

came to terms with the fact that he was dying. When they were ready to withdraw care, the other hospital staff and I were prepared for the farewell. I arranged a final video call between them, a call that expressed both the family's bitterness at losing Mr J but also relief at seeing him in tranquility and peace in his final hours. His family shared their appreciation for arranging the farewell, which made me feel honored to have helped bring comfort and closure to them.

My second experience with preparing and arranging a farewell was with Ms B, a woman in her 40s who had also developed multiorgan failure on the ventilator. As her condition deteriorated, I kept in touch with her mother, who understood that Ms B likely would not survive and that heroic measures were futile. Unfortunately, Ms B's situation had another tragic complication: her husband was sick with COVID-19 at the same time, and only after he adequately recovered did he join our conversation and learn of her dire prognosis. He struggled to cope with the news, and on his last video call with his wife before we withdrew care, he appeared frustrated. After I had connected their call, he sat and gazed on her in prolonged silence. "I love you," he finally said. I asked if he needed more time, as I wanted to make sure he left nothing unsaid. "We're OK now," he replied. Although Ms B died comfortably, I could sense the incompleteness, the lack of closure from her husband.

Thinking back, I observed that Mr J's and Ms B's deaths were marked by how different their families' expectations and preparedness were. It was important to have effective, continuous communication with their families and give them time to process and accept reality. For Ms B, it was especially difficult as she was younger, and her husband was initially excluded from the conversation due to his own illness. Witnessing many patients pass away during the pandemic has led me to reflect on the meaning of a good death. Everyone defines a good death differently; for me, it is when both the patient (if lucid) and family are prepared for the death and conclude the last chapter of life peacefully. It can be achieved through a process of working together to understand the severity of the patient's condition. Thanks to collaboration and communication with families, we overcame limitations and restrictions so that families could say goodbye to their loved ones. I will remember this pandemic for many reasons: the long, tireless working hours; the passion and dedication of hospital staff and physicians; and the opportunities to arrange and witness a good death.

Catherine Choi, MD 

Department of Medicine, Rutgers New Jersey Medical School, Newark, New Jersey, USA

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Pandemic Palliative Care Consultations Spanning State and Institutional Borders

To the Editor: Many critically ill patients with 2019 coronavirus disease (COVID-19) need specialty-level palliative care to manage symptoms, conduct goals of care conversations, and facilitate medical decision making in ethically and emotionally charged situations. During the apex of the COVID-19 crisis in New York, the Adult Palliative Care Service at Columbia University Irving Medical Center (CUIMC)/NewYork-Presbyterian (NYP) received a sevenfold increase in consultation requests. This unprecedented increase in demand outpaced the palliative care team's ability to respond. We describe the rapid development and implementation of a scalable virtual consultation model staffed by out-of-state palliative care specialist volunteers.

MODEL PROCESSES

Under Governor Andrew Cuomo's executive order,¹ administrative leadership at NYP facilitated a fast-track licensing and credentialing process for out-of-state palliative care specialists within a few days. Volunteer physicians were recruited from the University of California San Francisco (UCSF), Stanford University, and Dartmouth-Hitchcock. To ensure a high level of expertise requiring minimal quality control, volunteers were required to be experienced palliative care clinicians holding active board certification status in hospice and palliative medicine. Once credentialed, the volunteer physicians completed a rapid orientation process including use of the hospital's electronic medical record, the palliative consultative workflow procedures, and were briefed about the organizational culture.

Cases were selected for staffing by off-site consultants based on a number of criteria. First, patients were primarily intubated/sedated or otherwise unable to participate in conversation with clinicians. This allowed for the remote consultant to conduct all conversations with family members who themselves were not able to visit the hospital due to restrictions related to COVID-19. Second, cases were selected where the reason for consultation was clarification of goals of care, as opposed to symptom management or transition planning that require in-person assessment and management by clinicians with knowledge of local resources. Third, cases selected for remote consultants were generally high-complexity cases; lower complexity cases were reserved for home institution trainees.

