Journal of Patient Experience
2020, Vol. 7(5) 673-676
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DOI: 10.1177/2374373520956865
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# Development of a Communications Program to Support Care of Critically Ill Coronavirus Disease 2019 (COVID-19) Patients

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**Abstract**
A significant role of intensive care unit (ICU) workforce is ongoing communication with and support for families of critically ill patients. The COVID-19 pandemic has created unanticipated challenges to this essential function. Restrictions on visitors to hospitals and unprecedented clinical demands hamper traditional communication between ICU staff and patient families. In response to this challenge, we created a dedicated communications service to provide comprehensive support to families of COVID-19 patients, and to create capacity for our ICU teams to focus on patient care. In this brief report, we describe the development, implementation, and preliminary experience with the service.

**Keywords**
COVID-19, challenges, organizational communication, patient/relationship centered skills, relationships in health care, team communication

## Introduction

Effective communication between family members of critically ill patients and practitioners is an established component of patient-centered care in the intensive care unit (ICU) (1). Interventions which promote family involvement increase satisfaction and reduce the development of post-traumatic stress-related symptoms (2,3).

The global spread of SARS-CoV-2 and coronavirus disease 2019 (COVID-19) has dramatically changed the relationships between ICU workforce and patient families. For example, isolation precautions preclude family presence at the bedside, which in turn impairs the exchange of information, involvement (both active and passive) in patient care, and participation in decision-making (4). These changes are occurring simultaneously with unprecedented clinical demands on ICU workforce, brought about by high rates of ICU admission for COVID-19 critical illness with significant patient acuity. All of these factors limit the ability of ICU teams to communicate effectively with patient families. Given these changes, ICU teams require new working practices to be established so that families of critically ill COVID-19 patients can be supported and participate in informed decision-making. Our hospital recognized this gap in care relatively early in the pandemic. Here we describe the rapid development and implementation of a *Family Medical Communications Team (FMCT)*, whose primary function is to liaise with separated families on behalf of the ICU care team.

## Description

The FMCT was created in March 2020 within the Department of Anesthesiology, Critical Care and Pain Management

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**Table 1.** Summary of FMCT Workflow and Communication Processes.[a]

| Workflow Element | Communication Element |
|---|---|
| Patient admitted to the ICU | SEL and FMCT notified of admission |
| SEL assigned | Electronic medical record reviewed |
| SEL contacts family | Identify patient representative; identify surrogate decision maker; determine existence of health-care proxy documentation/advance care directive; establish mode of communication preference; establish communication expectations |
| FMCT medical provider assigned | Electronic medical record reviewed |
| FMCT medical provider liaises directly with the ICU provider | Confirm patient status, events of prior 24 hours and daily care plans; establish any concerns and questions to be conveyed to the family |
| FMCT medical provider contacts the family | Structured phone call emphasizing family concerns, questions and attitudes; summary of current patient status; discussion of any changes in care and/or goals of care. |

Abbreviations: FMCT, family medical communications team; ICU, intensive care unit; SEL, service excellence liaison.
[a]The Family Medical Communications Team workflow and key elements of communication at each stage. The process between identification of appropriate patients to contact from the team representatives is indicated.

at Hospital for Special Surgery (HSS), in New York City, New York. Prior to the coronavirus pandemic, HSS had 4 ICU beds. In response to the COVID-19 surge crisis, we increased our ICU capacity by 400% (20 ICU beds), with consequent strain on physician, nursing, and support staff resources. The multidisciplinary FMCT team includes expertise from Anesthesiology, Pain Management, Service Excellence, Palliative Care, Spiritual Care, and Social Work, with support and endorsement from departmental and hospital administration. The goals of the interprofessional team are to provide 24 hours a day, 7 days a week liaison service to support (1) the families of patients admitted to the ICU for COVID-19 and (2) our ICU workforce so that their time and efforts can be maximally directed toward patient care.

## Service Design: Staffing and Training

Existing resources and strengths were identified from the institution to create the FMCT. Personnel with substantial expertise in patient and family counselling were selected from the participating services. Our hospital had a preexisting Service Excellence Department, which functions primarily as a point of communication and coordination between families and the medical/surgical services. Prior to the pandemic, this team provided patient care status updates and served as a point of contact to help organize and provide information to families throughout the perioperative period. As part of the FMCT, this preexisting team facilitated day-to-day coordination and communication between the medical FMCT staff and the patient families.

An initial group of 10 anesthesiologists (with 3 subspecializing in pain management) provided staffing for the FMCT. These medical professionals were initially self-identified as a group whose frontline clinical responsibilities were curtailed because of significant risk factors for poor outcomes in the event of nosocomial coronavirus acquisition. The Anesthesia Patient Safety Foundation and the Centers for Disease Control and Prevention do not make formal recommendations on the clinical roles for high-risk medical providers, but they acknowledge that common sense dictates these individuals limit their exposure (5,6). The group was later expanded to include one internist and one pediatric rheumatologist.

While this group of providers possessed the necessary medical background and education to understand and interpret the medical ICU issues as well as clinical experience discussing complex issues with patients and families, we supplemented their training and guidance for directing these difficult conversations with families. Virtual educational sessions were provided by team members from the acute pain, palliative care, and bioethics services, emphasizing how to structure conversations about end of life and critical care decision-making. These sessions were also accompanied by an online course in Psychological First Aid, which teaches provider-skills to support people affected by crisis situations (7,8). This self-directed course comprises 6 hours of training. The course does not replace formal mental-health care or the involvement of the bioethics team, but does refresh the concepts important to a meaningful, supportive relationship such as reflective listening and assessment of needs.

