Contingency and Crisis Standards of Care – Palliative Care and Hospice Services

Contents

I. Overview and Rationale

The 2012 Institute of Medicine National Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response states that the **"provision of palliative care in the context of a disaster with scarce resources can be considered a moral imperative of a humane society."** With disaster, it is imperative that comprehensive guidelines to optimize the comfort and dignity of those who are seriously ill and dying accompany system crisis standards designed to fairly allocate scarce critical care resources and maximize lives saved. This commitment to provide palliative care and hospice aligns with public health principles reflecting the duty to care and to be fair, while stewarding resources to provide the best care possible to all patients regardless of allocation or treatment decisions (Appendix A).

During a disaster or pandemic, some persons may want hospitalization and critical care interventions while others may prefer comfort-oriented approaches to care at home or other community residences. Every attempt should be made to align treatment delivered with care desired. This document is not intended to promote one type of treatment or care over another, but rather to optimize the provision of palliative and hospice support to reduce human suffering regardless of treatment preferences, allocation decisions, or settings of care.

Conventional palliative care and hospice systems may be stressed beyond usual capacity during a mass casualty incident or pandemic, thus limiting access to high quality, comprehensive support for both seriously ill and dying patients respectively. In addition to unnecessary human suffering, gaps in the provision of adequate palliative care and hospice support across settings may delay or impede timely transitions to home- or community-based care, a phenomenon that impacts the care of patients across the entire system. It is imperative that all components of the system – both inpatient and community settings – proactively implement contingency measures to eliminate or mitigate barriers to provision of the best palliative care and hospice services possible to all patients.

Upon declaration of an emergency by State authorities, contingent strategies as outlined in this document will be initiated in proportion to predicted scarcities. With a further surge of patients, Crisis Standards of Care [CSC] may need to be implemented to limit the suffering of patients due to critical shortages in one or

more areas. If CSC are implemented, by definition, the care given to seriously ill and dying patients will be compromised relative to optimal conventional care standards. Conventional, contingent and crisis stages of a disaster are described here:

> ● *Conventional capacity:* measures consist of providing patient care without any change in daily contemporary practices. This set of measures, consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
>
> ● *Contingency capacity:* measures may change daily contemporary practices but may not have any significant impact on the care delivered to the patient or the safety of the health care provider [HCP]. These practices may be used temporarily when demands exceed resources.
>
> ● *Crisis capacity:* alternate strategies that are not commensurate with contemporary U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of expected or known N95 respirator shortages.

While the framework and principles outlined in this document serve as a general foundation for palliative care and hospice in anticipation of the possible need to implement Crisis Standards of Care, the current document purposefully includes targeted information and recommendations specific to the COVID-19 pandemic. The recommendations outlined in this document apply to the care and support of all patients during crisis, not just patients who are known or suspected COVID positive.

## II.	The Role and Responsibilities of Palliative Care and Hospice Services

Palliative care [PC] is specialized medical care for people living with a serious illness. This care focuses on providing relief from the symptoms and stress of a serious illness to improve the quality of life for both the patient and the family.

Palliative care – also referred to as "supportive care" in some systems and communities – is provided by a specially-trained team of palliative care physicians, nurses, and other specialists who work together with patients' other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Palliative care provides comprehensive, team-based support to meet the needs of seriously ill patients and their loved ones. Foundational tasks include:
- eliciting and understanding persons' care goals and preferences for treatment;
- managing pain and other distressing symptoms;
- coordinating necessary practical support across settings; and
- providing emotional and spiritual support (including grief and bereavement).

Conventional, specialty-level PC services, where available, are delivered across inpatient, ambulatory, home, and nursing home [NH] settings. While most hospitals with greater than 300 beds offer palliative care services, many smaller hospitals do not offer consistent access to PC consultative support. Community-based palliative care is still developing. Where access to specialty-level palliative care is limited or absent, hospitals and communities must rely on the core skills, experience, and capacity of usual care providers to manage seriously ill patients.

