Brief Report

Creating a Dedicated Palliative Care Team for ICU Spanish Speaking Patients in Response to COVID-19

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Abstract

Context. The Latinx population faced higher rates of infection and severe illness during the COVID-19 pandemic, resulting in an increased need for palliative care services.

Objectives. We describe the creation and impact of a formal palliative care initiative developed for seriously ill, Spanish-speaking patients during the COVID-19 pandemic at a tertiary care academic medical center.

Methods. Patients were enrolled in the Spanish Palliative Care Initiative during a two-month period starting in April 2020. Selected patients were longitudinally followed by a rotating team of Spanish-speaking palliative care clinicians. Following the intervention, a retrospective chart review was conducted to evaluate the impact of the program.

Results. We enrolled 22 patients. The most frequent palliative care task completed during the initial visit was information giving (77%) and during follow-up visits were goals of care discussion (59%) and coping support (59%). Fifteen patients (68%) had a change in code status and 4 patients (18%) were discharged to hospice.

Conclusion. The creation of a focused clinical program targeting a historically marginalized population offered opportunity for early palliative care intervention in clinical care for Spanish-speaking patients. This underscores the need for Spanish-language concordant palliative care to improve serious illness care, and end-of-life care, by providing continuity of care, spiritual care, and ICU team support. J Pain Symptom Manage 2022;000:e1−e6.

Key Words

Palliative care, Latinx / Hispanic population, COVID-19, Quality improvement

Key Messages

This article describes the creation of a novel dedicated palliative care team for hospitalized Spanish speaking patients that provided linguistic and culturally concordant care, in response to the first COVID-19 surge in an urban academic center.

Introduction

People from historically marginalized racial and ethnic communities have been disproportionately impacted by the COVID-19 pandemic in the United States, with an increased risk of infection, hospitalization, ICU admission, and death compared to non-Hispanic Whites.[1,2] In our urban quaternary academic medical institution, we found that Latinx patients represented over 40% of those admitted with COVID-19 infection during the spring 2020 pandemic peak compared to 9% of hospital admissions prior to the pandemic.[3] Similarly, over 40% of patients hospitalized with COVID-19 were Spanish-speaking, compared to 6% of all patients hospitalized at baseline.[4] This represents a rapid increase in the number of Spanish-speaking individuals who were experiencing a novel, critical illness at our institution.

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Prior to the COVID-19 pandemic, the Latinx population already faced multiple barriers to equitable health care, including lower rates of health care coverage,[5] poorer access to care,[5,6] language barriers, and systemic and institutional discrimination,[7] which all led to lower quality of care.[5,6,8] During the pandemic, one study showed that documented telephone encounters in the ICUs differed by race/ethnicity, with White patients having more documented calls per patient admission compared to Black or Hispanic/Latino patients, even though Hispanic/Latino patients had the longest length of admission compared to Black or White patients. This was thought to be due to the extra step of including an interpreter.[9] In parallel, the COVID-19 pandemic led to increased demand for palliative care that outstripped the availability of specialty-trained clinicians.[10] The pandemic highlighted preexisting health care disparities and the great need for culturally humble care to Latinx and Spanish-speaking patients and their families during this time of crisis. In response to this need, we sought to understand the feasibility of creating a targeted intervention to meet the palliative care needs of Spanish-speaking patients and families in our hospital.

Our palliative care department created an inpatient Spanish Palliative Care initiative to help meet the linguistic and cultural needs of these patients and assist with decision making. There was a hospital-led effort to have Spanish-speaking physicians available to communicate updates and assist with meetings for staff and patients' families - the Spanish Language Care Group.[4] However, there was still a need for palliative care trained clinicians to assist with addressing the hopes and worries of family members struggling with the unknowns of critical illness, particularly for this novel illness in the early stages of the pandemic. One author (CD) was an early member of the hospital's Spanish Language Care Group and quickly realized that in addition to language-concordant care, specialized palliative care communication skills were highly needed for Latinx and Spanish-speaking patients and families. This led to an innovative opportunity to create an interprofessional Spanish-speaking palliative care team which included three physicians, a nurse practitioner, and a chaplain (authors on this manuscript). To our knowledge, our program was the first dedicated Spanish speaking palliative care clinician-led effort to address the needs of Latinx patients during the COVID-19 pandemic. This article aims to describe the program creation, patients served, and outcomes of a novel Spanish Palliative Care program.

