

ACLP COVID-19 LIST SERVER CUMULATIVE DIGEST THROUGH APRIL 10, 2020

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This is a digest of e-mails, sorted by topic, since March 26, 2020, from the ACLP Covid-19 list server. The members of the list server generated a great deal of valuable content. That material may be hard to retrieve from the hundreds of individual e-mails, and we hope this digest will help you rapidly find ideas that will help your service. This list was generated by imperfect software, followed by hand correction, and we apologize for any errors.

*Paul Desan, MD, PhD, Chair
Ann Schwartz, MD, Vice Chair
Education Committee*

Personal Protective Equipment (3/26/20)

Allison B. Deutch, MD, 3/26/20

I am looking for some information about the type of PPE that you are using at your institutions for providers responding to behavioral codes? Given the unpredictable nature of these events, and the potential for bodily fluid exchange (via spitting, blood, etc) are you and your staff wearing N95 respirator masks? We have been told by infection control and prevention that a behavioral code does not constitute a super spreading event but would like to hear what others have been told and are doing? Thank you in advance.

Margo C. Funk, MD, MA, 3/26/20

We are using N95 for a behavioral code to COVID PUI/+ units. Otherwise, surgical mask. But also attempting telephone/intercom when possible – this part has been more difficult to gain consensus from nursing/medicine teams.

Avram H. Mack, M.D., F.A.C.P., 3/26/20

Thanks, this is the question I asked a few days ago; obviously we all care about our staff and the community in terms of preventing further disease and spread.
Has anyone seen the use of a Tyvek suit in restraint/behavioral code situations?

Paul Desan, MD, PHD, 3/26/20

I would think a mask with an eye shield would be useful too.

Allison B. Deutch, MD, 3/26/20

In terms of disinfecting equipment, you can simply use alcohol based sanitizing wipes after each patient encounter. Our infection control team has cautioned against the use of bleach as this has the potential to harm equipment and needs to be conserved for circumstances where alcohol-based products will not suffice (i.e: for spore producing organisms like C.diff, norovirus and salmonella).

Sara McNally, MD, Watford General Hospital, Hertfordshire, UK, 3/26/20

Here in the UK, there are FFP3 mask/respirators (? Equivalent to US N95) for which have to have specific fit-test and advised for use, along with visors, where there is high risk aerosol generating procedures (AGP) and examples given to include ICU/ intubation / bronchoscope/ endoscopy / CPR and ECT
We have been advised that surgical face masks plus visors are adequate PPE for the acutely agitated, aggressive +/- spitting patient because the aerosols generated by spitting are too large to penetrate surgical face mask. However, just how exactly you are supposed to be able to confidently distinguish between spitting and coughing in highly agitated patient is not clear and concerns persist Re risk of infection

Changes to Consult Service Operations (3/26/20 – 4/10/20)

Rachel Anne Caravella, MD, 3/26/2020

Greetings from NYU!

My colleagues and I developed a protocol to transform our service into a TELE CL service with the creation of a new nursing position we call the "TELE CL RN", 2 IPADs, and WebEx. Some of our rooms were recently renovated and include a bedside tablet with CISCO Jabber which is another option for Telemedicine for us. The role of the TELE CL RN is two-fold: 1. facilitate the MD consultation and, 2. Peer support of bedside RNs. For patients on respiratory precautions, ie COVID +, the TELE CL RN trains the bedside RN on how to connect to TELE during a time the bedside RN needs to go into the room anyway (thus preserving PPE and limiting exposure).

We are adding to this protocol every day. Any feedback would be welcome. It is far from perfect but it has helped us. In case anyone would find it useful, please see link below to the google document:

[SEE POST ON ACLP COVID-19 RESOURCES PAGE]

Priya Gopalan, MD, 3/26/2020

Stay healthy and safe.

Yes!! This is great, Rachel, and I'm relieved to see that it's very similar to what we have developed and did a soft launch on this week and will institute in earnest next week.

We in Pittsburgh are bracing ourselves - we are expecting higher COVID-19 volumes very soon as testing ramps up in this region. I've attached what we have developed for our own conversion to tele.

[SEE POST ON ACLP COVID-19 RESOURCES PAGE]

Rachel Anne Caravella, MD, 3/27/2020

As promised, please find the ED protocol for our institution written by our colleague, Maureen Martino. Hope it is helpful!

[SEE POST ON ACLP COVID-19 RESOURCES PAGE]

Priya Gopalan, MD, 3/31/2020

My team is asking me what other programs are experiencing in terms of consult volumes, especially in high-COVID regions. Would anyone be willing to share their experiences?

