

Peer Review File

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Reviewer A

This is a highly relevant innovation in care. However, the overall limitations are being related to the small size, short time intervention time (1 month), and lack of implementation outcomes related to integration into clinical practice. There are also several areas that would benefit from additional details to maximize understanding and dissemination.

Specific Comments:

Comment 1: Abstract: Although multiple outcomes are measured, including hospice care and ICU use, these are not mentioned.

Reply: We agree that these outcomes should be mentioned in the abstract and have done so as noted below. In addition, we added Intensive Care Unit utilization before consultation to the results section and in Table 2.

Change in Text:

Abstract (page 3, line 76): “While 8 patients (10.3%) utilized intensive care unit (ICU) level of care prior to consultation, 6 (7.6%) patients utilized ICU after consultation. After consultation, 11 (14.1%) patients were referred to hospice.”

Results (page 8, line 265): Eleven patients (14.1%) were referred to hospice after consultation. Prior to consultation, 8 (10.3%) patients required intensive care unit resources, while only 6 (7.6%) patients used intensive care unit resources after consultation.

Table 2, separate document (page 3): Added a row for ICU utilization before consultation .

Comment 2: Intervention is described in the title as “targeted”, though other than age, it is unclear what is meant by targeted.

Reply: Clarification of the intervention process including patient selection added to the abstract.

Change in Text (page 3, line 67): All patients admitted to a medical floor with COVID-19 were screened four days a week and if a patient was over the age of 65, the medical team was offered a consultation by geriatric medicine (ages 80 and above) or palliative care (ages 65-79).

Methods:

Comment 3: Insufficient detail of the needs assessment other than mentioning that interviews were conducted.

Reply: We added clarifying details for the roles of those who were interviewed.

Change in Text (page 5, line 137): We conducted key informant interviews with clinicians, educators and hospital staff to assess perceived needs; this included geriatric medicine and palliative care clinicians and educators, hospitalist physicians, advanced practice provider clinicians, and medical intensive care unit clinicians.

Comment 4: Unclear how four unique evidence-based ACP interventions were combined into one conversation guide. Is the guide available? How long was it? How long were training sessions?

Reply: The guide was created by clinician educators at Yale with specific expertise in communication skills, trained through Vital Talk. Clinician educators combined portions of each guide and separated phrases according to site of care. The guide was shared nationally through an online forum via the American Geriatrics Society in April 2020.

Change in Text: (page 5, line 143): A conversation guide was developed based on existing scripts from VitalTalk (7), Prepare for Your Care (8), Respecting Choices (9) and the Conversation Project (10). Two one hour virtual training sessions were held with geriatric medicine and palliative care clinicians to practice using these resources to guide discussions. The conversation guides were shared via a national forum through the American Geriatrics Society.

Comment 5: No measurement of fidelity of use of the conversation guide

Reply: Given that we utilized portions of conversation guides published via well reputed sources (Vital Talk, Prepare for Your Care, The Conversation Project), we felt the resource met the needs of our target clinical population. Given the urgency of the issue, we did not feel it would have been beneficial or meet the needs of our patient population to test the fidelity of the conversation guide prior to implementation of the project. In fact, it would have delayed necessary resources to a vulnerable population of patients.

Change in Text: (page 5, line 143): A conversation guide was developed based on existing scripts from VitalTalk (7), Prepare for Your Care (8), Respecting Choices (9) and the Conversation Project (10). Two one hour virtual training sessions were held with geriatric medicine and palliative care clinicians to practice using these resources to guide discussions. The conversation guides were shared via a national forum through the American Geriatrics Society.

Comment 6: No patient screening diagram, such as a CONSORT diagram, to understand the reach of the intervention. How many total patients were screened?

CONSORT diagram. Why did the 18 patients not receive consultation?

Reply: We note in the methods section how we arrived at the study sample, including why 18 patients were excluded. We stated in the results section of the text (page 8, line 138) that a total of 120 patients met criteria for inclusion after screening. Of these 96 teams assented to consultation and 78 patients received consultation. As noted in the methods section, the 18 patients for whom the team assented to consultation but did not receive consultation after chart review by geriatric medicine and palliative care clinicians led to no acute goals of care needs to be addressed. To clarify this process, we have added a consult diagram to the separate tables/figures document.

Change in Text: Consort diagram added to the tables/figures separate document. In results, (page 8, line 211) Of the 120 patients who met inclusion criteria, the primary team assented to consultation for 96. After clinician review, 78 patients received consultation (Consort Diagram).