Methods

In response to the inequitable distribution of early hospitalizations due to COVID-19, our palliative care division together with members of the ICU leadership decided to create and implement a focused strategy to provide enhanced palliative care services to Spanish-speaking patients in the ICU. At the time, our division and team were already stretched beyond our usual capacity in response to the heavy burden of COVID-19 for all patients across the hospital, with innovations of staffing in the emergency department[11] and the development of a dedicated inpatient palliative care unit.[12] Despite being overextended, our division leadership together with the clinicians who volunteered to lead the program felt strongly that a focused and formal response was morally imperative given the immense inequities that had been exposed for Latinx and Spanish-speaking patients and families.

We made several focused structural changes to initiate the program (see Fig. 1). These included: 1) adjusting the inpatient palliative care service schedule to ensure there was always at least one Spanish-speaking clinician on service each week for continuity, 2) limiting the outpatient nurse practitioner's clinical load to urgent visits that allowed her to then join ICU rounds twice weekly, and 3) instituting weekly warm hand-offs among team members.

We identified patients of Latinx/Hispanic origin who were or had a decision-maker who was primarily Spanish-speaking through four pathways: 1) chart review; 2) joint rounding in the ICUs; 3) referrals from Spanish Language Care Group members; and 4) consults through the traditional palliative care inpatient consult service. To direct our limited resources to patients with the highest needs, we screened potential patients' medical record using the following criteria: age, medical comorbidities (metastatic cancer, neutropenia, dementia, significant underlying lung disease, such as interstitial lung disease, asthma, or chronic obstructive pulmonary disease), number of days intubated (with emphasis for long duration of intubation, >10 days), evidence of multiorgan failure, and complex psychosocial dynamics (e.g., no identified decision-maker, health care decision-maker(s) also ill or hospitalized with COVID-19, or multiple family members involved without a clear decision-maker).

Our clinical team for the program included five Spanish-speaking clinicians (three physicians, one nurse practitioner, and one chaplain). Two clinicians were native Spanish speakers, two were nonnative advanced Spanish speakers at the C1 or higher level, and the chaplain was a level B2 Spanish speaker. Due to intentional scheduling, there was always at least one Spanish-speaking palliative care clinician on the inpatient service available to take new consults for Spanish-speaking patients and to follow existing Spanish-speaking consult patients. Additionally, the chaplain