Sameera Guttikonda, MD, 3/31/2020

Hi Dr. Gopalan,

Here in Chicago, we have not yet reached surge, which we are anticipating in the 1-2 weeks. In addition, our CL service has shifted to one in which we are largely doing telephone encounters, and only seeing in-person consults for those with emergent need (acute psychosis, suicidal ideation with unclear dispo plan, patients unable to speak, etc). The inpatient wards are all aware of our new telepsych plan of action. All of this being said, we have over the last week and a half seen no demonstrable change from "normal" in our consult volumes. Interestingly, the consult questions themselves have really not changed either. I had anticipated that there would be a surge in COVID -related anxiety and delirium but this might yet be on the way.

I'll await news from LA, NYC, New Orleans, or Seattle so that we can use that data to better prepare ourselves.

Samuel Greenstein, MD, 3/31/2020

Here at Long Island Jewish Medical Center- Northwell Health- over the past week and a half we are seeing an uptick in COVID+ CL consults while at the same time seeing a decrease in overall volume of consults. Looking at my current panel- half of my patients that I am following are COVID+. It will be interesting to see how things unfold as we (NYC, NY state) reaches the "apex" in the coming weeks.

Vicente Liz, M.D. FAPA, 3/31/2020

Here in NYC we've not seen an increase in COVID related consults. Up till yesterday we've seen 156 consults focusing heavily on the ED to attempt to decrease and expedite the flow. We've also been coordinating wellness checks with the staff, who've been overwhelmed to say the least. Mortality has been increasing this past week.

Raymond Young MD, FACLP, 3/31/2020

At present the current number of new consult requests has been lower than average at our respective hospitals. The overall hospital census at our hospitals has been reduced as the system is anticipating an increase in flux of patients who are PUI's or COVID-19 positive. We have seen a few patients who were PUI's that ultimately tested negative. We have not seen any patients confirmed positive with COVID-19. We anticipate that this will change as that patient population continues to increase. Stay safe and healthy

Philip R. Muskin, MD, 3/31/2020

Has anyone set up a process to provide support for families of patients? That is, getting the information from the primary team then calling families?

Vanessa L. Padilla, MD, 3/31/2020

At Jackson Memorial Hospital (Miami), we have noticed a decreased of requests, but still dealing with 10-15 patients per day. Our numbers can be higher than that when business as usual.

We are doing a lot of liaison (discussing with teams, curbside, referrals) - no way to bill, but ensures patient care and minimize use of protective supplies.

We are only evaluating urgent consults (2 teams - one with attending doing telehealth - limited equipment, but currently using our phones and the nurse manager or SW phone to connect devices via institutional approved zoom; second team consists of one resident in the floor with the patient, on zoom with attending and co-resident; our fellow triages all consults and do liaison decisions with back up from attending).

Vincente Liz, MD, 3/31/2020

Blair, we have: Total PUI: = 160 Total COVID+: = 96 right now. We've been thoroughly reviewing the chart, speaking to collaterals and staff about the patients, prior to engaging them in case we have to actually go in. Most rooms have phones and we call the patient and talk to them. If this is still not sufficient then we go in in full PPE. We still have supplies but we're trying to minimize use.

Telepsych has not been able to be set up at all. There's been a lot of resistance to get it up and running as the Clinical teams, particularly the ED, feel that their resources would not be able to be diverted at this time to set it up. Having an RN or PCT move the available COWs and sit with the patients while we do the evaluation. Pretty concerning.

Dahlia Saad Pendergrass, MD, 3/31/2020

Hello,

In Hartford we are seeing a decrease in overall consult numbers and increase in acuity. Overall hospital census was done as COVID cases are rising steadily. Our doubling rate has shortened from q4-5 days to q2-3 days. My guess is that only the sickest psych or medical patients are coming in for care, and once they do get admitted there has to be a glaring need for them to reach the threshold for consultation. Has given us an opportunity to refine/roll out our system of triaging consults to three categories as many of you are doing (sconsults/telehealth (video vs. in rare cases only phone vs. in-person).

Not very many COVID consults ... yet.

We have been making rounds on the COVID units to support the nursing staff. Also have made phone/ZOOM time available to staff in groups and individually.

Is anyone writing up (or interested in joining me in doing so) their COVID experiences for a workshop at the ACLP? As the neighboring state to NY, we have faced a reverberation of the wave ... mostly in staff/nursing anxiety. It would be great to have a reserved opportunity when (hopefully) all is said and done to reflect on the experience and learn from each other's experiences.

Avram Mack, MD, 3/31/2020

Our experience at CHOP has been low overall census. Ironically the week before this all hit we were dealing with an extreme number of boarders—our service was in the 70s which is not abnormal this time of year. Now we have around 19.