Hospice care focuses on optimizing quality of life for persons with serious and end-stage illnesses. Unlike PC support, where patients are often still pursuing aggressive therapies and have many months or years to live, patients eligible for the Medicare Hospice Benefit [MHB] have a life expectancy less than 6 months (or < 9 months for CO Medicaid) and choose to forego further "curative" therapies to focus on comfort care and natural death. While most hospice care is delivered in the home, hospice services are also delivered in hospice care centers, long term care (e.g., skilled nursing facilities [SNF], assisted living facilities, [ALF], and nursing homes), and in some contracted hospital settings. Access to care in facility settings is particularly important for patients, caregivers and families who are not able to manage the complexities of end-of-life care without additional round-the-clock support. The Medicare Hospice Benefit does not cover facility room and board costs (these would be the responsibility of the family) unless the patient meets specific criteria for General Inpatient Status [GIP].

III.   Public Health Principles to Prioritize PC and Hospice Services

The *entire system of care* is responsible for the comfort and dignity of seriously ill and dying patients. Given that access to PC and hospice services is limited in most hospitals and community settings, it is imperative that systems optimize use of available community-based services and expertise through partnership and collaboration. As stated in the Colorado Crisis Standards of Care for Hospital Triage, at no point should factors clinically and ethically irrelevant to delivering excellent palliative care (e.g. age, race, ethnicity, ability to pay, disability status, DNR status, national origin, primary language, immigration status, sexual orientation, gender identity, HIV status, religion, veteran status, "VIP" status, criminal history, income or housing status) be used to decide resource allocation.

Unlike triage for critical care resources, where saving the most lives or life-years drives prioritization, basic comfort and dignity must be a priority for all patients, regardless of treatments or triage decisions. **A foundational principle of PC and hospice services during crisis is to minimize human suffering across the health care system.** This includes the suffering of patients, families, providers, and the community. Specialty-trained palliative care and hospice teams are uniquely equipped to lead system-wide efforts to reduce human suffering. Example tactics include:

- providing just-in-time training and tools to other providers;
- flexing and targeting use of PC staff and other resources to accommodate system needs;
- creating virtual support by PC providers to improve reach;
- overseeing comfort-focused care units or teams;
- automating care systems where possible (e.g., comfort-focused symptom management orders);
- establishing new venues of care to amplify impact of limited community staff; and
- leveraging team expertise to lessen system-wide grief and moral distress.

Implementing every tactic is not possible during times of crisis. In contingent capacity times, regional and state leaders should work with PC and hospice teams and community stakeholders to prioritize and accomplish actions that avoid the degradation in care that would be necessary if crisis standards for palliative care

and hospice are reached. This crisis planning relies on tactics to optimally target and extend the use of currently existing palliative care and hospice resources and strengthen, through education and tools, the knowledge and skills of all health care providers, including physicians, mid-level providers, nurses, nursing assistants, social workers and chaplains. To effectively administer and prioritize support during contingency and crisis, it is important to identify and understand 1) persons who most need PC or hospice services, and 2) the palliative care and hospice resources most at risk for scarcity.

IV.   Persons in Need of PC and Hospice Services in a Disaster or Pandemic

Persons that would benefit from PC and/or hospice in a crisis or pandemic are heterogenous and include patients with needs in **hospital, long term care [LTC] facilities, clinic, and home settings.** Examples of patients (with or without COVID infection), as well as caregivers, families, and providers/staff, in need of PC or hospice services, include:

- patients in any setting whose goals of care are unknown or unclear;
- patients in any setting who are experiencing refractory symptoms or other physical, emotional, or spiritual distress;
- patients in home or community settings who forego hospital admission, opting instead for comfort-focused measures and symptom management in place;
- patients in hospital or other facility settings who are unable to transition to home or other community settings due to unsafe or inadequate home support, restricted facility access (e.g., COVID restrictions), or limited bed availability;
- patients with limited or no access to critical care services, including patients with no or delayed access to mechanical ventilation or ICU care due to (if applicable) CSC-invoked triage decisions (see Appendix B);
- patients in any setting who experience gaps or delays in access to hospice services;
- caregivers and/or families who need advice and support, whether practical, emotional, or spiritual, while caring for loved ones with serious or life-threatening illness;
- caregivers and/or families who need support coping with loss and grief, whether in anticipation of or bereavement following the death of a loved one;
- caregivers or families of patients who have died at home during CSC conditions when EMS may decline transport due to pre-existing cardiac arrest; and
- providers and staff across all settings who need palliative care or hospice team expertise and support (including information, knowledge and skills, and emotional support to cope with moral distress, loss, grief, and bereavement).

