COVID-19 Articles Fast Tracked Articles

The Creation of a Psychiatry-Palliative Care Liaison Team: Using Psychiatrists to Extend Palliative Care Delivery and Access During the COVID-19 Crisis

Daniel Shalev, MD, Shunichi Nakagawa, MD, Oliver M. Stroeh, MD, Melissa R. Arbuckle, MD, PhD, Rebecca Rendleman, MD, CM, Craig D. Blinderman, MD, MA, and Peter A. Shapiro, MD

Department of Psychiatry (D.S., O.M.S., M.R.A., P.A.S.), Columbia University Irving Medical Center and New York State Psychiatric Institute, New York, New York; Department of Medicine (S.N., C.D.B.), Adult Palliative Care Service, Columbia University Irving Medical Center, New York, New York; and Department of Psychiatry (R.R.), Weill Cornell Medicine, New York, New York, USA

Abstract

Context. During the course of March and April 2020, New York City experienced a surge of a 170,000 coronavirus disease 2019 (COVID-19) cases, overwhelming hospital systems and leading to an unprecedented need for palliative care services.

Objectives. To present a model for rapid palliative care workforce expansion under crisis conditions, using supervised advanced psychiatry trainees to provide primary palliative services in the acute care and emergency setting.

Methods. In response to the New York City COVID-19 surge, advanced psychiatry trainees at New York-Presbyterian Columbia University Irving Medical Center were rapidly trained and redeployed to a newly formed psychiatry-palliative care liaison team. Under the supervision of consultation-liaison psychiatrists (who also served as team coordinators), these trainees provided circumscribed palliative care services to patients and/or their families, including goals-of-care discussions and psychosocial support. Palliative care attendings remained available to all team members for more advanced and specialized supervision.

Results. The psychiatry-palliative care liaison team effectively provided palliative care services during the early phase and peak of New York City's COVID-19 crisis, managing up to 16 new cases per day and provided longitudinal follow-up, thereby enabling palliative care specialists to focus on providing services requiring specialist-level palliative care expertise.

Conclusion. By training and supervising psychiatrists and advanced psychiatry trainees in specific palliative care roles, palliative care teams could more effectively meet markedly increased service needs of varying complexity during the COVID-19 crisis. As new geographic regions experience possible COVID-19 surges in the coming months, this may serve as a model for rapidly increasing palliative care workforce. J Pain Symptom Manage 2020;60:e12–e16. © *2020 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

COVID-19, psychiatry, workforce, primary palliative care

Key Message

We present a model of a psychiatry-palliative care liaison team providing specific palliative care services under crisis conditions during the coronavirus disease 2019 pandemic to better meet increased demand and to more efficiently use the specific expertise of the limited number of available palliative care specialists.

Introduction

Coronavirus disease 2019 (COVID-19) is a novel respiratory infection caused by the severe acute respiratory syndrome coronavirus 2. The global pandemic has sickened millions and resulted in the deaths of hundreds of thousands.[1] New York City has been particularly affected, with more than 170,000 cases

Address correspondence to: Daniel Shalev, MD, Department of Psychiatry, Columbia University Irving Medical Center, 622 West 168th Street, 16th Floor, Center Suite, New York, NY 10032, USA. E-mail: ds3372@cumc.columbia.edu

Accepted for publication: June 8, 2020.

0885-3924/$ - see front matter
https://doi.org/10.1016/j.jpainsymman.2020.06.009

and 13,000 deaths as of May 3, 2020.[2] Early literature demonstrates the extreme demands on palliative care services responding to COVID-19. Palliative care teams are being called to manage symptoms including agitation and dyspnea in the critically ill, assist with bereavement support, and coordinate high-acuity and high-volume goals-of-care discussions for individuals being admitted in respiratory distress.[3] This work is complicated by the specter of limited resources and concern for rationing of life-supportive therapies, which have characterized COVID-19 surges in some health systems.[4] The demand for palliative care services in heavily affected areas has created the need for crisis-level care provision far beyond the usual clinical workload. Unfortunately, internists, intensivists, emergency room physicians, and other clinicians who may be comfortable providing primary palliative care are overwhelmed managing surge-level caseloads, precluding usual engagement with primary palliative care tasks.[5]

