



## Resource Allocation and Palliative Care Strategic Framework COVID-19 Pandemic – MSF-OCP

**Goal:** To provide a conceptual framework that may be adapted to specific MSF COVID-19 treatment units in order to **facilitate individual case decision-making on palliative care** in a collaborative and ethical manner based on the clinical condition of the patient and an ongoing situational analysis of available resources, and enabled by a structured system of communication with patients and/or their families.

### **Key concepts**

- COVID-19 Severity Census for each MSF treatment facility using WHO taxonomy
- Medical criteria for consideration of transition to palliative care predicated on clinical severity and grave prognosis
- Palliative care decision-making for individual cases proposed by clinical staff enhanced by a collaborative resource allocation analysis and final validation by Palliative Care Triage Team
- Patient and family communication on severity and palliative care decisions facilitated by a dedicated Patient Liaison Officer
- End of life patient symptoms managed by a standard protocol to alleviate suffering, maximize comfort and preserve dignity

### **Introduction**

The current COVID-19 pandemic is likely to push operational and medical personnel to unprecedented levels of difficulty in allocation of resources, particularly for **oxygen sourcing and delivery systems**. While a thorough understanding of COVID-19 illness characteristics is still emerging, vital clinical decisions will need to be made rapidly and with less precise prognostic certainty. Ongoing therapeutic treatment of patients with a grave prognosis will likely be unsustainable in many contexts, given the exponential expansion characteristic of the pandemic and the likely degradation of operational capacity as resource scarcity worsens (See Appendix: *The gradual degradation of quality as resource scarcity worsens*).

This strategic framework offers a general organizational structure for team members to monitor and assess available resources and to promote **informed and collaborative decision-making on palliative care**.

**This framework should NOT be considered a protocol or guideline for clinical care, rather a conceptual framework that may be adapted to the epidemiologic, cultural, and operational circumstances encountered in the field when the decision is reached to discontinue therapeutic care and offer palliative care.** Societal norms on death and dying should inform operationalization of the framework, and could lead to innovative adaptations to care, such as home-based hospice care or support from spiritual leaders or traditional healers.

Broadly, **ethical standards for clinical decision-making palliative care in COVID-19** should take into consideration the following elements:

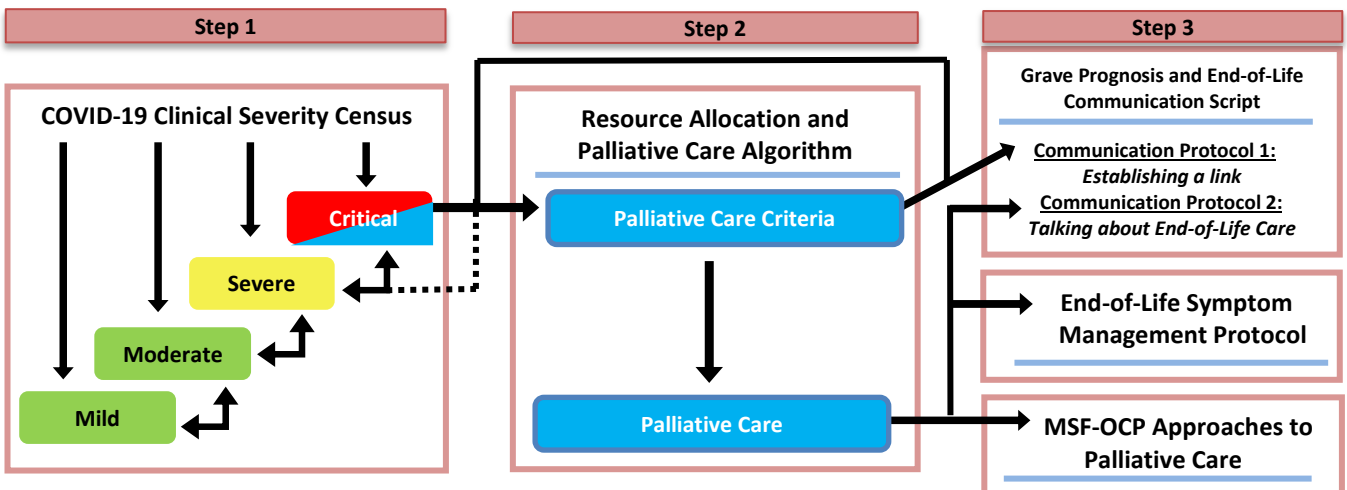
- Shared decision-making between two or more experienced clinicians;
- Consideration of the patient's and/or the family's stated wishes;
- Standardized evaluation of medical urgency, risk factors and clinical frailty of each patient;
- Ongoing analysis of available clinical resources;
- Evaluation of current and projected demand on clinical resources;
- Standardized record-keeping of decision-making processes;
- Availability of psychological support for clinical staff.