Shruti Tiwari, MD, 3/31/2020

We are seeing a similar trend here at Elmhurst Hospital, New York. Overall a decrease in the number of consults, Except that 99% of our consults are now COVID+.

We are doing teleconsults whenever that is possible to do!

Vincente Liz, MC, 3/31/2020

Priya, we've re-deployed the Collaborative Care and Primary Care Psychiatrists to come in to the main Hospital and each of them do one day (5 days a week) of counseling, guidance, sharing with staff. We go each floor and make ourselves available to the Teams. We've shared our phones for offline/private conversations and we're bringing in 2 Psychologists and one LCSW to help us.

We also want to reach out to families who have been struggling with their loved ones being in the hospital or who have passed.

We've also opened up a Zoom meeting once a day for people to join and do a group.

It's all very fluid but we're doing our best.

Rachel Caravella, MD, 3/31/2020

From our team at NYU manhattan campus:

During the first two weeks, we saw a decrease in overall volume of consultations. I think that our medical and surgical colleagues were very focused on airway, breathing, circulation - appropriately so.

We are really in the height of it now and consultations are starting to pick back up. Majority of new cases being called in are pretty acute: delirium w agitation, complex capacity, AMA requests for COVID pts who are homeless, anxiety in COVID patients who cant tolerate facemask or high flow O2, suicidality etc

We started proactively reaching out to colleagues to help before things reach crisis level.

Peter A. Shapiro, M.D., 3/31/2020

exactly

Carrie Ernst, MD, 3/31/2020

Hi all-

Writing from Mount Sinai Hospital in NYC, I would echo what others have said- maybe a slight decrease in overall number of consults but the consults we are getting are almost all COVID-19 patients and much more complicated than what we usually see- capacity to leave AMA, agitation/delirium, end of life/goals of care questions, patients hospitalized who also have very sick family members hospitalized, etc. We are finding that the behind the scenes admin work has increased significantly (figuring out staffing for service, deciding whether to curbside or do formal consult, finding out what telepsych modality is feasible for a particular patient, holding multiple daily team huddles/check-ins). Also, each consult is taking longer than usual because using telepsych has been challenging for many patients (ie, delirious patient who can't work a device and/or needs an interpreter, need to coordinate with very busy primary team/nursing staff to facilitate the telepsych, etc).

Belal M. Elamir, MD, MD, 3/31/2020

In Harrisburg, PA, we are also seeing similar reduction of overall psych consults. Perhaps the calm before the storm. We shall see how the next 1-2 weeks go.

We anticipated a surge of ED visits with some of our homeless patients, and have agreed to be more available to the ED to expedite the flow. So far, it has not been the surge we anticipated.

As of this week, we are now almost entirely a Telepsych service, with as few as possible in person contacts. We have had Telepsych, in some capacity, over the last 2 years using Vidyo. Since the Covid crisis, our IT folks have deployed more Telemedicine carts across our three hospitals. We are finding that other specialties are competing for the same telemedicine carts that we had been using previously.

No actual Covid + consults, but a few suspected cases, seen by Telepsych.

Ketty Thertus, MD, Mar 31, 2020, MD, 3/31/2020

I apologize if this was reviewed elsewhere. How are your psychiatric admissions being triaged/managed for patients in the ED or med-surg floors who test positive for COVID, are asymptomatic or mildly symptomatic and yet require psychiatric admission (particularly if they are floridly psychotic, aggressive or manic).

Michelle To, MD, Mar 31, 2020

Ketty - We made an agreement with Medicine that patients on psychiatric holds but who are COVID+ or PUI or with symptoms and awaiting a COVID test result, should go to medicine with CL psychiatry following. CL psychiatry can follow without ever seeing the patient in person as long as an adequate assessment can be made by phone, collateral, or chart review. We haven't had this happen yet. I imagine things will get very difficult when the hospital fills to capacity. We do not have AV equipment for video set up yet.

Vicente Liz M.D. FAPA, 3/31/2020

We've been using our Child CPEP for now but are emptying one of our units to serve as a PUI unit. The COWs have been very useful in this setting. Anyone in the Unit is donning full PPE. We've had only 2 cases as we're trying to discharge from the medical floor as much as we can.

Viveca Meyer, MD, 3/31/2020

At UNM, any child exposed or symptomatic is admitted to the pediatric hospital, if they also require psychiatric adm. No patient with covid or exposed within last 2 weeks can be admitted to the Child psych hospital, housed separate from the pediatric hospital. They are managed by us on C/L during their hospital stay. Peds ID doc on call is always available to discuss/direct. They are very clear about their recommendations.

