Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Research Objectives. Implement a novel virtual simulation curriculum to teach clinical management and serious illness communication skills for patients with serious illness. Explore IM/EM resident perspectives regarding the barriers to GOCCs in acute care settings.

Methods. Residents were invited to watch a 20-minute communication skills didactic video. They then participated in a 60-minute simulation exercise followed by a 60-minute semistructured group interview, both via Zoom, led by a faculty facilitator. The participants interviewed the simulated spouse of a patient with advanced cancer presenting to the emergency department with progressive symptoms and functional decline. The simulation was divided into 3 sequential 20-minute sections, allowing each participant to lead a third of the encounter. Afterward, participants were asked about their perspectives related to caring for seriously ill patients in these settings.

Results. Qualitative data from the group interviews (n = 6) revealed 3 perceived barriers to GOCCs in acute care settings: limited patient and family prognostic awareness, environmental barriers such as inadequate physical space and time, and a lack of real-time feedback from faculty around communication skills. All participants found the specific phrasing in the didactic video to be helpful.

Conclusion. Our novel simulation curriculum was well received by participants. Our study identified 3 important perceived barriers to GOCCs.

Implications for Research, Policy, or Practice. Our curriculum teaches physicians to recognize the syndrome of imminent death, effectively communicate prognosis, and propose a treatment plan that is aligned with patient goals.

Care for Patients Receiving Comfort Measures Only: Experiences of Bedside Nurses (S529)
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Outcomes.
1. Identify how frequently family and family members ask nurses about certain elements of end-of-life care
2. Recognize how often nurses prefer to be included in discussions about comfort care with providers and patients and their family members
3. State how frequently certain elements of end-of-life care caused nursing moral distress

Original Research Background. Transitions to comfort measures only (CMO) involve discontinuation of life-prolonging interventions with a goal of allowing a natural death. Despite frequent use of CMO in hospitals, little is known about involvement of nurses in discussions about CMO, questions nurses are asked by family about CMO, or whether those questions affect moral distress.

Objective. To examine experiences of nurses caring for patients receiving CMO.

Methods. Nurses in the neuro- and medical-cardiac ICUs at Harborview Medical Center in Seattle, WA, were invited to complete an online survey addressing their experiences caring for patients receiving CMO.

Results. Surveys were completed by 81 nurses (response rate 42%). Most nurses preferred to be present for discussions about initiating CMO (85% at least most of the time or always); however, only 30% reported being present this frequently. Questions from family about time to death, changes in breathing, and symptom management were common, and questions about nutrition and hydration were less so. Most nurses reported moral distress at least some of the time (53%) when providing CMO, but questions from family were not a source of distress for most.

Conclusion. Nurses are infrequently present when providers discuss transitions to CMO with patients and their family, despite a preference to participate. Family members ask a variety of questions about CMO, most about features of the dying process and symptom management. Moral distress was common for nurses providing CMO, although questions from family members did not appear to be a primary driver of distress.

Implications for Research, Policy, or Practice. Additional efforts are needed to actively involve nurses in discussions with families about CMO. Conversations with patients and their family members should be tailored to address common questions. More research is needed to elucidate contributors to moral distress experienced by nurses caring for patients at the end of life.

The Quality of Telehealth-Delivered Palliative Care During the Initial COVID-19 Pandemic Surge (S530)
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Outcomes.
1. Describe the use of telehealth-delivered palliative care at one of the largest hospitals in New England during peak COVID-19 infection rates
2. Compare differences in care quality provided by in-person and telehealth-delivered palliative care

Original Research Background. In March 2020, in response to rapidly increasing COVID-19 infection rates, the palliative care (PC) service at one of the largest hospitals in New England quickly shifted from in-person to telehealth-delivered PC (TPC).

Research Objectives. We compared the quality of TPC relative to in-person PC during peak COVID-19 rates in the setting of high clinical demands for PC, requiring rapid implementation of TPC.

Methods. We reviewed electronic health records of TPC and in-person consultation modalities of patients hospitalized between 3/2020 and 6/2020. We assessed established quality measures, including time from admission to inpatient PC consultation, interdisciplinary care, documented assessment at initial consultation of patient and family understanding of serious illness, and discussion of goals of care. Descriptive and bivariate statistics were used to describe differences by modality.

Results. Among 272 patients, mean age was 69.3 years (standard deviation = 18.3); 53% were male, 65% white, and 24% Black; 33% had primary cancer diagnoses; and 39% had COVID-19. Eighty percent of patients received TPC, and 20% received in-person PC. Median time from admission to PC consultation was 4.5 days (interquartile range 2-11). There were no differences between modalities by race, sex, or time from admission to PC consultation. Patients who received TPC were less likely to have cancer (25% vs 69%; p < 0.01). Patients who received TPC were slightly less likely to encounter more than 1 interdisciplinary PC team member (56% vs 61%) or to have a documented assessment of patient and family understanding of serious illness (60% vs 73%) or discussion of goals of care (71% vs 82%), though not statistically significant (p > 0.05).

Conclusion. Although PC quality measures varied by modality, the PC service demonstrated the ability to provide high-quality TPC, even under significant strain during the early COVID-19 pandemic.

Implications for Research, Policy, or Practice. Future work will evaluate opportunities to increase the quality of TPC beyond the initial pandemic surge and for sustained provision of TPC.

“That Little Bit of Time”: Transition-to-Hospice Perspectives from Hospice Staff and Bereaved Family (S531)
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Outcomes.
1. Describe how hospice admissions staff perceive the hospice admission process
2. Describe how caregivers of hospice patients perceive the hospice admission process

Original Research Background. Rising rates of hospice disenrollment and hospital readmissions suggest that many patients lack understanding of hospice services, and their preparation for the transition to hospice at home may be insufficient.

Research Objectives. This study explored how hospice admissions staff and caregivers of hospice patients perceive the hospice admission process and the transition to hospice.

Methods. We conducted in-depth, semistructured interviews with two subgroups: hospice admissions staff (n = 15) and bereaved caregivers of former hospice patients (n = 20). We performed 2-coder descriptive content analysis.

Results. There were 4 overall themes: issues relating to the referring/pre-hospice provider, issues relating to hospital discharge or care transition home, issues relating to the first touch of hospice, and the impact of COVID-19 on hospice admissions. Patients are often referred to hospice without clear prognostic understanding, at times placing staff in the uncomfortable position of breaking difficult news. Stigma may make patients and families fearful of enrolling in hospice, and misconceptions about hospice are common. Caregivers emphasize the need for increased attention to their emotional needs. Staff revealed the emotional challenges they experience conducting admissions. Both staff and caregivers indicate that the transition to hospice is often emotionally and logistically burdensome, especially when discharging home from the hospital. Both subgroups report insufficient caregiver preparation for taking care of a dying patient at home, particularly regarding medication management. COVID-19 created challenges yet prompted innovative changes to hospice admission processes.

Conclusion. Findings demonstrate a need to improve the hospice admissions process, better supporting terminally ill patients and their families.

Implications for Research, Policy, or Practice. This study adds a unique perspective of the hospice admission from two not often studied groups: hospice admission staff and bereaved caregivers. Optimizing the hospice admission process may improve the care...