Prior literature has demonstrated the potential of engaging psychiatrists in palliative care work and the overlapping skill sets used by psychiatrists and palliative care specialists.[6] These observations are particularly true of consultation-liaison (CL) psychiatrists whose training includes serious illness communication, diagnosis and management of delirium, and palliation of psychosocial distress associated with medical illness.[7] However, few models integrating psychiatry and specialist palliative care have been widely disseminated.[8]

In the setting of crisis-level demand for palliative care services, the Section of Adult Palliative Medicine and the Department of Psychiatry at New York Presbyterian (NYP)/Columbia University Irving Medical Center collaborated with NYP Graduate Medical Education (GME) to form and rapidly train a psychiatry-palliative care liaison team made up of advanced psychiatry trainees and supervising CL psychiatrists. The intention of this team was to work alongside palliative care and CL psychiatry in the delivery of acute primary palliative care services. We describe the development, structure, and function of the psychiatry-palliative care liaison team later.

Context

During the 45 days spanning early March to mid-April 2020, the NYP hospital system admitted 7600 patients with COVID-19, many of whom were critically ill.[9] As the cases of COVID-19 within the system surged, the NYP/Columbia University Irving Medical Center (one of the flagship hospital campuses of NYP) experienced an unprecedented need for palliative care services. The Columbia Adult Palliative Care Service responded by creating a palliative care consult team dedicated to the emergency department (ED), a COVID-19 palliative care unit,[10] and a proactive consultation model in the step-down units (in addition to ongoing services throughout the hospital). Despite this reorganization, the demand for consults quickly exceeded workforce capacity.

Initially, given long-standing collaborations between the Division of Consultation-Liaison Psychiatry and the Adult Palliative Care Service, CL psychiatrists attempted to absorb appropriate psychosocially oriented palliative care consults. Although initially feasible, given ongoing and competing demands to provide inpatient psychiatric consultations to the hospital's medical units and services, the CL psychiatrists did not have sufficient capacity to significantly offload the overwhelming demands from the palliative care service.

In parallel with institutional initiatives requiring the redeployment of house staff and other trainees to clinical services in need of greater workforce capacity, leadership of psychiatry training programs across the NYP enterprise (including the Columbia University Irving Medical Center and Weill Cornell Medicine campuses) worked NYP Graduate Medical Education to identify services on which the psychiatry trainees' skills and qualifications would best be used. As a result of these discussions, several psychiatry training programs affiliated with NYP, the Columbia University Irving Medical Center and Weill Cornell Medicine, made available to the NYP/Columbia University Irving Medical Center Section of Adult Palliative Medicine a group of 16 psychiatry trainees—including senior general psychiatry residents, child and adolescent psychiatry fellows, addiction psychiatry fellows, and postresidency T32 research fellows. These trainees, some of whom volunteered, were redeployed to the Adult Palliative Care Service for the purpose of establishing the psychiatry-palliative care liaison team. Factors that the training directors considered in assigning these trainees to the psychiatry-palliative care liaison team included the trainees' general availability and their additional responsibilities (e.g., ongoing outpatient clinical care or research projects).

Training

Although they did not have specialty palliative care training, most of the trainee members of the psychiatry-palliative care liaison team had previously completed Accreditation Council of Graduate Medical Education-accredited training in psychiatry. Thus, they possessed competencies[11] in the areas of serious illness communication and psychosocial aspects of medical illness.

To align their pre-existing skills with clinical need and facilitate their rapid contribution to clinical care, the redeployed psychiatry trainees worked in areas of natural psychiatry-palliative care overlap: carrying out goals-of-care conversations and providing psychosocial support to patients and/or their families. Redeployed psychiatry trainees received written materials and an e-learning module (delivered by palliative care faculty with the assistance of CL psychiatry service members) that reviewed the basics of severe acute respiratory syndrome coronavirus 2, COVID-19, and goals-of-care conversations. Child and adolescent psychiatry fellows on the team also participated in a two-and-a-half-hour VitalTalk/COVID Talk communication workshop that was provided by the palliative care and hospitalist medicine teams at the Weill Cornell Medicine campus.[12]

Given the new roles that many of the psychiatry trainees were assuming and the burden that supervising a large group of constantly rotating team members would impose on the palliative care and CL psychiatry services, the psychiatry-palliative care liaison team was designed to use immediate just-in-time supervision by a CL psychiatry coordinator, who also maintained communication with the palliative care service.