Shared decision-making attempts to blunt the potential for **moral distress or injury** and **severe mental health consequences** when the responsibility is placed on a *sole* clinical provider. Standardization of patient evaluation criteria is also an essential component of ethical decision-making processes in order to **mitigate implicit or overt bias**. Decisions about the clinical care appropriate for COVID-19 patients should be guided primarily by transparent and objective assessments of disease severity, co-morbid states, and clinical frailty or prognosis. Priorities of care should include **end-of-life symptom management** and attendance to **the psychosocial and spiritual needs** of patients and their families.

### Clinical severity categories (WHO) and need for oxygen therapy

<p><b>Mild</b></p> <p>(Uncomplicated upper respiratory tract infection)</p>	<p><b>Moderate</b></p> <p>(Pneumonia with no need for supplemental oxygen, SpO<sub>2</sub> &gt; 93% on room air)</p>	<p><b>Severe</b></p> <p>(Fever of suspected respiratory infection + one of the following: RR &gt; 30bpm; severe respiratory distress; SpO<sub>2</sub> ≤ 93% on room air)</p>	<p><b>Critical</b></p> <p>(Acute respiratory failure and/or shock)</p>
<p>Symptom management. Consider home care.</p>	<p>Problematic triage: Respiratory Rate and SpO<sub>2</sub> monitoring for deterioration. Unlikely need for oxygen</p>	<p>Likely needs between 6 and 10L of oxygen.</p>	<p>Likely needs &gt;10L oxygen and advanced oxygen delivery systems or if unavailable, transition to palliative care.</p>

### Strategic Framework





## Resource Allocation and Palliative Care Algorithm COVID-19 Pandemic – MSF-OCP

### Determinates of resource allocation

#### Patient characteristics:

- Age
- Comorbidities
- COVID-19 Patient Severity Classification
- Proposed or actual oxygen therapy
- Use or need of oxygen therapy
- Proposed or actual use of vasopressors for CV support
- Patient prognosis and potential for long-term complications

#### Project resources

- Supply of personal protective equipment (PPE)
- Supply of oxygen and/or oxygen generation capacity
- Number of available oxygen treatment stations
- Adequacy of staffing of qualified personnel
- Current patient census per unit
- Admission and patient influx projections