V.   PC and Hospice Resources at Risk for Scarcity in a Disaster or Pandemic

The following are examples of bed space, staff, and resources at risk for scarcity in a disaster or pandemic:

SUPPORT- Palliative care or hospice training and symptom management skills
- Inadequate system- and community-wide advance care planning conversations and documentation of advance directives *.
- Gaps in symptom management skills by usual care providers
- Regulatory barriers to the acceptance of verbal, electronic or copies of advance directive documents when in-person signing of documents not safe or possible.

- Inadequate psychosocial, emotional, and spiritual support for patients/staff across settings
- Patient physical and social isolation, often without access to family/loved ones in hospital, residential or home settings.
- Inadequate public understanding of the importance of Advance Directives

SPACE- Facility beds and other equipment
- Increased demand for community and hospital beds due to the complexities of caring for patients with severe symptoms associated with a pandemic or other disaster.
- Increased demand for facility beds due to the need to protect others (e.g., vulnerable caregivers at home) from infection or other danger, or care for patients who no longer have adequate family caregiver support in their home setting.
- Shortage of facility beds due to regulatory or administrative decisions (e.g., to not allow patients to remain in an LTC facility with possible or proven infection).
- Limited alternative sites (or opportunity for ongoing hospital care), which are necessary if patients cannot return to their home or facility residence after discharge from an ED or hospital bed, either for convalescence or end-of-life care.
- Shortage of other essential equipment (e.g., oxygen, pulse oximetry monitors, hospital beds) necessary to assure comfort-in-place during a pandemic or other disaster

STAFF – Palliative care- or hospice-trained personnel:
- Shortage of PC and hospice providers and staff (with little ability to flex) across hospitals, community providers, integrated systems, and hospice organizations.
- Shortage of PC and hospice providers and staff due to infection, injury, or other losses associated with disasters or pandemics.
- Increased system demand for PC and hospice providers and staff during crisis, including providers, social workers, nurses, and chaplains, further reducing system capacity.
- Decreased access to PC and hospice providers and staff due to visitation restrictions across hospitals, LTC, or other facilities (e.g., as a result of infection control policies).

RESOURCES – Critical supplies and other resources:
- Shortage of adequate pain and symptom medications, including IV and liquid opioids, sedatives, and other medications needed to assure comfort in both inpatient and community settings.
- Shortage of adequate PPE to protect staff, patients, and families during a pandemic or other disaster.
- Lack of efficient and reliable testing to identify active and resolved infections to preserve and protect specialty-trained staff.
- Insufficient equipment and training to facilitate virtual communication and encounters with patients and families at home or in other facilities (to reduce risk of infectious or other exposure, preserve PPE, and to extend system capacity for support (e.g., virtual consultation across large distances)).

VI. Identified Gaps in PC and Hospice Resources, Required Contingency Initiatives; Crisis Standards of Care Triggers and Actions or Consequences

	Identified Gap	Required Actions	CSC Triggers	Actions or Consequences
SUPPORT	Inadequate system- and community-wide advance care planning conversations and documentation of advance directives *.	• Have CDPHE issue and post on website guidance tools for provider-initiated conversations to elicit or update documentation of person with Medical Durable Power of Attorney (MDPOA) who would be authorized to speak for a patient if they were too sick to speak for themselves, and Medical Order for Scope of Treatment (MOST) forms (when appropriate)* for their residents/patients in residential facilities.** • Encourage similar discussions by primary and specialty clinic sites by supporting virtual outreach calls, virtual video visits and in-person engagement (when safe) through CDPHE messaging directly to provider; post tools or links to guide conversations on CDPHE website. • Encourage hospitals and other facilities to engage in timely review of MDPOA, other advance directives, and MOST at time of transfer and/or admission through e-mailings to targeted leaders of institutions.	• In the event of crisis allocation of scarce critical care resources, significant number of patients whose treatment preferences are not known or understood are (by default) included in the triage process, even if they may not have wanted such treatment.	• Default to full critical care interventions, if available, based on CSC hospital triage standards and processes. • Reduced access to critical care beds and resources all patients, including those with known and documented preferences for potentially curative treatments. • Patients die isolated in hospitals and ICUs when this may not have been their preference.
	Gaps in symptom management skills by usual care providers.	• Authorize formation of content expert group to provide on-line education for usual care providers and links to best practice tools (see Appendices) accessible from the CDPHE website. *(An education subcommittee for this is*	• No access to trained medical personnel to support symptom management	• Comfort care provided by untrained staff or lay providers • Excess suffering for patients and families

