Knox Community Hospital
Mount Vernon, OH

**Program includes** – Inpatient palliative care to 99-bed critical access hospital and a small home-based practice in a rural community.

**Current COVID Status** – COVID-19 is in the area; so far, they have not seen as many cases as expected. Question of delayed COVID-19 spread.

**Preparation to COVID-19**

Was involved in hospital planning as palliative program leader

→ Led the hospital’s group to consider the ethical considerations of the incident command plan.
  
  o Collaborated with legal counsel and critical care physicians to develop a plan for scarce critical care and allocations
  
  o Used Truog et al. *NEJM* article, White et al. *JAMA* article, Ohio state guidelines and Indiana state guidelines to frame document
  
  o Planned for 3-4 times their normal capacity
  
→ Participated in Ohio Hospital Association meetings with other ethicists around the state to review Ohio’s guidelines for resources
  
  o Provided a rural and palliative care perspective
  
  o Allowed connection with larger palliative care community and health care experts from whom to seek advice

**Community Planning**

→ Extended care facilities (ECFs) still accepting non COVID-19 positive patients even with restricted visitor policy
  
  o ECFs following a protocol of 2 negative COVID-19 tests before accepting a resident
  
→ Community providers include one private hospice with more limited PPE and a larger corporate home health/hospice with more resources, which translates in variable ability to take palliative care and hospice patients on any given day

→ Successfully working with the 2 local hospices in real-time communication about access
  
  o Lack of shared EHR meant using a centralized google document
  
  o Palliative care leader enters daily discharge needs – diagnosis, COVID-19 positive or negative
  
  o Hospices enter in real time their daily availability to take patients on any given day

**Role of Palliative Care**

→ Seeing all in-patients whether they have COVID-19 or not

→ Moved all home-based patients to telehealth
  
  o Routine checks delegated from the APRN to the RN
→ Focusing on determining surrogate decision-makers
→ Disseminating just-in-time palliative care information (such as CAPC tools) to the hospital and community

**Clinical Role**

**Advance Care Planning**
→ Fostering proactive ACP skills in the PCPs

**Clinical Partners**
Flexible to the daily work
→ Daily inpatient hospital rounding to be present and supportive for all patient care

**Telehealth**
→ All home patients are telehealth

**Observations**
Palliative care census lower with COVID-19

**Advice to Prepare for COVID**

**Collaboration**
→ In small community, collaboration and communication is essential due to lack of resources.
  o In conventional times, able to tap into larger regional and state hospitals
  o In COVID-19 pandemic, this is not possible and critical access hospital can feel isolated
→ Understand regional and state guidelines and get involved with planning groups
→ Consider the emotional and physical exhaustion and work together to support community and staff

**Clinical Care**
Be creative because previous transfers to regional centers will not be able to happen
→ Knox Palliative Care Plan for group of patients who need end-of-life care but cannot be discharged
  o Convert a hospital conference room into a small COVID-19 unit
  o Use hospice nurses to come in and take care of them so that the small palliative care team is not overburdened

**Personnel**
Proactive consideration
→ Created a plan for hospice nurses to come into the hospital to help palliative care team
→ Set up a bank of volunteer nurses from the community to help as needed through the hospital

5/2/2020. Consolidated, edited and condensed by C Dahlin from interview with Adonyah Whipple, MSN, AGCNS-BC, APRN, ACHPN – Palliative Care Coordinator and Palliative Clinical Nurse Specialist.