Team Structure

Throughout the peak of New York City's COVID-19 pandemic and in close collaboration with the palliative care service, the psychiatry-palliative care liaison team provided 24-hour coverage of potentially appropriate primary palliative care consults to the ED (Fig. 1).

Between 8 AM and 8 PM seven days a week, two psychiatry trainees worked on site and two psychiatry trainees worked remotely from home—all under the supervision and guidance of a CL psychiatrist with comfort in primary palliative care skills. The CL psychiatry coordinator communicated with the palliative care service to screen and direct those consults received from the ED that predominantly involved goals-of-care conversations and/or the provision of psychosocial support to the psychiatry-palliative care liaison team. The CL psychiatry coordinator assigned these consults to psychiatry-palliative care liaison team members based on individuals' caseloads, whether they were on site, and their language skills. The CL psychiatry coordinator oversaw the team throughout the day, fulfilling as-needed and just-in-time[13] teaching as well as supervisory roles that included discussing and troubleshooting cases, witnessing code status determinations, and cosigning notes. Supervision was provided indirectly, with direct supervision available throughout the day. If needed, the CL psychiatry coordinator also facilitated trainees' supervision by and/or reassigned complex consults to a palliative care attending and served as a liaison for cases that the CL psychiatry team was following.

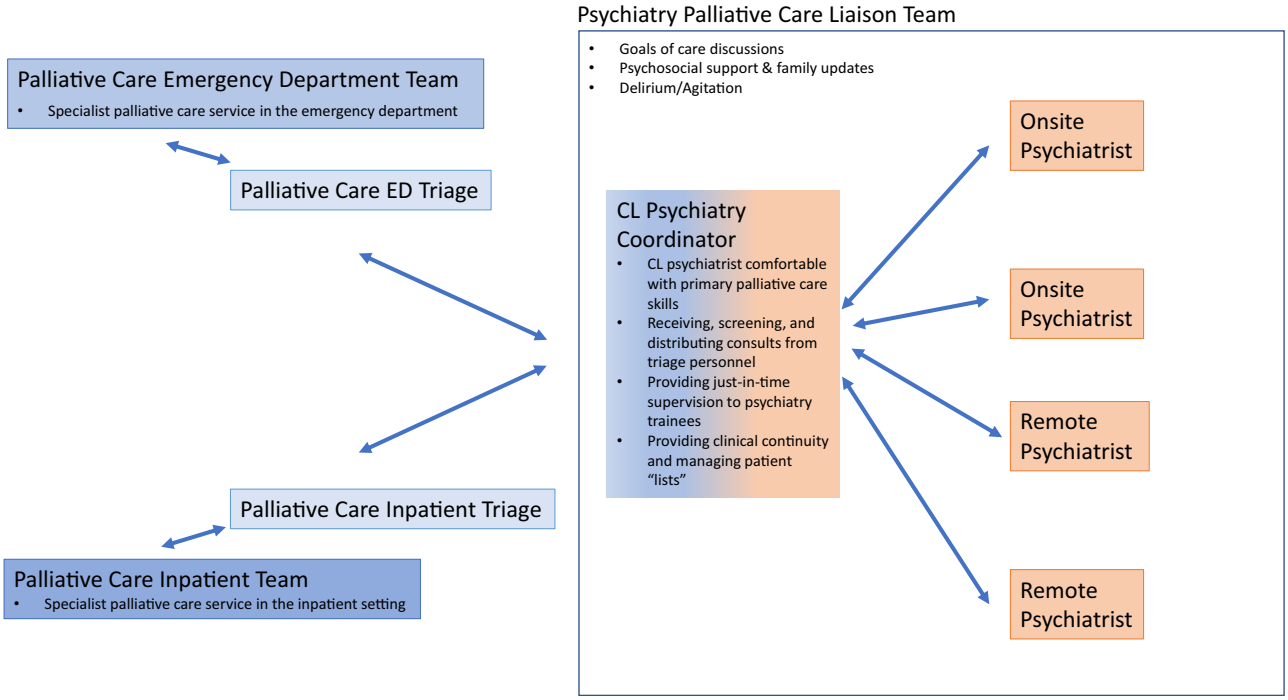

Fig. 1. Psychiatry-palliative care liaison team. ED = emergency department; CL = consultation-liaison.