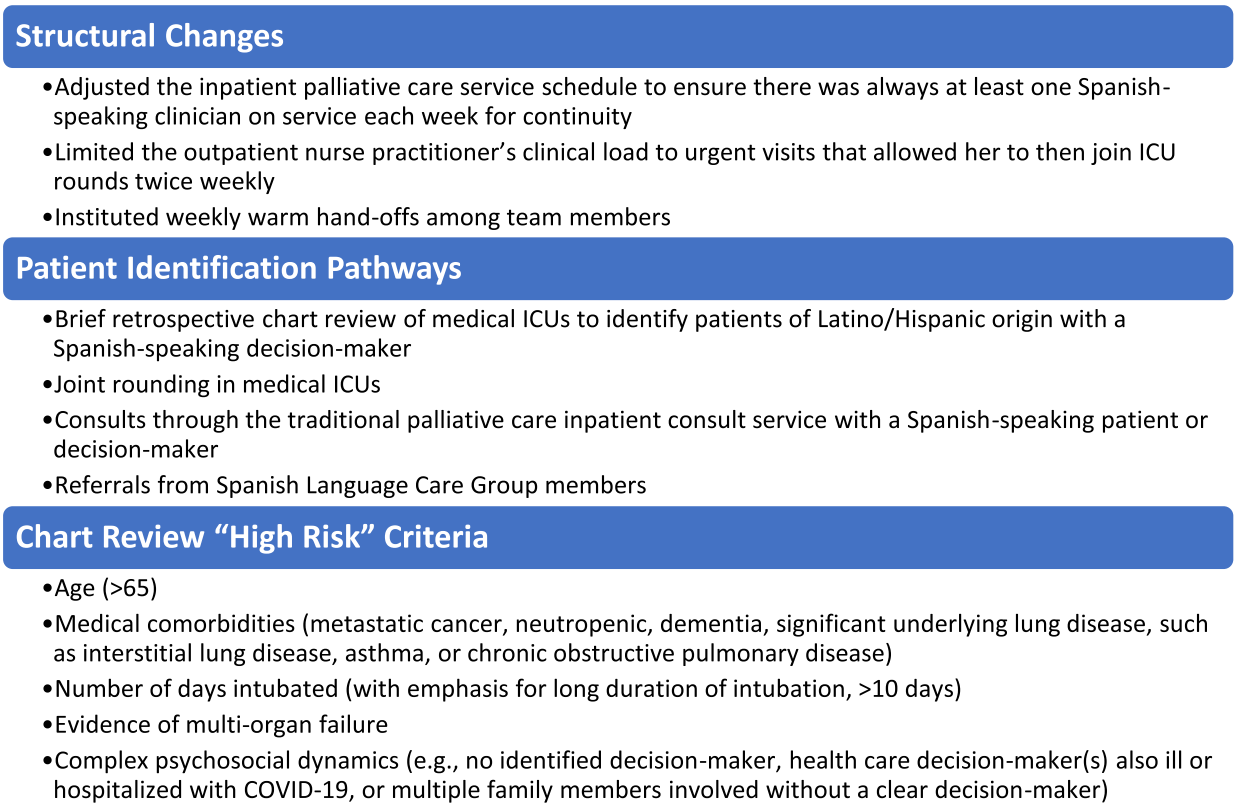

Fig. 1. Core components of implementing a Spanish palliative care initiative.

established care with these patients earlier and followed up with them more frequently than her other patients. Team members would communicate with families and the ICU team(s) frequently throughout the week. We also partnered with the Spanish Language Care Group to help train these clinicians on communication strategies and serious illness conversations, based on work done by our institution's serious illness care program.[13]

The program ran from April 21 to June 14, 2020. After the program's conclusion, a chart review was conducted for the purposes of quality improvement. Variables collected included age, gender, primary diagnosis, number of palliative care visits across clinicians, code status changes, and final disposition. Additionally, the initial consult note and an additional key progress note (if applicable) from the palliative care clinicians were analyzed by two separate reviewers for core tasks completed, including symptom management, information giving, coping support, goals of care discussion, and discharge planning. Multiple tasks could be identified within a given note. In our analysis, goals of care discussions were differentiated from other tasks, such as information giving, when a formal recommendation was made to make a specific change in the care plan. Any discrepancies were reconciled by a third reviewer. This work was considered exempt from Institutional Review Board oversight due to the quality improvement nature of the study.

Results

A total of 22 patients were seen by the Spanish Palliative Care team during the study period, see Table 1. Patients included 12 men (55%) and median age of 65 (range 21–82). The most common diagnoses were COVID-19 (59%) and cancer (14%).

Team members saw these patients an average of 8.1 visits (median 5, range 1–22), see Table 2. During the

Table 1
Demographics and Clinical Characteristics of Patients in the Spanish Palliative Care Initiative

		Number	Percentage
Age	Mean	62	
	Min	21	
	Max	82	
Gender	Male	12	55%
	Female	10	45%
Primary Diagnosis	COVID	13	59%
	Cancer	4	18%
	CHF	2	9%
	COPD	1	5%
	Dementia	1	5%
	ESRD	1	5%
Total	All	22	100%

Table 2
Impact of Spanish Palliative Care Initiative

		Number	Percentage
Visits	Median	5	
	Mean	8.1	
	Min	1	
	Max	22	
Tasks for Initial Consult[a]	Coping Support	13	59%
	Discharge Planning	0	0%
	GOC Discussion	10	45%
	Symptom Management	9	41%
	Information Giving	17	77%
Tasks for Key Follow-up Consult[a]	Coping Support	13	59%
	Discharge Planning	6	27%
	GOC Discussion	13	59%
	Symptom Management	11	50%
	Information Giving	11	50%
Code Status Changes	Full Code -> DNR	7	32%
	Full Code -> Comfort	3	14%
	DNR -> DNR/DNI	2	9%
	DNR -> Comfort	3	14%
	No Change	7	32%
Final Disposition	Death	9	41%
	Discharge to hospice	4	18%
	Discharge (Non-hospice)	9	41%
Days between Initial Consult and Outcome	Median	16	
	Mean	13.5	
	Min	0	
	Max	47	

[a]Note: As multiple tasks could be identified within a note, totals may be greater than 100%.

initial consult visits, the most common palliative care tasks completed included information giving (77%), coping support (59%), and goals of care discussion (45%). During follow-up visits, the most common tasks completed were similar to initial consult visit, though also included discharge planning (27%).

