Joining Forces: The Addition of a Palliative Care Practitioner to a Resident Teaching Service During COVID-19 Pandemic as a Tool to Improve Patient Care and Provider Communication

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Abstract
The COVID-19 pandemic has presented an array of novel issues for hospitals and their staff, one of the most noted being increased patient isolation due to visitation restrictions. This has created new challenges for health care systems and their workers. To leverage the expertise of Palliative Care Practitioners (PCP) as described here to improve patient/provider communication, patient experience, and quality of care during the COVID-19 pandemic. To address these new obstacles to patient care presented by the pandemic, a PCP was incorporated into the physician team caring for COVID-19 patients at the time of admission. Members of the care team were surveyed and interviewed regarding their experiences with this added support. During a period of peak hospital strain from COVID-19, team members consistently reported that daily PCP involvement led to improvement in communication with patients and families, greater provider awareness of psychosocial stressors, and decreased physician burnout. Integration of a PCP into a clinical care team during the COVID-19 pandemic was perceived as a valuable asset to patients, families, and clinicians.

Keywords
palliative care, internal medicine, residency, coronavirus, COVID-19, pandemic, isolation

Context
On March 11, 2020 the World Health Organization declared the novel coronavirus disease 2019 (COVID-19) a pandemic.¹ Since then, this disease has caused cyclical surges in hospital admission rates exceeding the capacity of many healthcare systems worldwide, with the Winter 2020 presenting a particularly strenuous time for American hospitals.² During these escalations in inpatient volume, public health and hospital infection control officers heavily restricted or disallowed hospital visitors, which exacerbated the feelings of isolation and fear experienced by many inpatients as they were unable to have the support of loved ones at their bedside.² While the loss of life associated with the pandemic can be quantified with statistics, the anguish of prolonged admission in isolation is much more difficult to appreciate. Fortunately, Palliative Care is a medical discipline focused on providing patients relief from physical symptoms and psychological stressors of serious illness. The end goal is to improve not only the quality of life for the patient, but the experience for family and support systems as well. Consultations are “based on need, not prognosis...and can be appropriate at any age and at any stage in a serious illness”.³ Palliative Care Practitioners (PCP) are not only skilled at conducting discussions related to goals of care at end of life, but also assisting in complex symptom management. In addition to these traditional roles, the often overlooked communication and psychosocial expertise offered by PCP’s is important to recognize. Here we present a novel approach to streamline clinical care and communication and, we hope, improve patient and family experience through the integration of a PCP to a COVID-19-specific internal medicine physician team at the time of admission.

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Background

Case: In early 2021, a 60 year-old man with no prior medical history presented to the emergency room with a chief complaint of dyspnea on exertion and cough for 2 weeks with worsening shortness of breath at rest. A SARS-CoV-2 PCR nasopharyngeal swab was positive and a CT scan of the chest revealed the bilateral peripheral ground glass opacities typical of COVID-19 pneumonia. He reported that several other family members had been recently hospitalized with severe acute respiratory distress syndrome (ARDS) related to SARS-CoV-2 infection. One of his parents had passed away while hospitalized for COVID-19 pneumonia, enduring the entire length of stay with family barred from visitation. The patient initially experienced an array of emotions which included fear of his uncertain prognosis as well as outright anger directed at a close relative who had attended a party just prior to several family members testing COVID-19 positive. He believed that his family had otherwise been very compliant with the public health guidance regarding masking and social distancing. His clinical course included several days in the ICU and over 3 weeks of total hospitalization. During that time, the local public health order in our area prohibited all hospital visitors, whether patients were in isolation for COVID-19 or not. The patient’s only interpersonal contacts included brief daily physician exams and nursing rounds, all of which occurred with full personal protection equipment (PPE) donned. This resulted in many hours alone in a hospital bed with little to comfort oneself aside from a TV and cellphone. His non-hospitalized family were also under strict public health quarantine at home due to COVID-19 exposure, relying on brief daily telephone updates from the clinical team regarding the patient’s condition.

This story is 1 of countless similarly tragic narratives that have occurred during the COVID-19 pandemic where families have been forcibly separated in the name of “isolation” or “quarantine.” The admitted patients were placed under airborne and contact isolation to protect others from contracting COVID-19 while their family members were strongly advised to quarantine at home for a brewing COVID-19 pneumonia. This sequestering of the patient away from family, friends, and even hospital staff seemed like a necessary evil to slow the highly infectious viral plague. While many infections were prevented and lives saved, the patients were subjected to a level of physical and emotional isolation not seen in decades.