		already formed with Jenn Klus at CDPHE.)		
	Regulatory barriers to the acceptance of verbal, electronic or copies of advance directive documents when in-person signing of documents not safe or possible.	• Declare scope of legally acceptable documented conversations about advance directives such as MDPOAs. This would include authorizing electronic signatures, "marks" or other methods of safely signing documents if in-person completion of Advance Directives (ADs) is not possible due to risk of infection, contamination or isolation rules, either in hospital or outpatient settings. • Accelerate development of an easily accessible Statewide registry or website where patients can complete and share advance directive documents from home, with guidance from their clinician via phone or virtually.	• Unsigned documents without State waivers or other solutions fully implemented	• Follow available information as best evidence of patient wishes. • State to protect providers from legal liability even if unsigned documents.
	Inadequate psychosocial, emotional, and spiritual support for staff across settings	• CDPHE to post on their website: a. resources such as VitalTalk ™ or CAPC (Center to Advance Palliative Care) to front line staff to support difficult conversations and allay staff and patient distress. (See Appendices.) b. counseling services to help with moral distress of front-line providers		• Burn-out and complicated grief, potentially causing critical loss of staff due to overwhelming stress.
	Patient physical and social isolation, often without access to family/loved ones in hospital, residential or home settings.	• Authorize chaplains, volunteers, or other palliative care and hospice support staff to be exempted from visitor restrictions for patients in hospice or who are dying and be provided with adequate PPE for adequate in-person visits to ensure no one dies alone across all facilities. • Recommend all institutions (e.g., hospitals, residential care sites,		• Patient dying alone • Families of isolated dying patients without closure and at risk for complicated grief and/or other emotional distress.

		hospice care facilities) allow at least one friend or family member to be present, if/as desired and assuring appropriate PPE and supervision, with patients who are actively dying or expected to die soon.		
STAFF	Inadequate access by specialist PC and hospice providers to consult on patients in isolation in multiple sites.	• Institute executive action to designate palliative care (PC) specialists (including social work, nursing, chaplains and volunteers) as essential caregivers to critically ill and dying patients to overcome facility restrictions (with appropriate PPE).	• Insufficient or no PC- or hospice-trained staff available and contingency steps exhausted.	• Use any available providers or staff to provide basic medical care, including nurses, home health workers, social workers, and chaplains, even without PC knowledge or experience. • Launch 24/7 PC Hotline, to provide consultation and advice (e.g., to support rural needs). • Use lay caregivers and pre-crafted algorithms support patient care and comfort.
	Shortage of PC and hospice providers and/or staff (with little ability to flex) due to increased system demand across hospitals, LTC facilities, community providers, integrated systems, and hospice organizations.	• Develop regional 24/7 Hotline or virtual telehealth systems for access to PC and hospice specialists to deliver remote advice regarding end-of-life communication, family support and pain/symptom management for those sites without direct access to PC support. • Command Center to identify regional resources to facilitate telehealth and specialty consultation access across systems.		
SPACE	Inadequate access to beds for all seriously ill patients who need symptom management and comfort-focused support across settings.	• Create or collaborate with a centralized Command Center to inventory community facilities and designate additional comfort-focused beds/units (COVID and non-COVID). • Allocate areas within Tier 2.5 or 3*** overflow sites with adequate PC or hospice support to address symptom management, emotional, psychosocial, and spiritual needs of this specific population, including ability of at least one family member/friend to be with	• No available hospital or community beds for patients requiring in-patient COVID or non-COVID treatment. • Patients being held in acute hospital beds without acute care needs.	• Admit patients to Tier 3 or comfort-focused care sites without access to additional PC or hospice support or access to critical symptom management medications. • Retain hospice and comfort-care palliative patients in acute care hospitals (if capacity).