For the 22 patients seen by the service, 15 (68%) had code status changes that occurred after the time of consultation over the subsequent course of their hospitalization (for additional details, see Table 2). Of the patients seen by our program, 9 (41%) died in the hospital, 4 (18%) patients were discharged from the hospital with hospice services, and the remaining 9 patients (41%) were discharged from the hospital without hospice services.

Discussion

The early days of COVID-19 were marked by an acute global pandemic on top of a chronic but equally severe pandemic of socioeconomic and racial/ethnic inequality. Times of change and upheaval are fertile ground for innovation and the creation of new programs. In our hospital, these inequities were seen in the disproportionate number of Spanish-speaking patients hospitalized and critically ill in our ICUs — many of whom were essential workers unable to socially distance themselves. There are innovations with Spanish-speaking clinicians supporting language-concordant care for patients with COVID-19 — both at our institution and external to our institution.[4,14] These interventions at first relied on a volunteer bilingual clinician workforce working supplemental shifts on those Spanish language services to support primary teams caring for Spanish-speaking patients. Our intervention, the Spanish Palliative Care Initiative, provided a tailored response to these dual pandemics to provide linguistically concordant and culturally sensitive, specialty-level palliative care services to a cohort of Spanish-speaking patients and their decision-makers. To our knowledge, it is the first such described service to provide specialty-level palliative care services. It is also different in that it was a model that was integrated into the workflow of inpatient palliative care service delivery, not requiring additional volunteered time by participating clinicians.

One of the benefits of this program was the early identification of Spanish-speaking patients with palliative care needs in the ICU, allowing our team to intervene before there was a need for urgent decision-making. Indeed, information giving represented the most common task during the initial palliative care consult visit. The program further offered the opportunity to improve continuity of care for a population for whom miscommunication is common.[15,16] Our team included a board-certified chaplain, as we recognized that spiritual and religious beliefs and practices are a crucial source of coping, decision-making, and meaning-making, particularly for Spanish-speaking patients facing serious illness.[17] This early consultation for critically ill patients also enhanced the palliative care team's ability to be present and involved for subsequent

critical transitions in care. Our clinicians spent a significant amount of time on communication focused tasks including information giving, goals of care discussions, and coping support including ongoing assessment of spiritual needs. In taking on these time intensive conversations, we were able to support and offload the already overwhelmed ICU teams and support patients and families who were now able to directly communicate with clinicians in their primary language.

We intentionally formed the Spanish Palliative Care Initiative within the existing structure of the inpatient palliative care consultation service to align with most of the clinicians' primary clinical responsibilities. One outpatient clinician was given protected time to join this inpatient initiative. While organizing the Spanish Palliative Care Initiative did involve additional time and dedication of the core team, the extra work did not take a significant toll on team members. Instead, we felt this work provided motivation, meaning, and increased resiliency amid the stress and uncertainty present within the early days of the pandemic.

We recognize that this model would not be wholly replicable in other settings whose teams do not have the benefit of a cohort of five bilingual, Spanish-speaking interprofessional palliative care clinicians. Many palliative care teams are much smaller and may not have clinicians with Spanish language skills. This reinforces the need to work collaboratively with interpreter services locally, particularly when providing specialist palliative care that relies on precise word choice and language use in communication. Nonetheless, it underscores the need to recruit more Spanish-speaking individuals into medicine and into Palliative Care, who can provide this important service for seriously ill Spanish-speaking patients and their loved ones.

The Spanish Palliative Care Initiative represents one hospital system's innovative response to structural inequities to meet the needs of historically marginalized Spanish-speaking patients and decision-makers. This paper underscores the need for Spanish-language concordant palliative care, through Spanish-speaking palliative care clinicians and/or with closer collaboration with interpreter services. This service can improve serious illness care, and end-of-life care, for this historically marginalized population by providing continuity of care, spiritual care, and ICU team support.