Comment 7: Unclear how long the follow up period is. One person is noted as “remains hospitalized”

Reply: We clarified the date of chart abstraction and length of follow up period in the methods section of the text.

Change in Text: Methods (page 8, line 238): Chart abstraction was completed for patients by June 9 and thus the outcomes were reported as of that date, for a total follow-up period of 30 days.

Results

Comment 8: No inclusion of intervention implementation process measures/outcomes, especially since this can impact staffing needs/capacity to provide these additional consultations to every older patient with COVID-19

Reply: We added implementation process measures including team staffing during the implementation of this intervention.

Change in Text: (page 6, line 185) In performing video consultations with patients, we utilized several electronic platforms including zoom (over iPad, assisted by bedside nurse), a hospital based virtual visit system, InTouch Health(13) and FaceTime vis iPad or iPhone. In Touch technology included bedside monitors residing at the patient bedside that could be used throughout the day by any clinician providing care to the patient. Telephone conversations were the first line of contact to patient surrogate decision makers, however we also offered zoom or FaceTime if preferred.

Through the use of virtual platforms, the inpatient consultation teams were able to increase baseline staffing during the COVID-19 pandemic. The geriatric medicine

consultation service, typically staffed by 1-2 full time MDs and 1 fellow, was staffed by 2-3 full time MDs, 1 APRN and 1-3 fellows during the implementation of this intervention. The palliative care consultation service, had no changes to the baseline staffing of MD, APRN, SW and chaplain clinicians. Notably, the volume of traditional consultations was less due to the hospital census being proportionately higher with patients with COVID-19 infection.

Comment 9: Limited description COVID-19 illness severity

Reply: We specify in the methods that our study population included patients who were hospitalized on a medical floor. This inherently excluded patients with disease severity requiring step down or intensive care utilization at the time of consultation.

Change in Text: We further clarify exclusion of patients requiring intensive care level of care in the methods (page 6, line 175). “Patients with COVID-19 disease severity requiring medical intensive care unit or medical step down unit level of care were excluded from this study”.

In table 2, we share proportion of the population who received each of the COVID-19 treatments available to add information that is relevant to severity of disease.

Discussion

Comment 10: Limited description of context, including whether POLST is present in Connecticut.

Reply: As our study focused on goals of care relevant to hospital medicine interventions, we did not explicitly state use of the MOLST form. We ascertained goals of care through direct conversation with patient or surrogate decision makers and electronic medical record documentation including forms such as Health Care Power of Attorney, Living Will and MOLST, if the patient had one. Additionally, we were not able to complete MOLST forms as our service was virtual and MOLST requires in person signature. We did, however add some context to the end of paragraph one in the discussion per the reviewer’s comment.

Change in Text: (page 10, line 299) Exploring the willingness to pursue invasive interventions in the context of an uncertain prognosis is one critical component in addressing the overall goals of care for older adults hospitalized with COVID-19. Studies have previously demonstrated that even when older adults have considered their wishes in serious illness and at the end of life, documentation of wishes and communication with surrogate decision maker and health professionals is inadequate (19). Due to increased demands and fractured communication lines, inpatient medical teams may not be able to carry out the critical goals of care conversations necessary to ensure that care older adults receive is consistent with their overall goals and wishes. We provided a critical resource to patients, surrogate decision makers and

primary medical teams through our targeted, virtual consultation model.

Comment 11: Line 205: The note of the decrease in proportion of patient who are FULL CODE at time of admission, to then time of consultation, could also be discussed in context of Heyland et al, JAMA Int Med 2013 “Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning”

Reply: Thank you for including this interesting and relevant publication. We will include context of this article in the discussion.

Change in Text: (page 10, line 299) Exploring the willingness to pursue invasive interventions in the context of an uncertain prognosis is one critical component in addressing the overall goals of care for older adults hospitalized with COVID-19. Studies have previously demonstrated that even when older adults have considered their wishes in serious illness and at the end of life, documentation of wishes and communication with surrogate decision maker and health professionals is inadequate (19). Due to increased demands and fractured communication lines, inpatient medical teams may not be able to carry out the critical goals of care conversations necessary to ensure that care older adults receive is consistent with their overall goals and wishes. We provided a critical resource to patients, surrogate decision makers and primary medical teams through our targeted, virtual consultation model.

Comment 12: Line 220 – 223: Observations about implementation of the intervention in the Discussion section are not supported by data presented.

Reply: We re-framed the presentation.