The peak months of the Winter 2020 surge drove hospitals to the brink with record numbers of patients admitted for COVID-19 and requiring isolation. The sheer number of patients left healthcare workers with less time and energy to consistently and effectively communicate with the family and friends of hospitalized patients. Communication challenges amongst providers, patients, and their families were compounded by the need for PPE and availability of virtual correspondence devices such as phones and tablets. These issues regarding communication during the COVID-19 pandemic have been shown to increase emotional exhaustion or “burn out” amongst doctors and nurses. Often during this time, healthcare providers were the only ones allowed to be at bedside for ailing and dying patients; a heavy emotional load to bear on individuals who were already feeling the heat of a healthcare system in crisis. To complicate things further, patients hospitalized with COVID-19 were more likely to be older and have comorbid illnesses, adding complexity to an already stressful situation. Given this situation, Palliative Care became an important part of the response to support patients, families, and healthcare teams during the pandemic.

Methods

Santa Barbara Cottage Hospital is a tertiary acute care teaching facility and level 1 trauma center. As with most healthcare systems in the region, the hospital experienced a substantial surge in hospitalized patients with SARS-CoV-2 from December 2020 to February 2021. At its height, there were 5 separate COVID-19 isolation units operating at capacity in mid-January. Throughout this time the hospital was operating with a formal capacity of 180 medical-surgical and 50 intensive care beds with an average daily census of 250 patients. As a teaching hospital, the internal medicine residency service provides care for an average of 35-50 patients at any 1 time distributed over 3 clinical care teams each made up of an attending physician and 4 residents. As the resident census ballooned to 50 and then 60 patients (over half of which were COVID positive), a fourth COVID-specific resident team was added to meet demand. This unique team was composed of 1 attending and 2 residents who operated in a more independent role compared to the teaching hospital’s typical format. The attending physician provided the expected indirect supervision around the clock with direct supervision of all patients during the day. This COVID-specific team took care of a total of 102 patients over a 3-month period with a daily census that peaked at 20. Palliative Care assisted in the care of 47 patients on this particular resident service.

Given each patient’s psychosocial complexity, the prohibitive hospital visitation policies, and need for detailed daily family updates, the care team was overwhelmed. There simply was not enough time in the day to both care for the patient and tend to the needs of their families at home. Thus the presence of a PCP (either a certified NP or RN) was incorporated into daily team rounds via a consult placed at the time of admission. Team rounds lasted 1-2 hours with detailed review of each patient’s case. The service provided by PCPs depended on the individual needs of the patient (see Box 1). Typically, the resident physicians and PCP would see patients separately in the morning and then meet briefly again to review cases midday to address ongoing care issues and identify emerging needs. The PCP was tasked with scheduling telephone updates
with patients’ family members in the afternoon to provide comprehensive updates on the plan of care.

Box 1. Palliative Care Services.

At Least One if Not All of the following Services was provided for Each Consult

1. Acute counseling or support to the patient
2. Communicating plan of care to family
3. Supporting family members in a period of restricted visitation and social distancing
4. Advocating for family visitations
5. Addressing and/or facilitating goals of care discussions with ensuing decision making
6. Bereavement counseling
7. Advance care planning to reduce risk of unwanted or non-beneficial cardiopulmonary resuscitation and intubation
8. Pain and symptom management

Initial patient and family communication led by the PCP relied on telephonic means whenever possible to preserve PPE and maintain healthcare worker safety. As vaccines became available, PPE scarcity eased and PCPs were able to physically work within the isolation units and conduct face-to-face visits. Throughout this period, outside visitation remained disallowed and family-patient interaction was mediated by telephone or video chat, though special exceptions were eventually made for end-of-life in-person visits. The PCP was integral in the coordination of these rare family visitations for critically ill patients.

At the end of the Winter 2020 surge, an online survey was provided to the internal medicine residents who served on the COVID-19 specific care team. Respondents were also invited to send in free text responses to the authors or through the online survey using an expansion comment box (eg elaborating on closed responses by providing details). The brief questionnaire was anonymous and consisted of 4 questions (see Box 2).

Box 2. Survey Questions for Resident Physicians.

1. On average, how long was your visit with the patient every day?
2. If you were to estimate, how much time did adding palliative care to the COVID-19 specific team save you per patient/family?
3. Do you believe having palliative care on service was beneficial for you? Please elaborate if possible
4. Do you believe having palliative care on service was beneficial for patients? Please elaborate if possible

To receive feedback from the Palliative Care Service perspective, the author interviewed the PCPs who were most heavily involved in the service to elicit their responses.

Outcomes

In total, 14 residents were surveyed and interviewed by the author. Feedback was overwhelmingly positive. There was 100% consensus amongst respondents that the integration of a PCP to team rounds was beneficial to both patients and physicians. PCPs were able to spend more time at the bedside with patients, which allowed for residents to speed up their physical rounds and dedicate more time to crafting plans of care and coordinating with consultants. The extra time that PCPs were able to spend with patients at bedside allowed for ample psychosocial support to be offered.

All interviewees mentioned the improvement in communication between the care team, patients, and their families during times of restricted visitation. One resident commented that incorporating a daily PCP “helped uncover patient needs more quickly and facilitated quicker turnaround on patient [centered] care.” The extra clinical interactions created by the PCP’s involvement led to the detection and treatment of more nuanced symptoms such as anxiety, dyspnea, and depressed mood, all of which have the potential to substantially improve the patient’s quality of life while hospitalized.

