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

**COVID-19 Palliative Care Response**

**Palliative Care & Support Services**

**Palo Alto Medical Foundation/Sutter Health**

**March 27, 2020**

**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. 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.

**Triaging**

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|  | **Home** | **New Referral-Patient in Facility (SNF, ALF, B&C)** | **Established Patient in Facility (SNF, ALF, B&C)** | **Clinic** |
| **Urgent \*** | See patient \*\*\* (requires physician/APC approval) | Telephone triage & Video Visit/Phone Call | Telephone triage & Video Visit/Phone Call | See patient \*\*\* (requires physician/APC approval) |
| **Non-Urgent** | Telephone triage and Video Visit/Phone Call | Team Triage & Video Visit/Phone Call | Team Triage & Video Visit/Phone Call when appropriate based on acuity level | Team triage & video visit/phone call when appropriate based on acuity level |

* \* Urgent/Crisis is defined as patients with acute and uncontrolled urgent symptom need, or high risk of death
* Telephone triage: RN, APC, or physician to call to assess need to see vs reschedule vs phone/video visit option
* Team triage: RN, LCSW, physician, APC, chaplain to determine next steps
* Phone call: RN, APC, or physician call

Using the above criteria, we triage based on location and acuity.

1. Location:
   1. Facilities (skilled nursing, assisted living, board and care) are subject to lockdown due to 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 nursing home providers whenever possible.
   2. Homebound patients are safest in their home, and while 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 (ie. requires physical exam, extremely medically complex, communication needs cannot be met through telehealth modalities, assessment for signs of dying) outweighs the risk for possible exposure.
2. We define urgent patients as patients experiencing a palliative care crisis, such as patient with acute/uncontrolled symptom needs or high risk of death.
3. 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.