the medical team and consistent, disease-specific messaging. Overwhelmingly, family members expressed that they felt adequately supported and regularly expressed their gratitude for the efforts of the care team. Likewise, overstretched ICU teams were relieved of some of the most time-consuming and emotionally-demanding duties in critical care — family communication and goals of care conversations—during an unprecedented surge in ICU census. Finally, the volunteers found the experience worthwhile and often opted to remain engaged in the care of their patients and families, as reflected in the high rate of sustained participation. Invested volunteers received longitudinal palliative care training with directly observed conversations and targeted feedback to improve their communication skills. All of this was accomplished with no increase in paid staffing resources. This pandemic has been a crucible, one that forged strong relationships between our Palliative Care team, physicians from the various critical care service lines, and our administrative partners. As a result of the successful implementation of the care model described above, Parkland Memorial Hospital has requested and funded the creation of a new Palliative Care service line, with a goal of extending this care model to every ICU at our institution. We expect to see immediate impact of increased Palliative Care access in our ICUs. As we add additional personnel to our team and develop additional scripts and communication tools, we expect our impact to deepen and to see a culture shift at our institution.

## Project Team

**Padmaja Reddy, MD**
Assistant Professor, Internal Medicine
and Hospice and Palliative Medicine
Parkland Hospital
Contact: padmaja.reddy@utsouthwestern.edu

**Anna Tomlinson, DNP, APRN, AGACNP-BC**
Nurse Practitioner
Parkland Hospital

## About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the Center to Advance Palliative Care and The John A. Hartford Foundation.

For more information, visit tippingpointchallenge.capc.org.