		dying patients. • • For rural areas without Tier 2.5 or 3 overflow sites, identify places for clustered management of patients needing specialized palliative care or hospice care services. • Obtain authorization for administration of essential palliative care medicines (i.e. opioids and sedatives) at Tier 2.5, 3 or alternate sites. • Or, develop alternative plan for hospitals to move convalescent patients preferentially to Tier 3 sites so that PC/hospice care patients can receive required symptom management medications and care in sites (i.e. acute care beds) that allow for essential medication administration and visitation..		
RESOURCES	Shortage of adequate pain and symptom medications, including IV and liquid opioids, sedatives, and other drugs needed to assure comfort in both inpatient and community settings.	• Command Center or state designee (e.g. CDPHE) should develop and maintain continuous inventory and usage tracking tools, depending upon phase or site of care (i.e. inpatient vs. community) to identify regional and State supplies • State to promote, mandate and require sharing and transfer of controlled substances (CII-CV) across organizations and communities to maintain continuity of care. during emergencies as allowed per Code of Colorado Regulations (3 CCR-719-1:14:07:00) and DEA Code of Federal Regulations. • Update regulations to allow Scheduled	• Gaps in opioids or other critical drugs despite exhausting all contingency interventions.	• Provide available medications based on allocation guidelines (developed in contingency planning).

		Drugs (e.g. sedatives) to be administered at Tier 3 sites. • Create pharmacy specialist consultation group to develop algorithms for alternative medications to achieve comfort, including potentially restricted drugs (e.g., marijuana).		
	Limited access to symptom management medications in the home	• During public health emergencies, establish outpatient and ambulatory care processes to develop a cache or premade kits available for dispensing symptomatic treatment by outpatient pharmacies. • Identify outpatient pharmacies who can develop and share stocking processes to support patients who a) want symptom management at home, but don't want or are not eligible for hospice care, or b) are experiencing delays in hospice or PC support due to crisis conditions.	• Gap in home medications despite exhausting contingency interventions.	• Move patients to acute care, LTC, or Tier 3 facilities despite preference to remain home.
	Shortage of other essential equipment necessary to assure comfort in place during a pandemic or other disaster.	• CDPHE to inventory and track essential equipment, e.g., oxygen, pulse oximetry monitors, hospital beds, (at organizational, community, and/or State level) among LTC facilities, hospice care and medical supply centers. • Require sharing of essential equipment across suppliers and organizations.	• Lack of essential equipment or oxygen for symptom management.	• Utilize available equipment or oxygen based on allocation guidelines (developed in contingency planning).
	Shortage of adequate PPE to protect staff, patients, and families during a pandemic or other disaster.	• CDPHE to inventory and track essential PPE (at organizational, community, and/or State level) among LTC facilities and hospices. • Require PPE sharing across organizations, institutions, hospices, and communities in accordance with PPE CSC guidelines.	• Critical lack of PPE despite implementation of contingency plans.	• Establish comfort-focused care units or other Tier 3 sites to consolidate PPE (even if not patient preferred site of care). • Exclude family visitation for dying patients. • Increased risk to HCWs, overutilization of PPE and

		• Provide virtual support for family delivering home symptom support without adequate or optimal (e.g., homemade) PPE.		• reduced system capacity. • Require PPE sharing across institutions in accordance with PPE CSC guidelines.
	Lack of adequate and reliable testing to identify active and resolved infections to preserve and protect specialty-trained staff.	• Prioritize testing of personnel and families to allow adequate care for patients dying, with or without COVID-19. • Shift testing resources from lower priority outpatient settings to institutions caring for patients requiring comfort-focused care.	• Critical lack of testing resources. • Illness and staffing shortages due to unsafe working conditions for long-term care facilities. • Resignation of HCW staff in LTC facilities due to inability to safely care for patients.	• Virtual support (only) of family in administering supportive care without PPE or testing available.
	Insufficient equipment and/or training to facilitate virtual advance care planning communication and other encounters with patients and families at home or in other facilities (to reduce risk of infectious or other exposure, preserve PPE, and to extend system capacity for support (e.g., virtual consultation across large distances)).	• State to set expectations and leverage foundations and other organizations to assure adequate equipment and training for virtual communication in institutions. • Command Center to convey importance of virtual access to all institutions where advance care planning and end-of-life communications may occur. • Command Center to recommend virtual access and physical access to at least one loved one by all institutions where advance care planning and end-of-life communications may occur.		

* ACP conversations and documentation are appropriate for all adults age 18 years or older regardless of health status, including older adults and those with chronic and/or serious illness based on their risk of complications and death from COVID-19.