To allow the members of the psychiatry-palliative care liaison team to manage their ongoing responsibilities (including ongoing outpatient telepsychiatry responsibilities), team members worked on a rotating schedule of one to three shifts a week. Because team staffing changed daily, the CL psychiatry coordinator maintained a psychiatry-palliative care liaison team-shared patient list, thereby ensuring appropriate follow-up and continuity of patient care.

Overnight between 8 PM and 8 AM, a trainee from the psychiatry-palliative care liaison team provided backup remotely from home to the on-call palliative care service attending or fellow. The psychiatry trainee would accept consults involving goals-of-care conversations or psychosocial support to assist the palliative care clinician with whom they were in direct communication. A CL psychiatrist was also available as backup to the psychiatry trainee.

To facilitate case assignment and optimize patient care coordination across the psychiatry-palliative care liaison team, palliative care service, and CL psychiatry service, the psychiatry-palliative care liaison team held an internal team meeting every morning and also joined the Adult Palliative Care Service for its daily morning virtual rounds.

Team Function

During the first two weeks, the psychiatry-palliative care liaison team fielded an average of six new consults a day, and team members completed approximately two to four follow-ups. However, as the surge of admissions began to recede, the volume changed dramatically, from a high of 16 new consults to a low of 2. The nature of the consults was largely in the domain of goals of care initially, although many consults were followed to continue managing family distress even in the setting of clarified goals of care. Most consults were remotely delivered because patients did not have capacity to participate in treatment planning, reflecting the high rate of altered mental status in patients being admitted and requiring urgent or emergent palliative care services. Even those patients assigned to the in-person team members were largely without capacity to engage in goals-of-care discussions, whereas the in-person team members were able to conduct consultations while also assisting the remote team by facilitating video conference visits between patients and families. Cases that developed specialist-level palliative care needs were referred back to the palliative care triage personnel unless the needs were in the realm of CL psychiatry such as delirium/agitation, in which case they were managed by the psychiatry-palliative care liaison team with CL psychiatry supervision.

After its two weeks of function as a discrete team, the psychiatry-palliative care liaison team was reduced to one in-person and one remote team member during the day, with elimination of night coverage. This was in response to the decrease in urgent and emergent palliative care consults as COVID-19 admission rates decreased. The two-person team continued to function similarly to the larger team but without the CL psychiatrist serving in a clinical coordination role. Rather, consults were distributed directly by the palliative care team with CL backup to support team members. One week after this, the team was further reduced to a rotating single on-site member integrated into the palliative care service.

During the course of the acute phase of the crisis, the psychiatry-palliative care liaison team conducted approximately 100 consultations and contributed to the care of many other patients by assisting the specialist palliative care clinicians. Although this represents only a fraction of the immense need experienced by the palliative care service during this time, the services of the team improved rapid access to palliative care services for hospitalized patients. At the time of writing, the psychiatry-palliative care liaison team is gradually transitioning toward a longitudinal family support model in recognition of the needs of families with loved ones experiencing prolonged hospitalizations with mechanical ventilation being required for most. However, this is still in the early stages of operationalization.

Discussion

By virtue of their communication skills, understanding of interpersonal dynamics, and biopsychosocial approach to patient care, psychiatrists are well positioned to learn primary palliative care skills.[6] This is particularly true in the domain of serious illness communication and management of psychological distress. We believe this may be less the case for opiate pain management and other more medically based competencies.[7] Currently, there is no Accreditation Council of Graduate Medical Education-mandated palliative care training for psychiatrists, although psychiatry residents are interested in such training.[14]

During the COVID-19 crisis, the need for palliative care services surged rapidly, overwhelming the existing workforce. We present a model psychiatry palliative-care liaison team in which advanced psychiatry trainees received rapid training and just-in-time supervision and functioned to provide supervised primary palliative care services at a relatively high volume and acuity. Psychiatry trainees were able to function effectively in this role, significantly buttressing the

palliative care workforce and preserving specialist palliative care services for higher complexity cases.