Change in Text: (page 11, line 353) Targeted consults using a virtual platform to address goals of care in non-ICU, hospitalized older adults with COVID-19 proved feasible and provided support to primary medical teams, the patients, and their surrogate decision makers during a particularly high stress period.

Minor

Comment 13: Description of outcomes is a little unclear. There is significant focus on code status, although ICU stay and hospital discharge disposition is also collected.

Reply: We described additional outcomes including ICU utilization and prevalence of hospital complications including delirium and lack of decision making capacity in the results section of the text. (page 6-7, line 183). In this revision, in response to Reviewer 1 comments, we have added information regarding ICU utilization prior to consultation. The authors are not clear by this comment which additional outcomes are unclear to the reviewer.

Change in Text: Page 9, line 265 Eleven patients (14.1%) were referred to hospice after consultation. Prior to consultation, 8 (10.3%) patients required intensive care unit resources, while only 6 (7.6%) patients used intensive care unit resources

after consultation.

Comment 14: Limited description of how chart review was done vs. what might have been asked of patients/surrogates. For example, iADLs, ADLs.

Reply: We have added details to the methods of chart review including review of physical therapy and case management notes.

Change in Text: Page 7, line 218 Patient comorbidities were determined through review of electronic medical record (EMR) notes and problem lists. Baseline functional status (i.e. IADL, ADL impairments) was determined by EMR review (problem list, review of case management and physical therapy notes, review of clinician notes) and through discussion with surrogate decision makers. Diagnosis of baseline probable dementia was determined by EMR problem list or discussion with surrogate decision maker (confirmation of presence of cognitive concerns and functional impairments due to cognition).

Comment 15: Descriptive information related to REDCap is more detailed than needed (lines 131-136)

Reply: The description of RedCap in the manuscript is that which is directly asked for by RedCap. See <https://projectredcap.org/resources/citations/>.

Change in Text: None

Comment 16: Line 196-199: Please clarify what is meant with this statement, including citing the relevance of race and health disparities

Reply: We felt it was important to note that age alone is not the only factor which can be associated with increased rates of complications of COVID-19.

Changes in Text: None

Reviewer B

Comment 1: The demographics of patients who did not change their code status would be interesting. Comparison to the patients who did not receive consultation would also be interesting: how many used ICU, ventilator, died?

Reply: We did not perform chart adjudication for the patients who did not receive consultation by our teams. As this was a case series, we did not have a matched cohort. We also did not collect intensive care unit information including ventilator utilization as we excluded patients actively receiving intensive care unit level of care at the time of consultation. We have, however, added a column to table which shows the demographics of those patients who did not change their code status after consultation.

Change in Text: Table 1, column added with baseline characteristics of patients who did not change CODE status.

Reviewer C

The authors conducted the case series of targeted virtual geriatric medicine and palliative care consultation for COVID-19 patients and reviewed the clinical outcomes, specifically the change of code status. This is an interesting topic and adds to the growing body of literature evaluating the effects of geriatric medicine/palliative care consult for clarifying goals of care. There are several issues to be addressed.

Major concerns

Comment 1: It was not fully clear why consultation had to be virtual. There are a couple of reports of virtual palliative care consultations in NYC.^{1,2} Was the institution of the study in a similar situation? Why did the consultants have to have a goals of care conversation with phone/video with patients? Was this virtual model in addition to a regular consultation team? If consultants were not on site, that reason has to be described.

Reply: Thank you for this comment. We agree that clarification on the rationale and benefits of a virtual consultation service are important. We added this information into the methods section.

Change in Text: Additional information on virtual consultation model in Methods:

Needs Assessment: (page 5, line 41) Based on these interviews, a need for additional support to inpatient medical teams in clarifying and defining the goals of care in high risk, non-critically ill, hospitalized older adults was identified. To directly address concerns regarding preservation of health system personal protective equipment and the efforts to minimize clinician workforce COVID-19 exposure, we employed a virtual platform for conducting goals of care consultations as our primary approach as deemed appropriate. Consequently, we specifically developed a virtual, targeted goals of care consultation model for older adults hospitalized with COVID-19 on non ICU-medical floors.

Intervention: (page 6, Line 185) In performing video consultations with patients, we utilized several electronic platforms including zoom (over iPad, assisted by bedside nurse), a hospital based virtual visit system, InTouch Health (13) and FaceTime vis iPad or iPhone. In Touch technology included bedside monitors residing at the patient bedside that could be used throughout the day by any clinician providing care to the patient. Telephone conversations were the first line of contact to patient surrogate decision makers, however we also offered zoom or FaceTime if preferred.