## Workflow

The FMCT workflow consists of process and communication elements and is described below and summarized in Table 1. Given their established role in our hospital, a service excellence liaison (SEL) was designated as an initial point of contact for the families of our COVID 19-positive patients. An FMCT medical professional was subsequently assigned to every family at the time of transfer to the ICU. This physician-administrative team was charged with developing and maintaining a relationship with the patient's family for the duration of the patient's stay in the ICU.

The SEL had primary responsibility for identifying the patient's representative and surrogate decision maker and any available health-care proxy documentation. Where no evidence of advance decision-making was available, and the

patient lacked decision-making capacity, the family was asked to appoint a surrogate, in accordance with the New York State Family Health Care Decisions Act (9). Finally, the SEL established expectations with the family that they would be contacted daily for assistance with any nonclinical questions and concerns, and as an administrative resource for the patient's family.

The FMCT medical professional served as the direct clinical liaison between ICU mid-level staff and the family representative. A telephone call between this FMCT member and mid-level provider was scheduled daily after morning ICU rounds, so the patient status and clinical plan for the day could be verified. The calls between the FMCT medical professional and family spokesperson were scheduled by the SEL, ideally in the afternoon, at the same time every day. This provided consistency for the families, and time for the daily consult and service notes and laboratory results to be updated and available for the FMCT caller.

### Documentation

We included formal documentation of family communications as part of the FMCT program. Documentation was not intended to replace direct communication between FMCT, ICU personnel, and family members or serve as a standalone communications tool. Rather, documentation was considered an allied mechanism to provide information to the ICU team from the family, particularly since only one member of ICU team spoke directly with the FMCT liaisons. The note thus allowed any member of the patient care team to directly review information communicated to and from the family. All members of the FMCT were provided remote access to electronic medical records. Our Information Technology Department created a "Family Communication Note" template, which was available to the entire care team. Here, the FMCT caller documents their discussion with the family, with an emphasis on any changes or concerns regarding goals of care. Importantly, this documentation does not supersede other processes for consent or changes to resuscitation status but allows the primary care team to be kept informed of family concerns. Any subsequent discussions or changes to consent or resuscitation status may include the FMCT medical professional but must also involve a member of the ICU team and are documented accordingly.

### Phone Calls

The FMCT medical professional begins each call with open-ended questions about family understanding of the patient's overall medical condition. These open-ended questions allow providers to understand family concerns, attitudes, and knowledge of the patient's medical status. A summary of events from the prior 24 hours is provided, together with the elements of care being provided, changes in care, and laboratory results and supporting information from consult services, as appropriate.

Goals of care are frequently raised by families as a topic for discussion. However, this is not a formal component of the call, due to potential for rapid changes in patient condition and because the FMCT member is not part of the primary care team. However, the FMCT-family relationship offers a valuable opportunity to discuss patient values, ethics, and how evolving circumstances may change goals of care and decision-making. Where these decisions and communications are clear, changes to consent or resuscitation status are referred directly to the ICU team. Where questionable, the palliative care and bioethics team members are asked to consult.

### End of the Relationship

Some patients and families have graduated from our program. Patients who are extubated are monitored for approximately 48 hours, prior to transfer to the floor. During this phase, the FMCT medical provider continues to provide updates to the family. When the patient can communicate independently, the FMCT medical provider ceases to be involved. However, the SEL remains in their role for the remainder of the admission.

Unfortunately, some patients have passed away. Whenever possible the FMCT medical professional has informed the family of the death. Where timing precluded this, the FMCT medical professional made a condolence phone call to the family.

## Results/Lessons Learned

We included approximately 20 patient-families in the program. Feedback from families and FMCT members has been positive and highlights several key contributions of the program. First, many families had no or minimal information for days, or longer prior to transfer to HSS. In addition to the benefits of understanding what care is being provided, families typically describe the value of consistent communication and express relief from fear that their loved ones are alone. Peer reviewed data are not yet available, but these experiences are consistent with recent reports from the popular press in which families receive no information between admission to the hospital and the death notification (10). Second, the program provides an important structure for families to provide information and documentation to support patient care. Finally, FMCT members have described a sense of renewed purpose as a time and care saving resource to their ICU colleagues.

## Conclusion

The development of the FMCT provides a framework to improve the care of patients with COVID-19 critical illness, support their families and extend resources during the pandemic. Although our preliminary feedback suggests the value of this program, future evaluation should formally address patient and family satisfaction, effects on systems

efficiency, and the potential for a longer-term, permanent role, after the surge crisis of the pandemic. Programs such as ours may not be universally applicable in structure, depending on local resources. Specifically, we benefitted from preexisting acute pain, service excellence, palliative care, and bioethics services, which facilitated creation of the FMCT teaching/training and support functions. Nonetheless, hospitals lacking these systems may be able to identify analogous people and resources to create a communications team to suit their individual needs.

## Authors' Note

This manuscript does not involve research on human subjects and meets criteria for exemption from approval by the institutional review board. Pamela K Wendel helped to draft, revise, and critically edit the manuscript and is a member of communications program. Roberta J Stack helped to design/implement the communications program and critically edit the manuscript. Mary F Chisholm helped conceive of the idea for the communications program, design/implement the program, and critically edit the manuscript. Mary J Kelly helped design/implement the communications program and critically edit the manuscript. Bella Elogoodin helped design/implement the communications program and critically edit the manuscript. Gregory A Liguori helped design/implement the communications program and critically edit the manuscript. Douglas S T Green helped design/implement the communications program and critically edit the manuscript. Mandip Singh Kalsi helped conceive of the idea for the communications program, design/implement the program, and critically edit the manuscript. Ellen M Soffin helped conceive, draft, revise, and critically edit the manuscript.

## Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by funds from the Department of Anesthesiology, Critical Care and Pain Management, Hospital for Special Surgery, New York, NY.

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