**Palliative Care Inpatient Response Plan for COVID19 Pandemic**

**STRATEGIES FOR SCARCE RESOURCE SITUATIONS**

**Purpose:** The following card is intended to address inpatient palliative capacity for emergency departments, intensive care units and medical/surgical floors in response to a COVID-19 pandemic. This guide seeks to ensure that palliative care needs for critically ill COVID+ patients and patients being evaluated for COVID-19 are systematically assessed and addressed given the high rates of morbidity and mortality within at-risk populations.

| Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. |
| Contingency Capacity – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). |
| Crisis Capacity – Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009). |

**Emergency Department**

1) The emergency department can access to onsite and in-person specialty palliative care most days from 9am to 6pm, by consult request. Additionally, palliative care telephonic coaching and support is available 24hrs a day, 7 days a week.

2) Additional planned daily huddles with the emergency department will occur to address increased need for palliative care.

**Palliative Care Intervention:**

- Consults for patients with poor prognosis and at risk of intubation or resuscitation will be prioritized.
- Patients admitted to the hospital will be followed during a daily check-in with primary team.
- Support for implementing DNAR orders using informed assent or based on medical futility when appropriate
- Chart review results and brief or full consults will be documented in the EHR

3) Palliative Care will embed a palliative care specialist in the ED to assist & address high volumes of patients and **screen patients based on the following criteria:**

   - COVID-19+/PUI or ARDS.
   - Multi-morbidity, severity of illness, & high oxygen requirement
   - Clinical status: symptom burden, frailty (using CFS*), baseline functional status
   - Review code status: DNAR/DNI vs. DNAR-intubation ok vs. Full code/high intubation risk

Based on screening the following will happen:

1. meet or call with family/legal surrogate to address GOC and code status
2. coach ED team on GOC and code status discussion
3. assist with documentation of outcome and transitions of care

After hours palliative care on-call provider can assist with telephone support and coaching.

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*CFS = Clinical Frailty Scale – See attached document*
### Intensive Care Unit (Routine Units)

1) An ICU can access to onsite specialty palliative care most days from 9am to 6pm, by consult request. Additionally, palliative care telephonic coaching and support is available 24hrs a day, 7 days a week.

2) Daily huddle with key ICUs to auto-assess all confirmed COVID+ for unmet palliative care needs or needs exceeding ICU team’s capacity, prioritizing:
   i. Lack clear GOC or full code by default
   ii. GOC or code status not aligned with likely prognosis
   iii. End of life (EOL) or moderate/severe symptom needs
   iv. Family needing high levels of support

**Palliative care intervention:**
- Assist through brief or full consultation

3) Follow Contingency Capacity approach regarding interaction and reasons for intervention and modify as follows.

**Palliative care intervention:**
- Invoke brief consultation, document critical/essential content
- Lead on symptom assessment and management including medication ordering and planning
- Assist with transitions of care (i.e. withdrawing life support, GIP hospice, discharge on hospice) when applicable & possible
- Support for implementing DNR orders based on medical appropriateness or scarce resource allocation models in accordance with institutional, city, county and state protocols

### Intensive Care Unit (Dedicated to COVID19 Patient Care)

1) Palliative Care will embed a palliative care specialist in the COVID ICU during prolonged daytime hours to assist & address:
   i. goals of care and code status discussions with family/legal surrogate
   ii. coach ICU providers with complex goals of care discussions
   iii. assist with documentation of transitions in goals of care, outcomes and transitions in site of care (i.e. GIP hospice, discharge with hospice)
   iv. support for implementing DNR orders based on medical appropriateness or scarce resource allocation models in accordance with institutional, city, county and state protocols, including DNAR based on informed assent or medical futility when appropriate

After hours palliative care on-call provider can assist with telephone support and coaching

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### Medical/Surgical Floors (Routine Units)

1. Medical and surgical teams can access to onsite specialty palliative care most days from 9am to 6pm, by consult request. Additionally, palliative care telephonic coaching and support is available 24hrs a day, 7 days a week.

2. Palliative care teams to check-in with primary team for all confirmed COVID+, to auto-assess based on EHR for unmet palliative care needs that exist beyond primary team’s capacity.

**Palliative care intervention:**

- i. Coach/guide teams on GOC and code status discussions for patients with poor prognosis/at risk of intubation or resuscitation
- ii. Consult if primary team needs assistance after first attempts on GOC
- iii. Support for implementing DNAR orders based on informed assent or medical futility when appropriate
- iv. Assist with EOL or moderate/severe symptom needs

PC support team members (social work & spiritual care) assist primary teams after primary SW and SC engaged for families experiencing a high distress level

After hours palliative care on-call provider can assist with telephone support and coaching.

3) Follow Contingency Capacity approach regarding interaction and reasons for intervention and modify as follows:

**Palliative care intervention:**

1. Daily huddle in person or by phone with key units to assess changing needs for COVID+ patients including symptom management, goals of care, EOL decisions and family distress.
2. Invoke brief consult for high needs cases
3. Advise on GIP hospice and discharge with hospice opportunities were possible

After hours PC on-call provide can assist with telephone support and coaching.

### Medical Floor (Dedicated to COVID19 Patient Care)

**Palliative care intervention:**

1. Daily huddle in person or by phone with key units to assess changing needs for COVID+ patients including symptom management, goals of care, EOL decisions and family distress.
2. Invoke brief consult for high needs cases
3. Advise on hospice opportunities were possible

After hours PC on-call provide can assist with telephone support and coaching.

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### Considerations

1. Challenges based limited palliative care subspecialty staffing:
   - If other specialty palliative care workforce exists, and they are assigned to other clinical duties, evaluating their greatest contribution to various clinical skills should be assessed and their assignment should match greatest need. This approach could increase the size and reach of palliative care team.
   - In multi-site systems, redeploying subspecialty palliative care workforce across sites may be necessary to level load resource.

2. PPE Preservation Challenges: If PPE shortages exist, palliative care is a consulting service and should only utilize PPE when necessary for the delivery of care. Only 1 PC provider should enter COVID+ and PUI rooms.

3. After hours: On-call palliative care attending will provide coaching to primary team and telephonic support to patient/family.

4. Routine PC consultation during this time will be heavily triaged and postponed where able, if urgent consult is not needed

5. Goals of Care and Code Status guidance for primary teams – all teams should be supplied with clinician discussion tools to assist with complex communication.

1. Creation of an End of Life Unit to be staffed by PC specialists: based on the number of patients experiencing a need for symptomatic support at the end of life, it may be necessary to create an end of life unit staffed by Palliative Care Physicians &/or APPs.

2. After hours coverage: in a Crisis Capacity state, telephonic support at all hours will need to be expanded to create greater capacity to provide coaching and symptom guidance to primary teams.

3. Code Status guidance for primary teams – all teams should be supplied with clinician discussion tools to assist with complex communication.

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