Blair Walker, MD, 3/31/2020

FYI here in Austin we are rapidly launching community donated iPads with zoom app locked in guided access so patients can't get out of it. This may also allow some families to zoom with their loved ones as well. Our current plan has been to place iPads in all covid/ruleout rooms that stay in the room, Plus more at nurse stations on no covid floors until entire hospital is a covid floor then redistribute across nurse stations if that happens.....the medicine and other specialties are using this plan to also tele where they can to minimize PPE per covid patient....

I located most of the donations from our local schools who had caches of out of date iPads for child testing but perfectly useable for tele at bedside. Then sourced large order for cases, and asking community for charger/cords and are getting them in droves!

Anyone can email me if you have questions about the process...

Stephanie Cho, MD, 4/1/2020

Hi Blair,

I'm in Los Angeles (Univ of Southern California). Our department covers both the private university hospital and LA County Medical Center. at the private hospital where I am based, I've gotten telepsych working because we already had hospital ipads and that infrastructure was already set up.

The county side is more difficult, but I'm more worried about our faculty's exposure there. Can you tell me more about how you were able to get the Ipads set up through your IT department? Do you have a public/gov site, or is it private? Sadly, in my experience it is easier to get things like this to happen in private orgs.

Our faculty are still seeing all consults in person and I am concerned for their welfare. Any advice or info on how you guys are doing things would be greatly appreciated.

Blair Walker, MD, 4/1/20

Sadly it is not easier with private necessarily, our IT department has not been willing to "support this tech" yet, we're working through bureaucracy but basically I and medicine docs pooled residents to do a bunch of the donated iPads (I had a ton land in my lap). Aside from that, Just the CL docs cobbled together old iPads and chargers and cords (you need cases to protect them too which are a beat to get right now, but if you only have a few, buy something fancier like Otterbox and crowdsource the cost). We have one per nurse station (10) now/almost up and running in two hospitals (waiting on cases I bought that docs are sharing costs for now, maybe we'll get paid back but no one cares much), then I deploy to locked med rooms Friday am and Im back to home to join my colleagues and our team for virtual visit.

Ipads are easy to set up with zoom app and the iPad doesn't need an account, just needs to have WiFi logged in, then locked in guided access so only person with a code can get into the ipad and out of zoom! (all credit to more apple techy colleagues who figure it out).

In Texas they've waived any concern for HIPAA compliance with video chat, sure it's same in Cali now but we do discuss w pt anyway and put "limits of confidentiality discussed, alternative modes of convo offered and pt agreed to proceed with zoom" at top of note for pts who can do that...just in case
Also our Med school has zoom pro account we use, they signed business agreement which turns on the HIPAA compliance for us apparently, allows learners and attending unlimited meeting time w patient as a group etc so will be a neat way to watch learners interview from afar and let them do the same with us, fo efficiency someone will scribe the note, or attending hops on near end.
Call me if needed! We have a workflow and info sheets on how to set this up! I have an amazing resident working with me on this as well as some awesome colleagues of course...;)
I'd say bootstrap it and ask for forgiveness later! Ask friends and fam, "who has iPads or iPad minis we can have, chargers etc....buy "wipe downable" cases and you're golden. We made it happen in days...will be 7 from first donation to fully done and out of hospital, only rate limiting step was the darn cases.

Blair Walker, MD, 4/1/20

So this is for hospital deployment, though we gave some donated ones to our chemo infusion center too"

One per nurse station for non covid floors, one per covid room on covid floors (less in and out and disinfecting, less PPE etc)

--all our room have windows from halls so can even eyeball with video then pivot to bedside phone or just give recs based on that cursory exam

--cases can be disinfected with just about anything

--using others idea for a "tele nurse" but actually using a nurse is a no way in our system, im doing it for now until cases come in, then we have various options which all are agreeable to for workflow to get ipad to non covid rooms (or go turn it on in room)

Non covid: consulting team vs float tech vs nurse logs in and brings to room

Covid: when someone is donning PPE, we coordinate to get them to turn on ipad while there, then the next time if they are coming back they turn off etc.

This one we have plans to try to coordinate followups via group tele for treatment team rounds per patient for all specialists, but hasnt happened yet, we'll see how it goes

Our hospital seems ("over"?) confident we'll have enough PPE to go around for our surge projected starting now to May peak cooling in June, so not thinking about full unit with providers wearing same PPE all shift (or until next break), but I mentioned this to nursing/infection leads to be ready for, then we'll again decentralize all ipads potentially as we'll run out per room (or they may double up patients per room too first to keep covid on certain floors). Trying to stay flexible as everything seems to change daily. Have fantastic relationship with all the service lines and administration bc we've been in this system for a long time and done the work to gain trust and rapport, so working together to make it all work, hopefully. Maybe we'll do a poster or paper on how it all went, though even considering abstract submissions feel terribly overwhelming!

