COVID-19 Articles Fast Tracked Articles

Rapid De-Escalation and Triaging Patients in Community-Based Palliative Care

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Abstract

Context. The coronavirus disease 2019 (COVID-19) pandemic created a rapid and unprecedented shift in our medical system. Medical providers, teams, and organizations have needed to shift their visits away from face-to-face visits and toward telehealth (both by phone and through video). Palliative care teams who practice in the community setting are faced with a difficult task: How do we actively triage the most urgent visits while keeping our vulnerable patients safe from the pandemic?

Measures. The following are recommendations created by the Palo Alto Medical Foundation Palliative Care and Support Services team to help triage and coordinate for timely, safe, and effective palliative care in the community and outpatient setting during the ongoing COVID-19 pandemic. Patients are initially triaged based on location followed by acuity. Interdisciplinary care is implemented using strict infection control guidelines in the setting of limited personal protective equipment resources. We implement thorough screening for COVID-19 symptoms at multiple levels before a patient is seen by a designated provider.

Conclusions/Lessons Learned. We recommend active triaging, communication, and frequent screening for COVID-19 symptoms for palliative care patients been evaluated in the community setting. An understanding of infection risk, mutual consent between designated providers, patients, and their families are crucial to maintaining safety while delivering community-based palliative care during the COVID-19 pandemic. J Pain Symptom Manage 2020;60:e45—e47. © *2020 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Pandemic, COVID-19, community-based palliative care, home-based palliative care, palliative care, triage

Introduction

The following practice recommendations were developed by the Palo Alto Medical Foundation Palliative Care and Support Services team to provide guidance for outpatient and community-based palliative care providers in triaging patients during the coronavirus disease 2019 (COVID-19) pandemic.

Background

The COVID-19 pandemic created a rapid and unprecedented shift in our medical system. Medical providers, teams, and organizations have needed to shift their visits away from face-to-face visits and toward telehealth (both by phone and through video). Palliative care teams who practice in the community setting are faced with a difficult task: How do we actively triage the most urgent visits while keeping our vulnerable patients safe from the pandemic?

The following are recommendations created by the Palo Alto Medical Foundation Palliative Care and Support Services team to help triage and coordinate for timely, safe, and effective palliative care in the community and outpatient setting during the ongoing COVID-19 pandemic.

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Measures

We triage referrals for community-based palliative care by location followed by acuity (Table 1).

Facilities

Facilities (skilled nursing, assisted living, as well as board and care) are subject to lockdown because of their high concentration of vulnerable and elderly patients. Many of these facilities, unfortunately, will not allow family members at the bedside during this time. These visits are conducted as telephone and video visits if possible. We actively provide guidance to all local facilities we visit whenever possible.

Home

Homebound patients are safest in their home, and although easily accessible to providers, they are also more vulnerable to outsiders who could introduce pathogens into their environment. Homebound patients are triaged based on acuity, starting with telehealth visits for patients who have access to technology, and escalating to face-to-face encounters for acute urgent patients. In this setting, we use active triaging to determine if the benefit of physical contact (i.e., requires physical examination, extremely medically complex, communication needs cannot be met through telehealth modalities, and assessment for signs of dying) outweighs the risk for possible exposure.

Clinic

Clinic visits are rapidly de-escalated and switched to telehealth if nonurgent. Rarely, urgent clinic visits are maintained for patients who are having an urgent crisis, live outside our general coverage radius, and have safe means of transportation.

We define urgent patients as patients experiencing a palliative care crisis, such as patient with acute/uncontrolled symptom needs or high risk of death.

We are not directly accepting patients with active symptoms of COVID-19 at this time. Patients with COVID-19 symptoms and a high risk for decompensation are being referred to frontline, primary care, and emergency providers who have access to testing and active management of infection.

Team-Based Care

Our goal is to allocate resources effectively by using each of our interdisciplinary team members to the best of their ability.

Medical Providers (Physician/Advanced Practice Clinicians)

Each clinic site has designated a single provider who does in-person visits. We stratified risk among our providers and asked for volunteers at each site. Instead of limiting each provider and gradually exposing the entire team to the virus, we decided to allocate our limited personal protective equipment resources to a single provider who only sees urgent visits. In general, each of the providers doing urgent visits does not live with a person who would be considered vulnerable to COVID-19 or young children who could spread virus to a vulnerable or immunocompromised person. Note: Obtaining consent, providing emotional support, and voluntary participation are essential to the process of designating a provider and creating an ethical framework for personal safety.