** Institutions = including LTC, independent living/retirement communities and organizations that serve them (e.g., Programs for All-Inclusive Care of the Elderly [PACE], home health care, non-medical home care, and care managers),

*** Tier 2.5 and 3: According to the CDPHE and the Colorado State Emergency Operations Center:

- *Tier 2.5 care facilities are former medical facilities that have resources that enable them to care for higher acuity patients than Tier 3 care facilities, but which are not currently operating as a surgical center, free-standing emergency department, or critical access hospital.*
- *Tier 3 care facilities will have resources and staff capable of caring for patients who are recovering from COVID-19 who no longer need a critical or acute level of care.*

VII.   References

Ethical Principles for Public Health: Palliative Care & Hospice

Institute of Medicine. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations. Washington (DC): National Academies Pres. 2012.

Makowski S. Voice and Role of Palliative Care in the Era of COVID-19. Pallimed.org. accessed 4.20.20 at16https://www.pallimed.org/2020/03/the-voice-and-role-of-palliative-care.html

Colorado and other examples of CSC for Palliative Care/Hospice

Minnesota Healthcare System Preparedness Program Strategies for Scarce Resource Situations.

CDPHE All Hazards Internal Emergency Response and Recovery Plan. Annex B: Colorado Crisis Standards of Care Plan, April 2018.

AHCA, NCAL, NHCPO. Guidance on the role of hospice services in LTC facilities during COVID19 pandemic. 4.9.20, accessed 4.16.20 at https://www.nhpco.org/wp-content/uploads/Hospice-and-LTC-Facilities-During-COVID-19_040920.pdf.

Resources for Palliative Care and Hospice Planning and Treatment:

https://www.capc.org/. Center to Advance Palliative Care. COVID-19 resources website

https://coloradocareplanning.org/ -- resources for advance care planning for Colorado

https://cha.com/wp-content/uploads/2017/03/medicaldecisions_2011-02.pdf -- Colorado Hospital Association booklet with printable CPR directive, Living Will and MDPOA forms.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html -- CDC standards for PPE, other treatments and precautions.

https://www.mypcnow.org/fast-fact/symptom-control-for-ventilator-withdrawal-in-the-dying-patient/). - algorithm for ventilator withdrawal from FastFacts.

Communication Skills for Palliative Care and End-of-life:

https://VitalTalk.org-- communication videos, scripts and skills.

https://www.ariadnelabs.org/coronavirus/clinical-resources/covid-conversations/ -- Serious Illness conversations and skills focused on COVID-19 decisions.

Appendix A: General Public Health Principles

Fairness: standards that are, to the highest degree possible, recognized as fair by those affected by them -- including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.

Duty to care: standards are focused on the duty of healthcare professionals to care for patients in need of medical care.

Duty to steward resources: healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.

Transparency: in designing standards, decision making, and information sharing.

Consistency: in application across populations and among individuals regardless of their human condition (e.g., race, age, disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).

Proportionality: public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.

Accountability: of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.

Abstracted from Institute of Medicine (US) Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations, Altevogt BM, Stroud C, Hanson SL, et al., editors, National Academies Press 2009.

Appendix B: Palliative Care Triage Tree

Triage Tree - Resource-dependent palliative care considerations

```
┌─────────────────────┐     Yes     ┌──────────────────────────────┐
│  Actively dying     │ ──────────> │ Provide palliative care only;│
│       or            │             │ minimize interventions that  │
│  certain to die?    │             │ 'prolong death'              │
└─────────────────────┘             └──────────────────────────────┘
         │ No                                    ▲ All
         ▼                                        │
┌─────────────────────┐     Yes     ┌──────────────────────────────┐
│ Poor prognosis      │ ──────────> │ Does demand limit all        │
│ relative to others  │             │ resources or just select     │
│ in need?            │             │ resources (ventilators,      │
└─────────────────────┘             │ select medications)?         │
         │ No                       └──────────────────────────────┘
         ▼                                       │ Select
┌─────────────────────┐             ┌──────────────────────────────┐
│ Provide all         │             │ Provide resources that are   │
│ available resources,│             │ available to improve         │
│ including symptom   │             │ prognosis                    │
│ management          │             └──────────────────────────────┘
└─────────────────────┘
         │                                       │
         ▼                                       ▼
┌──────────────────────────────────────────────────────────┐
│ Re-assess prognosis of ALL patients at regular intervals;│
│ optimize symptom management                              │
└──────────────────────────────────────────────────────────┘
```

Source: CDPHE All Hazards Internal Emergency Response and Recovery Plan. Annex B: Colorado Crisis Standards of Care Plan, April 2018.

