Palliative Care Quality Collaborative

# COVID-19 Palliative Care Case Report

Community Based Survey

For additional information and to submit this form visit PalliativeQuality.org

**Patient identifying information is not asked on the case report but could be helpful if you need to return to this form multiple times.

Medical record #: ________________________________________ Last name: ____________________________________________

**(1) Which area of the country is your palliative care program located?**

☐ US West ☐ US Midwest ☐ US South ☐ US Northeast ☐ International (outside US) please specify _______________________

**(2) What type of organization is your program's Administrative Home?**

☐ Hospital ☐ Hospice ☐ Long-term Care Facility ☐ Independent Organization
☐ Health System ☐ Physician Group, Office Practice, or Clinic ☐ Home Health Agency ☐ Other, please specific: __________________________

**(3) Please select the category that best describes the patient's location during this visit.** *If the location is not included in the list, please select other nd add the location. For those patients seen via telemedicine indicate the location where palliative care is primarily provided*

☐ Hospital- General Floor (includes step-down, pre-op)
☐ Hospital – ICU (includes MICU, SICU, TICU, CICI, Neuro ICU, PICU)
☐ Hospital Palliative Care Unit
☐ Emergency Department
☐ Outpatient (Clinic)
☐ Other: ___________________________________
☐ Long term care (includes LTAC, SNR, NH)
☐ Assisted Living Facility
☐ Other Domiciliary
☐ Home
☐ Unknown

**(4) How did you see the patient?**

☐ Bedside/ in person
☐ By telemedicine

**(5) What is the patient's age?**

☐ Under 1 ☐ 1-18 ☐ 19-34 ☐ 35-49 ☐ 50-64 ☐ 65-79 ☐ 80+ ☐ Unknown

**(6) What is the patient's current gender identity?**

☐ Female
☐ Male
☐ Transgender Male/ Female-to-Male (FTM)
☐ Transgender Female/ Male-to-Female (MTF)
☐ Non-Binary
☐ Decline to Say
☐ Prefer to Self-Describe
☐ Unknown

**(7) Does the patient identify as Hispanic and/or Latino?**

☐ Hispanic or Latino
☐ Non-Hispanic or Latino

**(8) Does the patient identify as belonging to one or more of the following race categories? Select all that apply.**

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaskan Native
☐ Not Reported
☐ Unknown
☐ Other, specify: _____________

**(9) What is the patient's current COVID-19 diagnosis?**

☐ Under investigation/ Suspected
☐ Confirmed
☐ Recovered

**(10) Select the type of institution or practice that referred the patient to community-based palliative care.**

☐ Emergency Department
☐ Group Home
☐ Health Plan
☐ Home Health Agency
☐ Hospice
☐ Hospital Inpatient Palliative Care Program
☐ Unknown
☐ Nursing Home/ Long Term Care
☐ Other Hospital Inpatient Service
☐ Patient/ Family Self- Referral
☐ Primary Care Practice
☐ Specialty Practice
☐ Other, please specify: ________________________

**(11) If a Specialty Practice referred the patient (question eight), what type of practice referred the patient to community-based palliative care?**

☐ Oncology/ Cancer Center ☐ Neurology ☐ Geriatrician ☐ Other, please specify: _________________________
☐ Cardiology/ Heart Failure Clinic ☐ Nephrology/ Dialysis Center ☐ Palliative Care Clinic ☐ Ambulatory ☐ Home

**(12) Please select the diagnosis category that best reflects the patient's primary underlying serious illness in addition to COVID-19. If the patient was previously well, please mark none.**

☐ None (patient was previously well with no serious illness)
☐ Cancer (solid tumor)
☐ Cancer (Heme)
☐ Cardiovascular
☐ Pulmonary
☐ Gastrointestinal
☐ Hepatology
☐ Renal
☐ Dementia
☐ Neurology (includes Neuromuscular or non-dementia Neurodegenerative)
☐ Infectious
☐ Trauma
☐ Vascular
☐ Metabolic/Endocrine
☐ Genetic/ Chromosomal
☐ Hematology (non-cancer)
☐ Prematurity/ Complications related to prematurity
☐ Fetal
☐ Unknown
☐ Other: ___________________________________

**(13) Please select the palliative care team members involved in the care of the patient. Select all that apply. The discipline must be a regular and specifically recognized member of the palliative care team and must have contact with the patient/family. The person of that discipline may have other responsibilities but is clearly identified and identifies as a member of the palliative care team. For example, a visit by a chaplain that sees all patients in the hospital but who does not participate as a member of the palliative care team would not be included. If that chaplain did attend palliative care team meetings (clinical and administrative), then the chaplain would be considered a member of the palliative care team, and the visit would be recorded here. Check all that apply**

☐ Physician
☐ Advanced Practice Nurse
☐ Physician Assistant (PA)
☐ Registered Nurse (RN)
☐ Licensed Practical Nurse (LPN)
☐ Psychologist
☐ Psychiatrist
☐ Social Worker
☐ Chaplain/ Spiritual Care
☐ Physical/ Occupational Therapist
☐ Other Therapist (e.g., massage, music/art)
☐ Child Life Specialist
☐ Dietitian/ Nutritionist
☐ Pharmacist
☐ Community Health Worker
☐ Other: ____________________________

**(14) Please select the reason(s) for the palliative care consultation at the time of the initial request (check all that apply)**

☐ Symptom Management ☐ Decision Making (includes Goals of Care) ☐ Appoint health care proxy ☐ Providing support to patient/family

☐ Providing support to colleagues/staff ☐ Other: ______________________________

**(15) What did the palliative care team help with?**

*Symptom Management*
- ☐ Pain
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Excess Secretion
- ☐ Restlessness
- ☐ Anxiety
- ☐ Agitation/ delirium
- ☐ Depression

*Decision Making/ Goals of Care*
- ☐ Appointing health care proxy/surrogate
- ☐ Discussing GOC with patient
- ☐ Discussing GOC with proxy/surrogate
- ☐ Discussing decisions to not start or stop life-sustaining treatment

*Providing Support*
- ☐ Providing support to patient/family
- ☐ Providing support to colleagues/staff

☐ Other: ______________________________

**(16) What was the formally indicated status of the patient at the time of the visit, with respect to the desire for resuscitative efforts. Formally indicated status implies signed documents are present that describe the patient's code status**

☐ Full ☐ DNR, not DNI ☐ Other, Limited DNR ☐ DNR/DNI (DNAR + AND) ☐ Unknown

**(17)What challenges, lessons learned, or ethical barriers did you encounter in caring for this patient? Please do not include any patient identifiable information in your response.**