Through the use of virtual platforms, the inpatient consultation teams were able to increase baseline staffing during the COVID-19 pandemic. The geriatric medicine consultation service, typically staffed by 1-2 full time MDs and 1 fellow, was staffed by 2-3 full time MDs, 1 APRN and 1-3 fellows during the implementation of this intervention. The palliative care consultation service, had no changes to the baseline staffing of MD, APRN, SW and chaplain clinicians. Notably, the volume of traditional consultations was less due to the hospital census being proportionately higher with patients with COVID-19 infection.

Comment 2: In introduction (both in abstract and text), the authors describe the importance of goal-concordant care, challenges in COVID-19 pandemic, communication skills of geriatric medicine/palliative care consultants, but not the characteristics of virtual medicine. Because “virtual” is emphasized in the title, I would suggest adding some context in the introduction.

Reply: Thank you for this comment. We agree that clarification on the rationale and benefits of a virtual consultation service are important. We added this information into the introduction.

Change in Text: Additional emphasis of benefits of a virtual service included in the Abstract and introduction.

Abstract: (page 3, line 59) Insurance expansion of virtual visits enabled inpatient virtual consultation, which preserved personal protective equipment and minimized clinical exposure.

Introduction: (page 4, line 108) To maximize access to specialist care and efficiency of visits, and given concerns surrounding personal protective equipment stores, many health systems took advantage of the expansion in coverage of virtual visits during the COVID-19 pandemic.

Comment 3: The readers of this manuscript would be interested in how to implement this model to their institution and would like to know the logistics. Can you describe the details of team structure? How many MD/fellows, APRNs, SW, etc? How many providers are on service at any given day? The consultation was 24/7 or only daytime? Weekday vs weekend?

Reply: Thank you for bringing this to our attention. We agree that for institutions looking for specific implementation of this model would require more information to assess its feasibility and sustainability. We added this information into the methods section.

Change in Text: Additional details on structure of the team and implementation logistics were added to the Methods section (page 6, line 185) In performing video consultations with patients, we utilized several electronic platforms including zoom (over iPad, assisted by bedside nurse), a hospital based virtual visit system, InTouch

Health and FaceTime vis iPad or iPhone. In Touch technology included bedside monitors left at patient bedside that could be used throughout the day by any clinician providing care to the patient. Telephone conversations were the first line of contact to patient surrogate decision makers, however we also offered zoom or FaceTime if preferred.

Through the use of virtual platforms, the inpatient consultation teams were able to increase baseline staffing during the COVID-19 pandemic. The geriatric medicine consultation service, typically staffed by 1-2 full time MDs and 1 fellow, was staffed by 2-3 full time MDs, 1 APRN and 1-3 fellows during the implementation of this intervention. The palliative care consultation service, had no changes to the baseline staffing of MD, APRN, SW and chaplain clinicians. Notably, the volume of traditional consultations was less due to the hospital census being proportionately higher with patients with COVID-19 infection.

Minor concerns

Comment 4: Line 52 and 172, “over one third of patients”. The specific number and % should be given here.

Reply: Specific number and percentage added to this line.

Change in Text:

Abstract (Page 3, line 74): Following consultation, 28 patients (35.9%) patients changed their code status to less invasive interventions.

Results (page 9, line 262): Following consultation, 28 patients (35.9%) patients changed their code status to less invasive interventions.

Comment 5: Line 173, “almost half (40.0%)”. Please give a specific number here.

Reply: Specific number of patients added to this line.

Change in Text: (page 8, line 263) Of patient who were FULL CODE at the time of consultation (n=42), 2 (4.8% transitioned to DNR only and 15 (35.7%) transitioned to DNR/DNI after consultation.

Comment 6: Line 177, “Notably, ...” This sentence is baseline characteristics (it is in table 1), and should be described in the previous paragraph, probably at the end (line 168).

Reply: Sentence moved to the end of paragraph one as suggested.

Change in Text: (page 9, line 246) Notably, one third (33.3%) of patients met clinical criteria for delirium, and two-thirds (66.7%) of the sample required surrogate decision makers to make medical decisions due to lack of patient capacity.

Comment 7: In table 2, the third row from the bottom says “no escalation of care”. This appears here all of the sudden. In the methods section, the primary outcome is described only briefly in line 138-139. If the authors would like to categorize in this way, it should be described in the methods section. Also it should be consistently categorized in that way in “at admission”, “time of consult”, and others.