At times when the hospital census was especially high, residents appreciated the time saved by PCPs taking on the task of delivering daily family updates on the patient’s status. This saved resident physicians an estimated 1-2 hours per day, which allowed more time and effort to be instead directed towards patient care. This is a loose figure that may actually be an underestimate, based on discussion with palliative care representatives. PCPs approximated they spent an average of 20 minutes per day talking with the patient (ranging from 5 to 45 minutes), whether in-person or via bedside phone. Another 15 minutes was needed for family member updates (longer if an interpreter was required), though this took as long as 50 minutes in some cases.

At the peak of the surge, the Palliative Care consult service carried a daily census of approximately 50 patients, of whom 50-70% were battling COVID-19. With the high patient volume, PCPs remarked that, by being present for morning rounds, they were better informed on the case and thus “communication with family and patients was substantially easier.” A Palliative Care nurse reported that by listening to patient presentations she was able to “hear the compassion from the physicians and build upon the empathy to relay it to family members.” The ability of the PCPs to take on this joint collaboration was dependent on several factors. These included a relative decrease in non-COVID admissions (ie; elective surgeries) during the peak surge as well as the hospital administration’s financial and staffing support.

A Palliative Care nurse practitioner heavily involved in this effort mentioned another benefit with this team structure was the exponential growth observed in participating residents’ autonomy and abilities as it relates to patient care. This was most notable in the case of interns, as they were encouraged to formulate and defend care plans on their own without input from a senior resident. Unlike with the resident care team, which had a rotating cast of physicians each week, the same PCP would see a patient throughout their stay from admit to discharge. This allowed for some physical continuity of care.
that could not be accommodated otherwise by residents whose schedule changed weekly.

Discussion

The COVID-19 pandemic has been a monumental challenge in many ways and has required a timely and flexible response from healthcare systems across the world. It is important to recognize that the acute illness of COVID-19 not only affects patients, but the fear and uncertainty it portends also extends to their family and friends. As described in our representative case, this pandemic is unparalleled in the combined mental and physical isolation it has caused over the past 2 years. To mitigate these underappreciated consequences of COVID-19, PCPs with expertise in communication and psychosocial support were heavily utilized and played a crucial role in our multidisciplinary approach to providing holistic patient care.

The unique strategy we deployed was advantageous in many ways. By participating in clinical team rounds, the PCP was able to develop an intimate understanding of the patient’s clinical course and status. Because of this, they were able to share and explain medical information to a greater degree than would be expected for a social worker or other support staff. The Palliative Care team member acted as another layer of filtration for picking up concerns from patients and their families, often able to dedicate more time for this purpose than the primary medical team. This enhanced two-way communication was critical in managing expectations and providing updates for families of patients who were failing to make clinical progress or deteriorating.

Adding a PCP at the time of admit was also beneficial in introducing the idea of code status and goals of care. These are often difficult conversations to have with patients for a variety of reasons, but they are crucial to the patient’s care plan. With the PCP’s added attention to these topics, our team felt that we were able to more clearly understand the patient’s desires if their condition were to worsen. With this approach we believe we were able to avoid unwanted intensive care (ie; intubation) and/or surgical intervention (ie; tracheostomy, gastrostomy tube).8,9

In retrospect, there have been other long-lasting benefits from this model. Upon further discussion with participating PCPs, they described an increased sense of comradery between themselves and resident staff. While residents are often a transitory fixture in our hospital (3 years of internal medicine residency), this gave PCPs much more facetime than usual with current residents. The Palliative Care team at our facility also feels that residents are more liberal with their requesting of palliative consults now compared to prior to the pandemic. While PCPs got to know the residents personally, the residents also were able to develop a more comprehensive understanding of all that palliative medicine has to offer to the ailing patient.

The team structure and functions described above do have some notable limitations. This approach was conducted on a small scale in a single healthcare system over a relatively short period of time. While we primarily share our experience qualitatively, the study design lacked metrics for a more objective analysis. There was also no mechanism to gauge the patients and their families’ perspective on this approach to care. Both of these would be important factors to consider for future study. Nevertheless, our collaboration with Palliative Care in a time of systemic strain has highlighted 1 methodology to improve quality of care from the provider’s perspective and help distribute the workload of an inpatient service pushed to the brink by COVID-19.

Looking ahead as the COVID-19 pandemic wears on, we hope this example of close collaboration will encourage the inclusion of Palliative Care into future variant-driven inpatient surge planning. Through further research, efficient application of such efforts may have positive effects such as decreased ICU stays, reduced medication costs, shorter duration of hospitalization, fewer unnecessary tests, and more seamless transitions of care which could result in reduced healthcare costs.10 We offer our experience and observations so that other institutions can consider adopting and molding our model to fit their needs if and/or when their healthcare system experiences high volume strain.

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