Nurses

Our nurses are actively engaged in the triage process by directly communicating with families, referral sources, and obtaining information about a patient's clinical status. They are also able to engage in telehealth visits ahead of a consult and can participate in COVID-19 screening.

Social Worker and Chaplain

Social worker and chaplain visits are conducted remotely. Although we acknowledge the value of physical presence in assessing patients for psychosocial and

Table 1
De-Escalation and Triaging of Community-Based Palliative Care Patients

Acuity	Home	Facility (SNF, ALF, and B&C): New Patient	Facility (SNF, ALF, and B&C): Established Patient	Clinic
Urgent	Face-to-face visit (requires physician/APC approval)	Telephone triage and/or telehealth visit	Telephone triage and/or telehealth visit	Face-to-face visit (requires physician/APC approval)
Nonurgent	Telephone triage and/or telehealth visit	Interdisciplinary triage & telehealth visit	Interdisciplinary triage & telehealth visit by acuity	Interdisciplinary triage & telehealth visit by acuity

SNF = skilled nursing facility; ALF = assisted living facility; B&C = board and care; APC = advanced practice clinician.
Urgent/crisis is defined as patients with acute and uncontrolled urgent symptom need or high risk of death; Telephone triage: physician/APC or registered nurse (RN) call to assess urgency and need for telehealth vs. face-to-face visit; Interdisciplinary triage: physician/APC, RN, social worker, and chaplain to determine next steps; and Phone call: physician/APC or RN call.

spiritual distress, we believe that the risk to both providers and patients at this time is too high to warrant an in-person visit.

Coordinators, Medical Assistants, and Other Staff

Our staff are essential. Their role in coordinating patient visits presents another opportunity to screen patients and their families for COVID-19 symptoms during the scheduling process and before a designated provider arrives at the home.

All interdisciplinary team meetings are held virtually at this time to minimize the risk for cross contamination and maintain social distancing. Infection control is a team effort.

Scheduling Guidelines for Designated Providers

Referrals are actively triaged by our physician, advanced practice clinician (APC), and nursing staff, and then discussed with the on-call physician/APC to determine if the crisis warrants an in-person visit.

The physician/APC should arrange with the coordinator directly about scheduling the patient. We do not add in-person visits unless that provider is aware and approves of the in-person consult. Both provider and patient consent to an in-person visit is essential to maintaining safety.

Low-risk patients, wherein the follow-up plan was three months or longer, are subject to medical record review, triaging, and nurse telehealth visits. We are conservative about scheduling routine follow-up visits at this time to create availability for urgent patients during this time of crisis.

We use three rings of defense for screening for COVID-19 before our visits: 1) during scheduling, all patients are screened using standardized COVID-19 screening questions; 2) all patients are screened again during an appointment confirmation call the day before the scheduled visit; and 3) finally, the patients are screened again by the designated provider on arrival to the home before entering the premises.

We used this opportunity to rapidly expand telemedicine to serve our vulnerable patients. Our patients often welcomed video visits in lieu of house calls when it was communicated that the decision was deliberate with the intention of maintaining patient safety. We discovered that clinicians and patients are capable of building strong connections through video visits when available. We actively engaged with institutional leadership to determine the right technology, infrastructure, and platforms for a high-quality telehealth experience. Best practice guidelines, billing, and security for telehealth are rapidly changing and still in development.

Summary

Our intention with these guidelines is to create a practical framework for triaging, infection control, and safety so we can continue providing community-based palliative care during the COVID-19 pandemic. In the absence of in-person team meetings, we encourage and rely on active and frequent communication between team members to maintain our interdisciplinary approach. Given the limited supply of personal protective equipment and challenges facing frontline providers, we believe this approach is effective in conserving important resources and minimizing the risk for infection between patients and palliative care team members. Active triaging, communication, understanding of risk, and consent between designated providers, patients, and families are essential to delivering safe and appropriate community-based palliative care during this time of crisis.

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