Grieving and Hospital-Based Bereavement Care During the COVID-19 Pandemic

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As of July 25, 2020, there had been 146,073 deaths from COVID-19 in the United States and 641,273 worldwide, with a disproportionate number of deaths occurring in historically disadvantaged minority groups, specifically African Americans.[1,2] The number of decedents will continue to increase over the coming months, even as the number of new COVID-19 cases decreases. Given that, for each death, five persons are believed to be significantly affected,[3] the number of bereaved individuals whose loved ones died during the pandemic in the United States alone is likely to be in the millions.

COVID-19–related mortality has become a pressing public health issue, and as a result, support for bereaved family members, especially for minority populations, is also an important public health issue.[4] It is likely that bereaved individuals are at greater risk of poor bereavement outcomes during the pandemic—irrespective of whether the death was a result of COVID-19—because of social isolation. This is particularly true if loved ones died in the hospital and, due to visitor restrictions, faced limited or no visitation. For many, bereavement will be affected by stay-at-home orders and social distancing restrictions that reduce access to emotional support and rituals, such as funerals, that usually provide comfort.[5]

Urgent attention is needed to support bereaved individuals, to flatten the curve of mental health disorders associated with the death of loved ones during the pandemic. Within a preventive model of care, we offer guidelines for how hospitals, longitudinal providers, and mental health clinicians can provide bereavement outreach to all individuals whose loved ones died during the COVID-19 pandemic.

PUBLIC HEALTH MODEL OF BEREAVEMENT SUPPORT

The provision of bereavement care, including the assessment of risk for poor bereavement outcomes, is an essential component of high-quality end-of-life care endorsed by the hospice and palliative care movement.[6] However, the development of standardized bereavement services has lagged behind that of other components of palliative care, varying greatly by institution and provider.[7] Approximately 10% to 20% of bereaved individuals experience psychiatric difficulties following the death of a loved one, including prolonged grief disorder, posttraumatic stress disorder, and major depressive disorder.[8] Risk factors include a hospital-based death, death in an intensive care unit (ICU), sudden death, not being able to say goodbye, and a history of psychiatric disorders.[8,9]

One of the biggest barriers in providing standardized bereavement services is the lack of a systematic process to identify individuals at risk of poor bereavement outcomes.[10] Aoun et al developed a public health model of bereavement support that comprises a three-tiered approach to risk and the corresponding need for support.[11] They propose that the low-risk group, approximately 60% of bereaved individuals, would primarily need support from family and friends, the moderate-risk group (30%) would need support from the wider community, and the high-risk group (10%) would need support from mental health providers.

It is reasonable to assume that many individuals whose loved ones died during the pandemic will fall into a high-risk group for poor bereavement outcomes, as identified by Aoun et al.[11] Given a higher than usual inpatient mortality due to COVID-19 for certain populations and that bereavement care is already underrecognized within healthcare systems, hospitals and other healthcare facilities and their providers need to fill this void.

EDUCATION, GUIDANCE, AND SUPPORT MODEL

We adopted an education, guidance, and support model of bereavement support in 2019.[7] This model has been shown to positively affect the experience of bereaved individuals, especially because of condolences from providers and psycho-educational information about coping with grief.[7] Each month, a list of deceased patients and family contacts is generated from a mortality review database,[12] and bereavement packets are mailed to family members; the packet includes a condolence letter from senior management, a psycho-educational grief guide, and a list of community-based resources. A social worker is also available to provide telephone support and to assist with mental health referrals. For patients who died in the COVID-19–specific units, social work also provides support and outreach to families.

Psycho-Education

During the early weeks of the pandemic, a tip sheet—"Grieving during a pandemic"[13]— was created to include in the bereavement packet and for distribution to community organizations

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TABLE. **Components of a Condolence Call Using the Acronym TEARS**