Appendix C: CAPC 2018 - Prescribing Opioids: A Reference Guide

Prescribing Opioids: A Reference Guide

Center to Advance Palliative Care™

capc

Starting Doses in the Opioid-Naïve Patient
START LOW AND TITRATE BASED ON RESPONSE

Drug Name	Oral Dose	Intravenous Dose
Morphine	7.5 mg (15 mg pill cut in half)	2 mg
Hydromorphone	1 mg (2 mg pill cut in half)	0.2 mg
Oxycodone	2.5 mg (5 mg pill cut in half)	—
Hydrocodone	5 mg	—

CAUTION: Prescribers should always consult the individual drug monographs for comprehensive information. Transdermal fentanyl should not be used in the opioid-naïve patient.

Equianalgesic Conversion Table

Drug Name	Equianalgesic Dose		Oral to Parenteral Ratio
	Oral (mg)	Parenteral (mg)	
Morphine	25	10	5:2
Hydromorphone	5	2	5:2
Oxycodone	20	n/a	n/a
Hydrocodone	25	n/a	n/a
Oxymorphone	10	1	10:1

Potency ratios:
→ oral morphine: oral hydromorphone is 5:1
→ oral morphine: oral oxycodone is 1.25:1
→ oral morphine: IV hydromorphone is 12.5:1
→ transdermal fentanyl 25mcg/hr: oral morphine 50mg/24hr

Oral hydromorphone is 5 times as potent (mg per mg) **as oral morphine**

This conversion table is adapted from: McPherson ML. Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd ed. American Society of Health-System Pharmacists, Bethesda, Maryland, 2018.

Common Dosing Strengths and Availabilities

Formulation	Strength
Morphine Sulfate	IR 15 mg, 30 mg
Morphine Sulfate Oral Solutions	10 mg/5 ml, 20 mg/5 ml. Also available in a highly concentrated 20mg/ml solution
Morphine Sulfate ER	15 mg, 30 mg, 60 mg, 100 mg, 200 mg
Oxycodone IR	5 mg, 10 mg, 15 mg, 20 mg, 30 mg
Oxycodone Oral Solutions	5 mg/5ml and 20 mg/ml
Oxycodone ER	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
Hydromorphone	2 mg, 4 mg, 8 mg
Hydromorphone ER	8 mg, 12 mg, 16 mg, 32 mg
Oxymorphone IR	5 mg, 10 mg
Oxymorphone ER	5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg
Fentanyl Patch	12 mcg/hour, 25 mcg/hour, 50 mcg/hour, 75 mcg/hour, 100 mcg/hour
Methadone	5 mg, 10 mg
Methadone Oral Solutions	5 mg/5 ml, 10 mg/5 ml, 10 mg/ml
Buprenorphine Transdermal System	5 mcg/hour, 10 mcg/hour, 15 mcg/hour, 20 mcg/hour

This reference is part of the CAPC online Pain Management Curriculum. Learn more at capc.org/painmanagement.

CAPC = Center to Advance Palliative Care, https://www.capc.org/

Appendix D: CAPC 2020 - Medication Chart: Symptom Management in the Home

Medication Chart: Symptom Management in the Home

Medication	Indication	Formulation	Dosing	Quantity	Notes
Acetaminophen	Pain or fever	650 mg rectal suppository	As needed every 4-6 hours	16 suppositories	4-day supply; expect most will have tabs in house already
Morphine sulfate	Pain, dyspnea [Note: Oxygen may provide relief for shortness of breath and can be used if available]	Liquid: morphine 20mg/mL concentrate PO	2.5mg-5mg every 2 hours as needed, titrated to effect	30mL	This is a 10-day supply of 5mg (0.25cc) q2 hours
		Tablet: Morphine IR 15mg can be given PO or rectally	Morphine 7.5mg-15mg every 2 hours as needed, titrated to effect	50 tablets	This is a 10-day supply
Oxycodone		Oxycodone IR tablet 5mg can be given PO or rectally	Oxycodone 2.5mg-5mg PO q2 PRN		
Hydromorphone		Hydromorphone IR tablet 2mg - PO or rectally	Hydromorphone 2mg-4mg PO q2 PRN		
Lorazepam	Anxiety, insomnia, nausea	Liquid: 2mg/mL concentrate PO/SL	0.5mg-1mg every 4 hours as needed	30mL	This is a 10-day supply of 1mg (0.5cc) q4
		Tablet: 1mg tablet can be given PO or rectally		60 tablets	This is a 10-day supply of 1mg q4
Haloperidol	Confusion, agitation, nausea	Liquid: 2mg/mL concentrate PO/SL	0.5mg-1mg every 4-6 hours as needed; Can be titrated to more frequent dosing	30mL	This is a 10-day supply of 1mg (0.5cc) q4
		Tablet: 1mg tablet can be given PO or rectally		60 tablets	This is a 10-day supply of 1mg q4
Ondansetron ODT tabs	Nausea and vomiting	4mg tablet	1-2 tablets orally q8 when needed for nausea	12 tablets	2-4-day supply (nausea not prominent)
Prochlorperazine		25mg suppository	1 suppository every 12 hours as needed	8 suppositories	This is a 4-day supply
Atropine	Secretions	1% solution PO/SL	1-2 drops every 4-6 hours as needed	5mL	
Bisacodyl	Constipation	10mg suppository	As needed	6 suppositories	3-day supply