Our model optimizes several potential workforce disruptions associated with palliative care redeployment. For redeployed psychiatry trainees, their rotation on to the service only one to three days/weekly allowed them to continue managing their outpatient and research obligations. The potential disjointedness of this model was mitigated by the presence of a CL psychiatry coordinator who was able to provide a longitudinal perspective on the cases and be a first-line supervisor given areas of overlap between CL psychiatry and palliative medicine. More intensive training requirements were mitigated through the palliative care triage service, which directed only cases within specific skill domains (psychosocial support, goals of care, and delirium/agitation) to the psychiatry-palliative care liaison team.

As the COVID-19 pandemic continues, new epicenters and multiple waves of infection remain possible. With new surges in cases, sudden increases in demand for high-acuity palliative care service threaten to overwhelm existing specialist palliative care workforce. Collaboration with psychiatry to meet these workforce needs is attractive because psychiatrists are more likely to be available than other potential collaborators like emergency medicine physicians, hospitalists, or intensivists who will be called on to manage COVID-19 in their respective settings. Furthermore, psychiatrists have skills that make them rapidly trainable in aspects of primary palliative care. Looking beyond COVID-19, psychiatry-palliative care collaboration may serve as a bridge for postpandemic paradigms of collaboration, something that has been called for in both disciplines to optimize mental health care for individuals with serious medical illness, build on existing models of psychologically informed palliative care, and address care disparities for individuals with comorbid serious mental and medical illness.[15–17]

Disclosures and Acknowledgments

This research received no specific funding/grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare no conflicts of interest.

References

1. Coronavirus. Available from https://www.who.int/westernpacific/health-topics/coronavirus. Accessed March 16, 2020.

2. COVID-19: data—NYC health. Available from https://www1.nyc.gov/site/doh/covid/covid-19-data.page. Accessed April 26, 2020.

3. Fausto J, Hirano L, Lam D, et al. Creating a palliative care inpatient response plan for COVID-19—the UW medicine experience. J Pain Symptom Manage 2020;60:e21-e26.

4. Vergano M, Bertolini G, Giannini A, et al. Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian perspective during the COVID-19 epidemic. Crit Care 2020;24:165.

5. Flores S, Gavin N, Romney M-L, et al. COVID-19: New York City pandemic notes from the first 30 days. Am J Emerg Med 2020. https://doi.org/10.1016/j.ajem.2020.04.056 [Epub ahead of print].

6. Irwin SA, Ferris FD. The opportunity for psychiatry in palliative care. Can J Psychiatry 2008;53:713–724.

7. Shalev D, Nash SS, Levenson JA, Shapiro PA. Palliative care training for consultation-liaison psychiatry fellows: a national survey project. Psychosomatics 2020. https://doi.org/10.1016/j.psym.2020.02.002.

8. Shalev D, Docherty M, Spaeth-Rublee B, et al. Bridging the behavioral health gap in serious illness care: challenges and strategies for workforce development. Am J Geriatr Psychiatry 2020;28:448–462.

9. Kumaraiah D, Yip N, Ivascu N, Hill L. Innovative ICU physician care models: COVID-19 pandemic at NewYork-presbyterian. Catalyst 2020.

10. Sun H, Lee J, Meyer BJ, et al. Characteristics and palliative care needs of COVID-19 patients receiving comfort directed care. J Am Geriatr Soc 2020;68:1162–1164.

11. ACGME: ACGME psychiatry. Available from http://www.acgme.org/Specialties/Overview/pfcatid/21/Psychiatry. Accessed January 1, 2017.

12. COVID Ready Communication Playbook. VitalTalk. Available from https://www.vitaltalk.org/guides/covid-19-communication-skills/. Accessed May 2, 2020.

13. Hinkle LJ, Fettig LP, Carlos WG, Bosslet G. Twelve tips for just in time teaching of communication skills for difficult conversations in the clinical setting. Med Teach 2017;39:920–925.

14. Forster BC, Proskurin H, Kelly B, et al. Psychiatry trainees' views and educational needs regarding the care of patients with a life-limiting illness. Palliat Support Care 2017;15:231–241.

15. Meier DE, Beresford L. Growing the interface between palliative medicine and psychiatry. J Palliat Med 2010;13:803–806.

16. Shalev D, Brewster K, Arbuckle MR, Levenson JA. A staggered edge: end-of-life care in patients with severe mental illness. Gen Hosp Psychiatry 2017;44:1–3.

17. Emanuel L, Brenner KO, Spira N, et al. Therapeutic holding. J Palliat Med 2020;23:314–318.