Reply: We agree with the reviewer’s comments and removed this from the table.

Change in Text: Removed line from Table 2.

Comment 8: Line 210, “less aggressive goals of care”. Goals of care should not be categorized as aggressive or not. Please rephrase.

Reply: We re-phrased the sentence.

Change in Text: (page 10, line 324) Despite primary team communication regarding goals of care, we observed additional patients transitioning to goals of care directed at less invasive interventions following consultation, in concordance with their values and treatment preferences.

Comment 9: Line 219, “were valued by primary medical teams”. Although I agree it is probably the case, no data was presented to show the perception of the primary team, so it cannot be stated this way.

Reply: We re-framed the sentence.

Change in Text: (page 11, line 353) Targeted consults using a virtual platform to address goals of care in non-ICU, hospitalized older adults with COVID-19 proved feasible and provided support to primary medical teams.

Comment 10: Ankuda CK, Woodrell CD, Meier DE, Sean R, Morrison MD, Chai E. A Beacon For Dark Times: Palliative Care Support During the Coronavirus Pandemic. NEJM Catalyst. <https://www.nationalacademies.org/documents/embed/link/LF2255DA3DD1C41C0A42D3BEF0989ACAEC3053A6A9B/file/DE1469CD733E0BB57246FEA7E4D3677999B6092F3FBA>

Reply: Thank you for emphasizing the relevance of the article above. We will include reference to it in the introduction.

Change in Text: (page 4, line 107) To maximize access to specialist care and efficiency of visits, and given concerns surrounding personal protective equipment stores, many health systems took utilized the expansion in insurance coverage of virtual visits during the COVID-19 pandemic (5, 6).

Comment 11: Nakagawa S, Berlin A, Widera E, Periyakoil VS, Smith AK, Blinderman CD. Pandemic Palliative Care Consultations Spanning State and Institutional Borders. J Am Geriatr Soc. Published online May 22, 2020. doi:10.1111/

jgs.16643

Reply: Thank you for emphasizing the relevance of the article above. We will include reference to it in the introduction.

Change in Text: (page 4, line 107) To maximize access to specialist care and efficiency of visits, and given concerns surrounding personal protective equipment stores, many health systems took utilized the expansion in insurance coverage of virtual visits during the COVID-19 pandemic (5, 6).

Reviewer D

Introduction

Comment 1: Lines 68-70: I'm not sure this statement regarding healthcare preferences varying in terms of outcomes and interventions is unique to older patients. I think this is probably true across the board for any patient with a serious illness.

Reply: We agree with this reflection. We focused on older adults in this sentence, as the study referenced was done with older adults. We have re-worded the sentence.

Change in Text: (Page 4, line 92) Goal concordant care is often nuanced, as patients, including older adults vary in the outcomes that matter most to them, and the interventions they will accept to achieve them.

Comment 2: Line 74: would change “impaired patient capacity” to “impaired patient capacity for decision making” for clarification

Reply: We agree and have made the recommended change to the wording.

Change in Text: (Page 4, Line 97). “...potential impaired patient capacity for decision making.”

Comment 3: Line 75: for clarification would add “varied levels of training and experience” to account for the sub-specialists who have received training but had virtually no experience on the inpatient floors.

Reply: We agree and have made the recommended change to the wording.

Change in Text: (Page 4, Line 101) “...varied levels of training, experience and comfort..”

Comment 4: Line 85: unclear what “uncertainty” is being referred to – prognostic uncertainty? Uncertainty regarding priorities and values?

Reply: We specified that the uncertainty was in prognosticating and predicting the specified outcomes (cognitive and functional recovery)

Change in Text: (page 4, line 95) The COVID-19 pandemic presents clinicians with additional challenges to providing goal concurrent care, including uncertainty regarding expected long-term cognitive and functional trajectories after recovery, fractured lines of communication due to isolation protocols and visitor restrictions, and potential impaired patient capacity for decision making.

Methods:

Comment 5: Line 99: it is insinuated that the outcomes of the needs assessment was addressing goals of care but it would be helpful to state explicitly.

Reply: Yes, the reviewer is correct that the needs assessment identified a need for assistance with goals of care conversations in older adults. We have specified this.