https://www.capc.org/toolkits/covid-19-response-resources/

Appendix E: CAPC 2020 - Palliative Care for COVID-19

Palliative Care for COVID-19

capc — Center to Advance Palliative Care

Relief of Dyspnea

Flowchart:

- Refractory Dyspnea
- Manage underlying causes of dyspnea
- Is the patient hypoxic?
  - **Yes** → Manage underlying causes of hypoxia → Supplemental O2 → Still dyspneic? → **No** / **Yes**
  - **No** → Non-pharm Interventions → Is patient comfort care or actively dying? → **No** / **Yes**

- Opioid PO q2h PRN dyspnea
- Opioid IV q1h PRN dyspnea
- Titrate to relief
- Avoid benzos

- Opioid IV q15 min PRN dyspnea
- Double dose q15 mins if no relief
- Lorazepam 0.5-1 mg IV/PO q30 min PRN anxiety/refractory dyspnea

Non-Pharmacologic Interventions:
- Bring patient upright or to sitting position
- Consider mindfulness, mindful breathing

Pharmacologic Interventions:
- Opioids are treatment of choice for refractory dyspnea
- For symptomatic patients, using PRN or bolus dosing titrated to relief is more effective and safe compared to starting an opioid infusion

Dosing Tips:
- For opioid naïve patients
  - PO Morphine 5-10 mg
  - PO Oxycodone 2.5-5 mg
  - IV/SC Morphine 2-4 mg
  - IV/SC Hydromorphone 0.4-0.6 mg
- Consider smaller doses for elderly/frail

Opioid Quick Tips

Pharmacodynamics of Opioids:
- **Time to peak effect / Duration of Action**
- **PO Opioids: 30-60 minutes / 3-4 hours**
- **IV Opioids: 5-15 minutes / 3-4 hours**
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

Other Opioid Principles:
- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

Relative Strengths & Conversion

Opioid Agent	Oral Dose	IV Dose
Morphine	30	10
Oxycodone	20	--
Hydromorphone	7.5	1.5

*Avoid fentanyl due to shortage

If Using Opioids, Start a Bowel Regimen:
- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs q HS, can increase to 4 tabs BID
- Add Miralax 17 gm daily, can increase to BID
- Bisacodyl 10 mg suppository if no BM in 72 hrs

Appendix E, page 2: CAPC 2020 - Palliative Care for COVID-19

Communication Skills

What They Say	What You Say
How bad is this?	From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day**, and we will update you.
Is my mother going to make it?	**I imagine you are scared.** Here's what I can say: because she is 70, and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.**
Shouldn't she be in an intensive care unit?	You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.**
What happens if she gets sicker?	If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her.
How can you just take her off a ventilator when her life depends on it?	Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different.

Resuscitation Status COVID-19	Example Language
Approach to when your clinical judgment is that a patient would not benefit from resuscitation	Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life**. My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear.
If in agreement:	These are really hard conversations. **I think this plan makes the most sense for you.**
If not in agreement:	These are really hard conversations. **We may need to talk about this again.**

When/How to Call for Help

[Insert Palliative Care Contact Info Here]

We are here to help. We've got your back.

In addition to typical circumstances and consults, please consult us if:
Patient in respiratory distress and not getting comfortable with initial efforts

Additional Resources

www.capc.org/toolkits/covid-19-response-resources/
Download these apps (Google Play or App Store) for more palliative care resources:

VitalTalk Tips (Communication)   Fast Facts (Symptom Management)