To all our front line/hard hit colleagues, hang in there and thankyou for letting us know how its going for you, it's great info to help us prepare!

This list serve is so great, never felt so connected as a speciality before, despite how fantastic ACLP is in connecting us. Once again, another new idea that will change to some extent how we interact nationally with each other and probably how we deliver care in future. Nothing like a crisis to force us towards change, just hoping we will all survive it--stay strong!

Sameera Guttikonda, MD, 4/1/20

Blair, this is truly inspiring. We've been struggling as a CL service with similar bureaucracy issues (the joys of working for a county hospital) and have been limited by our ability to perform telephone-only encounters. I would love your workflow and info sheets, and will probably have to follow your "ask for forgiveness instead of asking for permission" model.

Blair Walker, MD, 4/1/20

Thanks Sameera! Hopefully thats not just a Texas thing;) and I'm managing and working closely with our lead hospitalist and CMO who are fantastic supporters/drivers of this work....being mindful of political pitfalls etc. It has also been likely dumb luck and using social media to find cahes of tech for us-seems ipads are easiest, but we didnt try that hard with other tablets, tehy may work great too! Cheers!

Janice M. Mattson, LCSW, 4/1/2020

Hi all,

Does anyone have experience with relocating an ED crisis unit to a section of an inpatient behavioral health unit? This is on the table at our organization to free up Emergency Department space. Our unit is rather small, 16 beds, the idea is to transition an area (front alcove) of 2-3 rooms into a small crisis pod. Among others, some questions are sufficient medical clearance and question of moving pts from the ED while intoxicated. Any feedback is appreciated. Thanks to all on the listserv, it has been an invaluable resource.

Meg Brennan, MD, 4/1/2020

We have resisted moving "crisis" patients out of the ED. For some of the reasons you cite (lack of medical clearance) and also related to potential covid exposures on our unit and the very limited ability to control for that on our communal psych unit.

We had a recent experience that has reinforced this concern. A woman with psychosis was brought in to a nearby hospital by police. Her covid screening exam was negative, but, she had just travelled from NYC and had been in/out of 2 ERs there. Although there was no trigger/criteria for testing, given she was in NYC and the vulnerability of the inpatient psych unit to a potential exposure, we asked that she be held until covid test completed (this is more reasonable as we are getting turnaround times ~24 hrs now). She tested positive and is now admitted to their medical unit in a NP room w/ precautions and we are providing psychiatry via telehealth. Remains asymptomatic. The potential high percentage of asymptomatic carriers makes these triage questions complicated.

Paul Desan, MD, PhD, 4/1/2020

Dear Colleague,

We would like to call your attention to three pages on the ACLP website hosting Resources, Links, and Stories submitted by members (all pages available from <https://www.clpsychiatry.org/covid-19/>).

For the Resources page, we are seeking reports from services about the situation at your institution and changes in your operations, new policies and procedures, case reports or clinical comments, ethical discussions, or any other documents that may help your colleagues respond to this crisis. For example, do see the detailed manual for telepsychiatry contributed by the University of Washington.

For the Links page, we are seeking web addresses that offer useful Covid-19 information. For example, the first link offers an excellent account from a pulmonologist at the front lines in New York City.

For the Stories page, we are seeking stories or pieces of 55 words or less about your experiences. Such stories have been used for sharing and support in many contexts, and were proposed for the medical setting by an article in JAMA in 2000. Three have been posted so far!

Please send your submissions to covid-19@list.clpsychiatry.org (this is not the same as the list server email). All items are peer-reviewed and posted promptly.

Thanks for all submissions so far, and thanks in advance for your future submissions,

Paul Desan MD PhD
Chair
Ann Schwartz, MD
Vice Chair
Education Committee

Blair Walker, MD, 4/2/20

Sorry for delay here in Austin, side tracked yesterday! Victoria Nettles is our awesome PGY3 Psych resident down here helping with tip sheets for ipads and zoom in guided access! She'll attach so all can see and use!!

[SEE POST ON ACLP COVID-19 RESOURCES PAGE]

Ashley Ellison, MD, 4/2/2020

I am in search of some specifics regarding billing for telephone and video CL visits. I saw per Brigham and Women's CL service documents that they are including a statement about how the visit was conducted and the reasoning for that then billing as a new or follow-up visits as usual plus a GPH modifier for phone and GT modifier for virtual visits.

Can anyone from Brigham or another hospital using these modifiers provide me with some further info regarding this? I have not been able to locate much helpful info online. If other hospitals are billing phone and televisits in different ways, I'd love that info too.

Thanks all! I very much appreciate the collaboration and wisdom from you all in these times.

Stay safe,

Sejal B. Shah, MD, 4/2/2020

Dr. Ellison,

I hope you are well!