Timing
Ideally call within the first 1-2 weeks.
Allow yourself enough time so as not to feel rushed.
Remember that, if you don't learn of a death immediately, it's never too late to call.
Express condolences
Expect emotion.
Express condolences: *"I am so sorry to hear . . ."*
Share a story about the patient.
Emphasize the good job the family did in caring for the patient because this can help them challenge their thinking if they are second guessing their actions
Ask
Inquire about the circumstances of the death: *"Can you tell me about what happened at the end . . .?"*
Ask factual questions, which are usually easier for the bereaved to answer, especially if they are upset, eg, *"Is any of your family staying with you?"*
Find out how they are coping: – *"How are you managing at the moment?"*
Recommend
Provide psycho-education, eg, how grief comes in waves.
Advise checking in with their family doctor.
Suggest seeking counseling or attending a group, especially for those considered at risk.
Offer a team meeting at a later date to answer lingering questions.
Say goodbye
Decide whether this call will be your final goodbye or you will be available for future contact:
It was an honor to care for _____ and to meet you and your family. I wish you all the best in the months ahead.
I am not sure whether our paths will cross again—I wish you and your family all the best.
If in the future questions arise, you are always welcome to contact me.

within the hospital's geographical area. This tip sheet offers strategies to facilitate coping based on the psychological model of cognitive-behavioral therapy (CBT).[14] Topics addressed include understanding the nature of grief, self-care, adapting bereavement rituals in light of social distancing, challenging unhelpful thinking patterns that might lead to feelings of guilt especially regarding the death of the patient, and ways to obtain support during the pandemic. The tip sheet was made available in Spanish, French, Chinese, Haitian Creole, Portuguese, Arabic, and Russian given that our mortality data, consistent with preliminary findings from New York State, suggested higher death rates among Black/African American and Hispanic/Latino groups, compared with historical mortality statistics.[15]

Virtual Support

As part of our bereavement response during the COVID-19 crisis, we have launched virtual bereavement support for families impacted by the pandemic. It is challenging to identify the optimal type of support and timing, given the reliance on virtual outreach without in-person screening. With the increased distress and trauma associated with deaths during the pandemic, one clinical challenge is managing emotions in a virtual group without access to the usual tools that clinicians rely on, such as reading body language. Following a graded exposure approach, a form of behavioral therapy,[14] we recommend offering a psycho-educational seminar first in which facilitators can control the content and limit exposure of sharing stories from participants. For support groups (eg, 6 to 8 sessions), we recommend that participants be screened prior to assess their risk factors and readiness and provide individual therapist referrals as needed.[10]

Community Outreach

Many diverse communities have been affected significantly by COVID-19 and faced high mortality rates.[16] We recognized that proactive bereavement outreach to these communities was essential. Grief guides and tip sheets in various languages were made available as part of our community outreach programs, which included vans traveling to severely affected communities and providing testing, masks, alcohol-based hand sanitizer, and written materials.

Education About Bereavement

Many clinicians and staff express feelings of inadequacy about providing bereavement outreach. Such feelings are not uncommon, especially because clinicians tend to receive little training in dealing with the emotional toll of patient deaths and bereavement care.[17,18] These feelings are likely to be heightened during this pandemic given the increased exposure to patient deaths, concern for personal safety, and changed practices in providing care, including the need to socially distance. Providing support for clinicians to process their feelings about the death of patients is crucial.[19] In addition to our Employee Assistance Program, psychosocial clinicians are facilitating weekly virtual support groups for providers to discuss the effects of the pandemic on their personal and professional lives.

Bereaved family members report they benefit from hearing from the clinical team and receiving condolences, which is seen as humanizing the physician-family relationship. This personal outreach is likely more important during this time because many providers will have interacted with family members virtually.[7,20,21] To help facilitate offers of condolences, we developed the TEARS acronym to describe the components of a condolence call that can also be adapted for writing condolence cards (Table).

GUIDELINES

We recommend that hospitals and other healthcare facilities that might not have well-established bereavement programs consider adopting a building block approach to provide basic outreach to families of their deceased patients.[7] Tapping into existing resources, the major components are as follows: (1) a letter of condolence from leadership, (2) psycho-educational information about grief, (3) a list of community/online resources, including information about local hospice bereavement programs and bereavement camps or programs for children, (4) offers of condolences from individual providers/teams, and (5) mental health outreach as indicated.

CONCLUSION

The COVID-19–related mortality, particularly among already vulnerable populations, coupled with the existing underrecognition of bereavement has created an urgent public health issue that needs to be addressed. Given that few institutions offer standardized bereavement follow-up, we believe that

hospital providers and mental health clinicians need to take a proactive approach to providing bereavement outreach to families affected by death during the pandemic.

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