Unlike the 24-7 PALLIATIVE Care Help line (PATCH-24) intervention, which was primarily focused on providing onetime palliative care consultations in the emergency department,² our intervention was focused on critically ill patients, some of whom were intubated for weeks. Indeed,

given the evidence that onetime palliative care led consultations for critically ill patients are ineffective,³ we felt this population required a longitudinal approach.

Key quality control processes included ongoing case monitoring by CUIMC palliative care physicians, periodic weekly or biweekly joint service check-ins to troubleshoot workflows and debrief experiences, and frequent relaying of feedback from primary inpatient care teams, as well as from patients and family members.

STRATEGIES USED AND LESSONS LEARNED

We have learned several valuable lessons in this process that we hope will be useful for others who hope to emulate this model.

1. **Consider how best to engage trainees and other learners in the virtual consult process.** At UCSF, we were approached by fellow trainees who wanted to observe these consults. These trainees wanted to observe for good reasons. Trainees heard the attendings talk about the many lessons they were learning while engaging in distant consults. We recognize the strong arguments for making a decision to involve trainees. But in the end, for several reasons, we decided not to allow trainees to participate. First, liability concerns exist around having trainees participate in meetings at an institution where they are not credentialed. Second, these trainees could focus on caring for the patients at our home institution, taking on greater responsibility and thus freeing the attendings' time for distant consults. Third, although we are sure the fellows' intentions were to learn, we were concerned about the possibility of so-called disaster voyeurism, that is, the unconscious motivation to witness a major catastrophe as it unfolds.⁴
2. **Adapt the remote staffing model in response to evolving needs.** We initially developed a shift-based model, where consultants could sign up for two different time slots (4–7 PM EST and 7–10 PM EST). We quickly pivoted from the need for consultations in the emergency department to focus on our staggering levels of critically ill patients. Therefore, it made more sense to provide longitudinal continuity of care for consultants to build trusting relationships with both teams and families needing ongoing support and clarification of the goals of care. We established a model in which one to two remote consultants worked as a team, and each team followed one to three cases longitudinally. In this model, remote consultants could be more efficient by using their time according to their schedule during the day, which resulted in more cases handled by distant consultants.
3. **Recognize and capitalize on the variable availabilities of volunteer virtual consultants.** Because remote consultants are volunteering their time in addition to their daily duties in their home institutions, their availability was variable. Time differences can be used to advantage to provide extended hours of daily coverage. We created a Google sheet to clarify “number of active consults currently following” and “availability to add another consult.” Based on this availability, the home team contacted the remote consultants and assigned cases.
4. **Expect and respect institutional, cultural, and legal differences.** Institutional cultures shape access to palliative care, the conduct of goals of care conversations, and the mechanics of making decisions about life-sustaining treatment. Both practical and conceptual variations require consideration. Legal requirements for withdrawal of life-sustaining treatment, for example, differ from state to state, and remote consultants must be equipped with the resources necessary to ensure they are able to adhere faithfully to legal requirements including appropriate documentation. Remote consultants must also adapt to the varying roles of consultants in general across different institutions: whether inpatient care is highly centralized, with the primary team retaining essentially exclusive ownership over treatment plans, or whether it is primarily consultant driven, in which primary teams delegate aspects of care more freely.
5. **Leverage home-site insight about primary team members' attitudes toward palliative care and relationships to help off-site clinicians tailor their initial approach.** Recognizing that palliative care is a specialty built on relationships, it is critically important to help remote consultants rapidly understand the customer they are serving (ie, the primary team physician requesting the consult, as well as other stakeholders involved). Navigating the various players involved in a case can be difficult when the consultant has neither social capital nor advance knowledge of clinician behavior patterns, style, or biases toward palliative care. Home-site palliative care clinicians are crucial for providing these insights. Having easy access to a set of boots on the ground, as it were, familiar with primary clinicians' patterns, can help remote consultants anticipate and quickly troubleshoot moral distress, ambivalence, misguided prognostic optimism, stonewalling, avoidance, or other primary team behaviors or statements commonly encountered by palliative care consultants.
6. **Provide interdisciplinary palliative care remotely.** The CUIMC/NYP social workers and chaplains worked collaboratively to provide interdisciplinary support to patients and families being followed by the remote palliative care consultants, when needed.
7. **Create a structured way to discuss and debrief the virtual consults and provide support to the virtual consultants.** The need to debrief is heightened by the uncertainty around prognosis for patients with COVID-19, consultants working in an unfamiliar system, and the lack of in-person contact with family members of seriously ill patients. Off-site consultants often wondered, “Did I say the right thing?” For example, one consultant, when discussing code status, added this statement to his usual approach: “And I worry about the doctors and nurses who would be exposed to infection in the process of