Yes, our hospital system (including billing/compliance) has advised us to continue using the same E&M codes for initial consultations and follow ups and adding the GT or GPH modifiers as described in the document you reviewed on the ACLP website. This has been in the context of relaxing of "rules" by insurance companies. We do add a "header" to the note indicating that due to the COVID-19 pandemic, the evaluation was not performed in-person.

A huge thank you to Dr. Naomi Schmelzer on our team who created this Epic Smartphrase very early on:

Due to the current COVID pandemic, consult was completed by telepsychiatry

Modality: real-time video or telephone

Location of Physician:

Location of Patient:

Consent:

Telepsychiatry consult completed without issue:

Recommendations have been communicated to Provider:

Dahlia Saad Pendergrass, MD, 4/2/2020

Our billing department is asking us to use "GT" as a modifier for all virtual VIDEO patient visits. They will parse thru the bills later and change some to "95" modifier based on payor. The conversation is still active on phone consults. For the moment we are using the GT and relying on clear documentation in the note to alert the billing specialists.

For e-consults without any patient contact we are billing using 99446-9

Helpful references:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcfsctsh.pdf>

<https://codingintel.com/interprofessional-internet-consultations/>

Virginia O'Brien, MD, 4/2/2020

Not sure if this helps, but at Carilion Clinic, the billing department has requested that all visits be coded as COVID with documentation in the note regarding phone or video and length of time for the appointment. There is a dot phrase for all of that. On the back side of this, our billing dept will go through and sort out what codes to apply. I guess I'm luck I don't have to figure all of that out!

Junji Takeshita, M.D., 4/2/2020

Has anyone used asynchronous store and forward telemedicine (this is where the interview is recorded for example by a resident) and then viewed later by attending. The attending can then bill for services on the day that the video was reviewed.

Re telephone only consults (no telemed) – fairly limited billing options with low payment. I think the most common is G2012 for a brief non-face to face.

Patrick Aquino, 4/2/2020

Can also consider using codes 99456-99452

[Codingintel.com/interprofessional-internet-consultations/](https://codingintel.com/interprofessional-internet-consultations/)

Andrew J. Lancia, 4/2/2020

This speaks a bit to my question. Are people assessing the patient twice, once by the resident and once by the attending by phone? I think the zoom option with the resident and attending sounds great if available. I have been staffing consults similar to the way we do on call with the residents doing their evaluation and then deciding disposition or need to do a fuller evaluation with the patient (i.e. "live consult").

Dahlia Saad Pendergrass, MD, 4/2/2020

We are avoiding going in twice. We review together w the resident and decide on Econsult w phone discussion w the service, ZOOM video eval or in person eval. If the resident starts the ZOOM meeting the attending joins them or starts another meeting afterwards. If the resident goes in first to do their assessment, they then contact the attending via FaceTime (or zoom but facetime is easier) and the attending "joins" the latter part of the interview. If the attending decides they need to be physically present in the room we do not send the resident in ... we sometimes have them on facetime for their education.

In essence, we are making this up as we go along ... but the more we utilize these new paths/ techniques the more natural they have felt.

Morgan Fader, MD PhD, 4/2/2020

We list the chief complaint as “social distancing” and put a dot phrase at the beginning of the note indicating phone or video and then bill as usual, leaving it to be cleaned up at the back end.

Gita Ramamurthy, MD, 4/2/2020

Dear Colleagues, we were advised that we should have the following clarifications when billing for televideo or telephone visits:

Telemedicine smartphrase ▪ .TELEMEDICINEDISCLAIMER

"This is a tele-medical visit. The patient was informed of the risks including security breach, technological failure, inability to perform a comprehensive physical exam which could delay or prevent an accurate diagnosis, and potential complications from treatment decisions rendered over a telemedical platform. The patient understands and consented to the use of tele-health services."

Telephone smartphrase ▪ .TELEPHONICDISCLAIMER

"This is a telephonic visit which was performed without the use of video technology due to patient inability to connect with video. The patient was informed of the risks including security breach, technological failure, inability to perform a physical exam which could delay or prevent an accurate diagnosis, and potential complications from treatment decisions rendered over a telephonic platform. The patient understands and consented to the use of a telephonic visit/telephone call."

Manon B. Mashburn, MD, MSPH, 4/2/2020

Much appreciated. I'm at the VA in New Orleans. Right now, with the influx of COVID19 cases, our inpatient and ED consult load has dropped to almost nothing. Currently, we only have two attending for consults and ED. I am trying to get some form of telework and eConsult arrangement in place. Aside from reducing exposure, we really need to preserve PPE. I've spoken w leadership on the Medicine and ICU Services and they would utilize CL via telepsych. Unfortunately, there is an incredible amount of resistance from MH Leadership who are insisting that all ED and CL patients must be seen 1:1. Does anyone have any advice or experience with this so far?