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References

1. Acosta A, Garg S, Pham H, et al. Racial and ethnic disparities in rates of COVID-19–associated hospitalization, intensive care unit admission, and in-hospital death in the United States from March 2020 to February 2021. JAMA Netw Open 2021;4:e2130479. https://doi.org/10.1001/jamanetworkopen.2021.30479.

2. Mackey K, Ayers CK, Kondo K, et al. Racial and ethnic disparities in COVID-19–related infections, hospitalizations, and deaths: a systematic review. Ann Intern Med 2021; 174:362–373. https://doi.org/10.7326/M20-6306.

3. Rios S. For non-english speakers, difficult language barriers become dire amid outbreak. WBUR News. 2020. Available at: https://www.wbur.org/news/2020/04/07/coronavirus-translation-problems. Accessed April 8, 2020.

4. Knuesel S, Chuang W, Olson E, Betancourt J. Language barriers, equity, and COVID-19: the impact of a novel Spanish language care group. J Hosp Med 2021;16:109–111. https://doi.org/10.12788/jhm.3542.

5. Smedley B, Stith A, Nelson A. Racial and ethnic disparities in diagnosis and treatment: a review of the evidence and a consideration of causes. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003. https://doi.org/10.17226/12875.

6. Sommers BD, McMutry CL, Blendon RJ, Benson JM, Sayde JM. Beyond health insurance: remaining disparities in US health care in the post-ACA era. Milbank Q 2017;95:43–69. https://doi.org/10.1111/1468-0009.12245.

7. O'Reilly KB. AMA: Racism is a threat to public health. 2020. Available at: https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health. Accessed June 6, 2022.

8. Betancourt JR, Green AR, Carrillo JE, Park ER. Cultural competence and health care disparities: key perspectives and trends. Health Aff 2005;24:499–505. https://doi.org/10.1377/hlthaff.24.2.499.

9. Piscitello GM, Fukushima CM, Saulitis AK, et al. Family meetings in the intensive care unit during the coronavirus disease 2019 pandemic. Am J Hosp Palliat Care 2021;38:305–312. https://doi.org/10.1177/1049909120973431.

10. Abbott J, Johnson D, Wynia M. Ensuring adequate palliative and hospice care during COVID-19 surges. J Am Med Assoc 2020;324:1393–1394. https://doi.org/10.1001/jama.2020.16843.

11. Stoltenberg M, Jacobsen J, Wilson E, et al. Emergency department-based palliative care during COVID. J Palliat Med 2020;23:1151–1152. https://doi.org/10.1089/jpm.2020.0285.

12. Drutchas A, Kavanaugh A, Cina K, et al. Innovation in a crisis: lessons learned from the rapid development of an end-of-life palliative care unit during the COVID-19 pandemic. J Palliat Med 2021;24:1280–1283. https://doi.org/10.1089/jpm.2021.0035.

13. Jacobsen J, Jackson V. 1,000 serious illness conversations: delivering on what matters most during the pandemic and beyond. Health Aff Forefront 2020. https://doi.org/10.1377/forefront.20200714.156660.

14. Ivarez-Arango S, Tolson T, Knight AM, et al. Juntos: a model for language congruent care to better serve Spanish-speaking patients with COVID-19. Health Equity 2021;5:826–833. https://doi.org/10.1089/heq.2020.0124.

15. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? J Gen Intern Med 1999;14:409–417. https://doi.org/10.1046/j.1525-1497.1999.06198.x.

16. Hsueh L, Hirsh AT, Maupomé G, Stewart JC. Patient-provider language concordance and health outcomes: a systematic review, evidence map, and research agenda. Med Care Res Rev 2021;78:3–23. https://doi.org/10.1177/1077558719860708.

17. Delgado-Guay MO, Palma A, Duarte E, et al. Association between spirituality, religiosity, spiritual pain, symptom distress, and quality of life among Latin American patients with advanced cancer: a multicenter study. J Palliat Med 2021;24:1606–1615. https://doi.org/10.1089/jpm.2020.0776.