performing CPR.” Most, although not all, of the consultants found that working in pairs offered not just practical advantages to splitting up the work (eg, one person writes the note while the other speaks), but more importantly a mechanism for debriefing and processing difficult conversations. We additionally organized weekly videoconference debriefing sessions among distance consultants. Indeed, many consultants found the debriefing sessions to be one of the most valuable parts of the experience.

DISCUSSION

The COVID-19 pandemic has created significant challenges for healthcare systems, especially in hard-hit areas. One of these challenges is to meet the dramatic increase in demand for specialty-level palliative care services created by the sudden surge of critically ill patients. These circumstances have led to new opportunities for palliative care colleagues in different institutions to collaborate in unprecedented ways. The cross-pollination experienced in the course of the model described here provided a humbling reminder of the mutual benefit that accompanies extramural collaboration.

Our experience with providing high-quality specialist-level palliative care spanning institutional, state, and perhaps even national borders can serve as a model for other sites during this pandemic. Underserved racial and ethnic minorities and immigrant or displaced communities have been especially hard hit in crisis times, and the current pandemic is no exception.⁵ Unfortunately, palliative care is one of the subspecialty areas to which these populations routinely experience diminished access.⁶ Collaborative efforts such as the one described here may prove critical in meeting demand for palliative care with greater equity and justice across our systems and societies.

Looking forward, this collaborative model may also serve as a guide for meeting palliative care needs during non-pandemic times in resource-limited settings, where access to specialist-level palliative care may be limited. Consideration should be given to the extension of policies to facilitate nationwide licensure and universal credentialing created in states of emergency, so the feasibility and ease of providing these palliative care consultative services across institutional and state borders can continue into the future beyond the current crisis.⁷

*Shunichi Nakagawa, MD and Ana Berlin, MPH, FACS
Department of Medicine, Columbia University Irving
Medical Center, New York, New York, USA*

*Eric Widera, MD
Department of Medicine, University of California San
Francisco, San Francisco, California, USA*

*Vyjayanthi S. Periyakoil, MD
Department of Medicine, Stanford University, Palo Alto,
California, USA*

*Alexander K. Smith, MD
Department of Medicine, University of California San
Francisco, San Francisco, California, USA*

*Craig D. Blinderman, MD, MA
Department of Medicine, Columbia University Irving
Medical Center, New York, New York, USA*

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MORTALITY IN OLDER PATIENTS WITH COVID-19

To the Editor: Dr. Sun and colleagues¹ report risk factors for mortality in 244 older patients with 2019 coronavirus disease (COVID-19) in Wuhan, China. They found older age and lower lymphocyte count were independently associated with in-hospital mortality (IHM) in both men and women who were aged 60 and older. This early retrospective study disclosed an IHM rate as high as 49.6% (number of deaths/cases = 121/244), substantially higher than 10.0% of the 1,474 COVID-19 patients aged 65 and older from 169 hospitals in Asia, Europe, and North America,² and 32.7% of the 1,425 COVID-19 patients aged 60 and older