Avram Mack, MD, 4/2/2020

Hi All,

I'm writing to seek feedback for a staffing model that maximally protects the home/family of a CL psychiatrist who is seeing COVID+ patients in person. And, of course everyone's situation is different—some systems have more or fewer available staff, some psychiatrists have home responsibilities that make the below untenable. But, I suppose the question I'm asking is whether it makes sense in principle? Maybe it is attractive for some and not for others?...

My idea, which requires the psychiatrist to have a separate place to sleep, would be:

Lengthy period on-service (like 2 weeks staying away from one's family) followed by greater-than-2-week period off service either at home or, if mandated, in quarantine.

My rationale is that by concentrating the “on” period, then when one is done, then assuming one need not quarantine, then there is a clear period for rest, attending to family and no re-exposure. Or, there;s a built in quarantine period.

Does anyone else see value in this? Please tell me if it seems I'm barking up the wrong tree.

Philip R. Muskin, MD, MA, 4/2/2020

Hi Avram et al: What system forces a person to put his life at risk and cannot utilize telepsych with only special situations for in-person interviews? Assuming maximal PPE for this person, without which the person is essentially sentenced to death, then separate clothing, separate housing, decontamination, etc. are all appropriate. That means a 2 week period after each patient encounter. As Willy S so aptly put it:

The weight of this sad time we must obey; / Speak what we feel, not what we ought to say. / The oldest hath borne most; we that are young / Shall never see so much, nor live so long

Cathy Crone, MD, 4/2/2020

I would be concerned that a 2 week stretch is a long time and could be very stressful and wearing. When people are worn down, there is higher chance for error, I am specifically thinking of needing to take care with wearing PPE or following even basic safety concerns (handwashing, distancing, etc) in the situation of indirect/telepsych consults. However, one really needs to ask one's staff as to whether this model makes sense to them and their families or not.

Manon B. Mashburn, MD, MSPH, 4/2/2020

Well Phil, just today we had this email on this listserve (copying it in):

...Unfortunately, there is an incredible amount of resistance from MH Leadership who are insisting that all ED and CL patients must be seen 1:1. Does anyone have any advice or experience with this so far?

So, to carry on my thesis, I would think that after the psychiatrist's ultimate in-person encounter (maximal PPE included), then, yes a planned 2 week period away would be "correct" (although completely unrealistic).

Meg Brennan, MD, 4/2/2020

I find the requirement for all ED and CL patients to be seen 1:1 (if meaning in person only) highly questionable and far off from the rapidly establishing standard of virtual care and in-person only if essential. I am curious of their rationale. Hard for me to imagine one.

Christopher Ryan, MD, 4/2/2020

Australia is a far less litigious society than the US, and the laws around actions in negligence apparently set a much higher standard for a successful action in Australia than in the US (if not formally than in practice). However in Australia, a practitioner or service continuing to seeing patients face-to-face when reasonable, suitable and safer alternatives were available via telephone and video conference would be opening themselves up to actions relating to any damages that could be shown to have flown from this breach of duty of care.

(This is not the primary reason to see any one you can by Telehealth, but it is one that is likely to have considerable bite among managers, who still haven't quite grasped what is happening here.

Alan Hsu, 4/2/2020

I completely agree. I cannot see any defensible rationale for mandating that all ED and CL patients be seen in-person during the pandemic when 1) alternatives methods are available that can be used without significantly compromising patient care, 2) providing only in-person consultation for all CL and

ED patients will place both consultants and patients at unnecessary risk, and 3) the emerging standard of care during the pandemic is to provide these services without in-person contact when feasible.

Philip R. Muskin, MD, MA, 4/2/2020

Perhaps time for us to say to administration and chairs, "Sure as long as you come in the room with me to be sure I do a good evaluation."

Sarah Reed, MD, 4/2/2020

We have been reviewing patients using VC (zoom) in the ED and the wards (including an anxiety and support consult for the hospital's first COVID case), and arranging follow-ups through zoom, and it has been working great so far. So far we are relying on people using their own devices in the hospital (we are trying to source some ipads on the suggestion from earlier) and have some acute stations set up for VCing in clinics

Attached is the workflow the community/ acute teams developed for deciding who is seen by VC, and we are using a similar set of guidelines in the general hospital.

Helpfully the NZ government and MOH has states that anyone who can work remotely MUST do so, which helps when making arguments for this type of work.