Change in Text: (page 5, line 141) Based on these interviews, a need for additional support to inpatient medical teams in clarifying and defining the goals of care in high risk, non-critically ill, hospitalized older adults was identified. To directly address concerns regarding preservation of health system personal protective equipment and the efforts to minimize clinician workforce COVID-19 exposure, we employed a virtual platform for conducting goals of care consultations as our primary approach as deemed appropriate.

Intervention

Comment 6: Line 120: wondering if you can provide clarification as to what factors impacted the decision to use telephone vs video for conversations with patients/surrogate decision makers. Also would be helpful to hear a brief overview about the technology utilized to complete these consults – was it video via a bedside tablet, telephone via a nurse-assisted personal phone?

Reply: Clarification provided.

Change in Text: (page 6, line 185): In performing video consultations with patients, we utilized several electronic platforms including zoom (over iPad, assisted by bedside nurse), a hospital based virtual visit system, InTouch Health(13) and FaceTime vis iPad or iPhone. In Touch technology included bedside monitors residing at the patient bedside that could be used throughout the day by any clinician providing care to the patient. Telephone conversations were the first line of contact to patient surrogate decision makers, however we also offered zoom or FaceTime if preferred.

Through the use of virtual platforms, the inpatient consultation teams were able to increase baseline staffing during the COVID-19 pandemic. The geriatric medicine consultation service, typically staffed by 1-2 full time MDs and 1 fellow, was staffed by 2-3 full time MDs, 1 APRN and 1-3 fellows during the implementation of this intervention. The palliative care consultation service, had no changes to the baseline staffing of MD, APRN, SW and chaplain clinicians. Notably, the volume of traditional consultations was less due to the hospital census being proportionately higher with

patients with COVID-19 infection.

Results

Comment 7: I'm curious if there was any correlation between number of comorbidities and change in code status? Also any correlation between living site (as a surrogate of functional status) and change in code status?

Reply: We agree that this information would be extremely interesting and information to future clinical decision making. We were, unfortunately, not reliably powered to assess for these outcomes. If we are able to accrue significant numbers with continued use of this model of care, we agree it would be something to investigate further. We have however, in response to another reviewer's comments, added demographic information for those patients who did not opt for a change in goals of care in Table 1. We have also added a section to the results to discuss these observations.

Change in Text:

Results (page 8, line 250)

Comparison of the demographic characteristics of patients who did not have a change in code status following consultation are compared to the demographic characteristics of the entire cohort in Table 1. There were no substantial differences in age, gender, insurance status, number of comorbidities or mean number of medications. There was a slightly lower proportion of patients with probable dementia in the subset of patients without a code status change. Additionally, there were a higher number of patients residing in assisted living and fewer residents of nursing facilities within the subset of patients who did not change code status. There were lower proportions of patients with dependence in ADLs and IADLs in the subset of patients without code status change compared to the entire cohort.

Discussion: (page 11, line 337) Though we are not powered to detect statistical significance between the demographic characteristics between subsets of patients in our cohort (i.e. patients who changed their code status vs. those patients who did not), we did find several notable observations. Those patients who did not change their code status appeared to be less likely to live in nursing home settings and have less IADL and ADL dependencies. This likely reflects that more functional patients were more willing to pursue invasive interventions, possibly due to perceptions of likely recovery from acute illness.

Table 3: column 3 added

Comment 8: Line 205: clarification on this statement re decrease in proportion of patients who were full code between admission and consult... decrease in terms of what?

Reply: The proportion of patients who were full code decreased from admission to prior to the consultation, as a result of primary team clarification of goals of care.

We clarified this.

Change in Text: (page 10, line 321) There was a decrease in the proportion of patients who were FULL CODE between the time of admission and the time of initial geriatric medicine or palliative care consultation (Table 2). This change was likely the result of primary team communication with patient and surrogate decision makers regarding overall goals of care.

Comment 9: Were there barriers to carrying out the consults virtually? Difficulties with technology? Barriers to utilization due to noise/hearing impairments particularly in this older patient cohort?

Reply: Thank you for bringing this important point to our attention. We did not quantitatively assess for this, however we have added potential barriers of virtual care and the impact they could have in the discussion.

Change in Text: (page 11, line 334) Through expansion of technology enabling video visits and through expansion of insurance coverage of such visits we were able to utilize virtual visits during inpatient visits during the COVID-19 pandemic. The benefits of this model include expansion of access and preservation of personal protective equipment. While many patients were able to engage well with video visits, there were some barriers in terms of hearing impairment and patient understanding due to cognitive impairment. In addition, there was some increased needs placed on bedside nurses, though we timed visits during usual nursing care to minimize burden.