### Consider palliative care when:

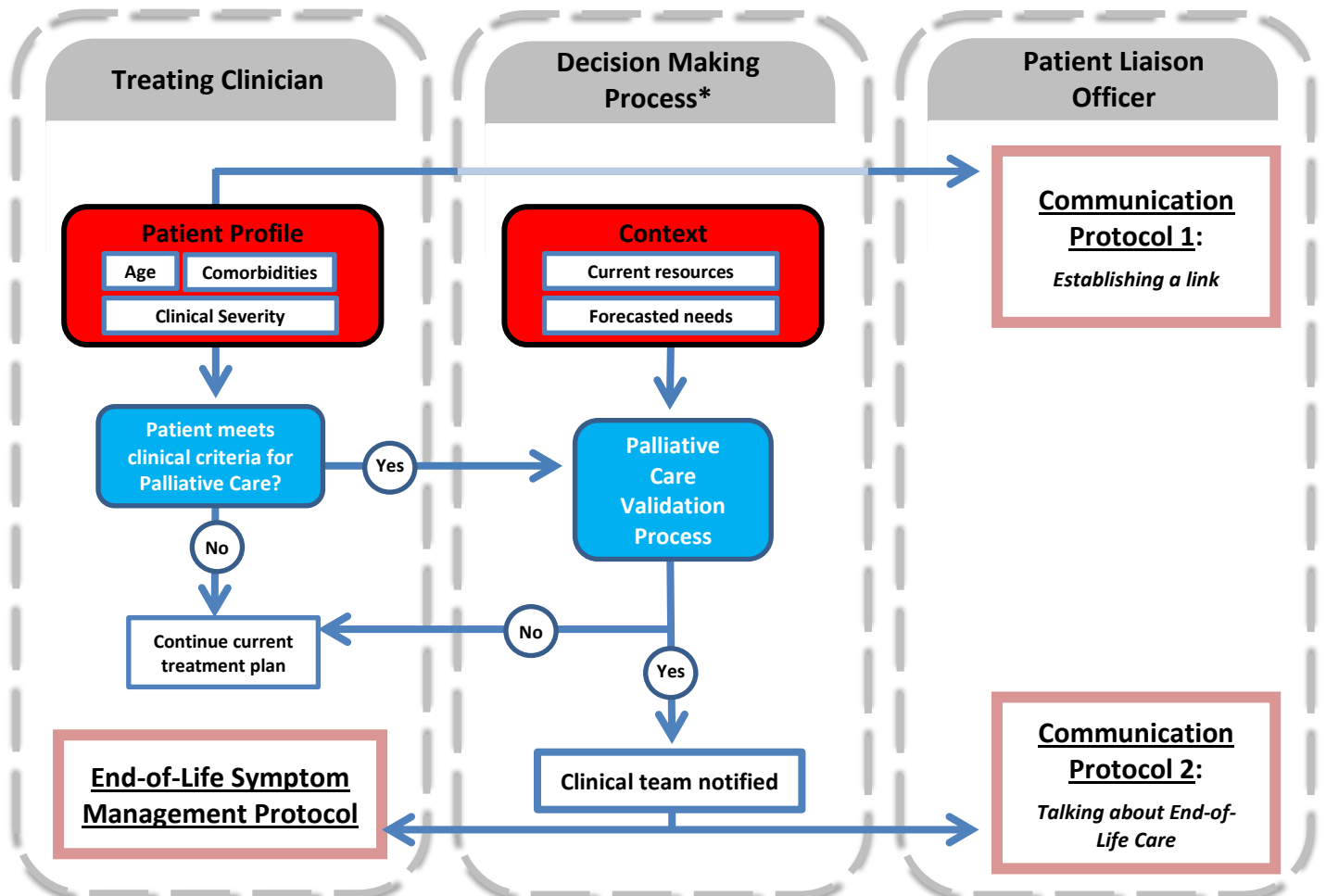
#### Patient profile includes:

- Elderly and/or patients with severe comorbidities + critical condition on admission or after resuscitation
- Patient severity score critical
- Oxygen requirement  $\geq 15$  L
- High-flow oxygen therapy > 24 hours
- Vasopressors for cardiovascular support required
- Grave prognosis
- Ongoing clinical deterioration

#### In context where:

- Oxygen supply diminished
- Limited or no current oxygen treatment stations
- Inadequate staffing or lack of qualified providers
- High patient census
- Admission/patient influx potential elevated

AND



## \*Decision-Making Process

Organize each day a **Resource Allocation Briefing** (RAB) among key project stakeholders to share relevant information about:

- oxygen sourcing and treatment station census,
- human resource availability,
- pharmacy stock,
- epidemiological trends,
- context security,
- status of community and individual patient perceptions of MSF COVID-19 activities.

Important participants should include the Project Coordinator, Project Log, Admin, Pharmacist, Epidemiologist, MH manager, and the **Patient Liaison Officer**, who is responsible for coordinating communication with the patient and/or family (See MSF PCCG EMACC MHWG *Palliative and EoL Care COVID-19* Job description: Patient Liaison Officer).

Also participating in the RAB will be a **Palliative Care Triage Team**—composed ideally of the Medical Team Leader and Hospital Director/Head Nurse—who will be responsible for final validation of individual case decisions made by the clinical team. During the RAB, the **Palliative Care Triage Team** will share the current **COVID-19 Severity Census**, a summary of palliative care decisions from previous day, as well as global trends in project patient outcomes. After an updated assessment, the **Clinical Team** should be advised of any potential changes in criteria based on resource allocation.

After a final decision is made (*validation or not for palliative care*) by the **Palliative Care Triage Team**, both the **Treating Clinician** and the **Patient Liaison Officer** are notified, so they can implement the medical and communication measures respectively. In situations where significant ethical dilemmas arise, the case should be referred expeditiously to the Medical Coordinator, for further deliberation.

## Bibliography

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## Appendix

### Hastings Center: Degradation of operational quality as resource scarcity worsens

This figure illustrates the granular nature of care quality as it gradually degrades from usual care through contingency and then crisis operations, with illustrative examples of strategies used by organizations to maintain optimal quality of care at each stage despite increasingly severe shortages of staff, space, and supplies. Note that resource categories are interrelated, so shortages in one category affect other categories. For example, there may be adequate numbers of oxygen stations but not enough trained personnel to use them. There may be a need to use crisis standards of care for some resources but not others.

