As the COVID-19 pandemic spreads, palliative care programs and staff are asking:

→ The COVID-19 pandemic has not impacted my area yet – what can we do to prepare?
→ My clinic practice has been closed – how can I help or be useful?
→ My organization has asked us for a COVID-19 workplan – what should it include?
→ I’m worried we will have more referrals than we can handle or maybe should not see some patients to save on PPE - how should we decide who to see?

The following are steps to prepare palliative care teams for the COVID-19 crisis:

Step 1: Assess your team

1. Assess each team member’s readiness and availability to work remotely, prioritizing those at higher risk for COVID-19 due to known medical issues.
2. Develop a staffing plan/schedule that includes down time.
3. Engage the full interdisciplinary team (IDT) in defining flexible roles based on needs (e.g. social workers and chaplains may be the most important team members to support health systems with communication skills support and embedded self-care practice of their discipline).
4. Be strategic with use of personnel. Recruit retired clinicians and contract employees to support care. Enlist volunteers to assist with social calls to support patients and families.

Step 2: Connect with referring partners and participate in organizational planning

1. Actively participate in organizational COVID19 preparedness workgroups. This ensures consistency with and appropriate influence of organizational priorities and policies.
2. Proactively and continuously reach out to understand challenges and needs of collaborating providers and your organization so your team can assess best use.
3. Reach out to high-volume partners to discuss their needs and options for reducing or changing referral criteria.
4. Connect with other clinical teams through joint rounding or phone calls to assess new or emerging needs.

Key Referring Partners to Work with During Peak or Crisis Periods

- **Hospitalists** – Re-prioritize referrals or provide just in time training for performing goals of care conversations and symptom management to share higher volume
- **Intensivists** – participate in joint rounding to assess the most complex, high-need patients
- **Emergency providers** – provide just in time training for goals of care conversations
- **Hospice** – refine transition processes, particularly if the hospice’s availability or capacity is limited

**Step 3: Be ready and creative**

1. Prepare the team to work telephonically or with telehealth technology. Scarcity of personal protective equipment (PPE) with higher patient demand will require care delivery via telephone or telehealth (e.g. smart phones and tablets, if available).
2. Consider the platform to be used for telehealth prior to the crisis. Work with IT department on this, and be aware that it may change.
3. Familiarize the team with available tools and resources:
   - [Telehealth at a glance](#) – CMS has allowed for billing for telehealth visits (using video and audio together, not just audio) using site code 02.
   - [Symptom protocols](#) – Share with colleagues and offer telephonic or telehealth support for patients that do not respond to these first line treatments.
   - [Create a flow sheet for crisis palliative care involvement](#) – How do we best deploy our resources?
   - [Know the new rules from CMS and your state](#).

**Step 4: Refine and revise team processes and policies**

1. Schedule frequent check-ins, at least daily face-to-face, either in person or online, take scheduled breaks and meals, and maintain balanced work schedules.
2. Review/revise referral criteria – CAPC has created sample COVID-19 referral criteria [here](#).
3. Re-define the team’s and the health care environment’s “new normal.” Collaborate with your organization and your partners to determine the effective role in the crisis. (Co-management of symptoms and facilitator of goals of care, consultant for primary palliative care needs, education about communication, deployment in ED, ICU, and/or triage areas.) (Resources: [Role of Palliative Care in crisis](#), [Role of Palliative Care in the time of COVID](#)).
4. Develop new or refine existing policies and procedures (e.g. stratification criteria).

**Step 5: Continuously think about continuity across all settings (outside the hospital)**

1. Create algorithms to keep palliative patients at home, as appropriate, with the support they need. Assure they have ongoing support from a community, palliative care, or primary care team.
2. Facilitate ACP for palliative care patients about the possibility of contracting COVID-19 and their preferred care.
3. Determine processes for palliative care patients who need to be admitted and how palliative care will provide continuity in the hospital.
4. Work with case management to understand community resources for COVID-19 patients – including Long Term Care, Hospice and Home Health.
5. Work with your health system and organization to determine alternatives such as hotels, student housing, etc. for stable COVID-19 patients to receive care.
6. Consider development of 24/7 patient and family support lines, or for providers, to assist in the care of patients and support to colleagues).
7. Consider developing “comfort packs” of crucial symptomatic medications for use at home or in residential care facilities.
8. Research setting-specific guidance (e.g. [Home care](#), [Hospice care](#), [Nursing home](#)).

**Tip:** Use “scenario planning” techniques to think beyond today’s issues (e.g. What if volume doubled? Tripled?)