Michele To, MD, 4/2/2020

We are having tremendous difficulty doing tele-work in our VA ED as well. The biggest hurdle is that we don't have nursing buy in. Our nurses float between the medical and psych parts of the ED and are stretched extremely thin. Asking them to be arrange AV equipment for every patient encounter is too much to ask. Additionally, there is only one phone in the patient area. There's no easily accessible wifi (only VA furnished equipment can gain access, and that's been difficult to obtain). There is no cell phone reception in that area of the hospital either.

Christine Skotzko, 4/3/2020

Tell them if they continue with this practice they will soon have no providers as team is more likely to be ill or put on quarantine,

We are employing telepsych to facilitate allowing folks who are well but not allowed in hospital to still perform duties.

Give them doomsday and ask what they will do when there is no one left for face to face. In a kind and gentle way.....

Paul Desan, MD, PhD, 4/3/2020

Dear colleagues,

We posted on the ACLP website this morning Reports from the Field from Dr. Tiwari at Elmhurst, NY, and Dr. Arango in Madrid, Spain. These are institutions which were hit early in this crisis. Their reports are essential reading for anyone planning for their own hospital. Dr Tiwari discusses triage of consults to remote interventions and limiting in-person examinations. Dr Arango describes conditions in his hospital and expansion of the CL role to caring for providers, providers who have fallen ill, and family members of patients. Their service is very involved in the care of dying patients. We thank Drs Tiwari and Arango for their accounts.

Also posted this morning is an editorial by our Past President Dr. Brendel and her colleagues on practice in a time of limited resources, and a presentation on factors affecting immune response From Dr Lewicki.

Please send reports, resources, and links to covid-19@clpsychiatry.org, thanks!

Paul Desan MD PhD
Education Committee

Devendra S. Thakur, MD, 4/3/2020

I completely agree, that such a policy of in-person consultation during a viral pandemic is indefensible. Suggesting administrators come in with you is frankly a justified response. I might also ask, "How does maximizing in-person encounters fit with the general message (of self-isolation and social distancing) that the scientific community is giving to the public? How do I explain to the media that our institution is choosing to increase risk of transmission and therefore increase harm to society as a whole? When other institutions are going to significant lengths to do as much as possible remotely with technology, why are we guided by different principles?"

Dwayne R. Heitmiller, MD, FACLP 4/3/2020

A few thoughts:

Be flexible and creative in your approach. Speaking to someone over the phone while being able to see them through a window would in my mind constitute a 1:1 encounter, while decreasing exposure for all and use of valuable PPE. You don't necessarily need to go into a room and all the way up to the bedside to see someone who is agitated or psychotic, observing from a distance will often suffice.

There seems to be a lot of angst about how to bill (perhaps too much). This is important, no doubt now more than ever, but for perspective the billing by the CL psychiatrist is insignificant when compared to the revenue being lost by all the elective surgeries that have been cancelled. We will not be the downfall of our institutions and surely this will get worked out in time.

Last, and most importantly, it is of paramount importance that we mind our own safety if we are to be able to continue caring for our patients. I feel lucky to work for an institution that seems to be approaching this in a sensible and reasonable manner, but I recognize that this is not the case everywhere (particularly given the regional differences we see) so please don't let 'leadership' dictate anything that would fly in the face of common sense. Do your best while being safe, look after each other.

With gratitude and admiration for all of you,
Dwayne

Stacey Heit, MD, 4/3/2020

We are being asked to use a "reassigned" staff member (eg. surgical tech) to carry iPads into the rooms of patients while we work at home. I'm having a hard time with the idea of asking someone to be, essentially, the sacrificial lamb. Nursing staff already working with these patients has declined to be the ones taking in the iPads.

CL psychiatrist in metro Atlanta

Shruti Tiwari, MD, 4/3/2020

Answer to an earlier question about who passes the phone to the patient: We usually ask the primary team member when they would be stepping in or the nurses and pass on the phone when they go in, or if the patient has a sitter then pass on the phone via the sitter. In rare occasions when there's no one to pass on the phone, one of us puts on the PPE to give the phone but we avoid that because there's such a shortage of PPE... so we try and work it out with the staff

Rachel Caravella, MD, 4/3/2020

Our staffing model at NYU in case it is helpful:

MD Rotation Schedule for 1 onsite MD

	MD1 (RC / AD)	MD2 (PY)	MD3 (AS)	MD4 (CC)
Week 1	onsite	remote	remote	remote (T,W,F)
Week 2	remote	onsite	remote	onsite (T,W,F)
Week 3	remote	remote	onsite	remote (T,W,F)
Week 4	onsite	remote	remote	remote (T,W,F)
Week 5	remote	onsite	remote	onsite (T,W,F)
Week 6	remote	remote	onsite	remote (T,W,F)

Onsite CL MD Responsibilities (service quarterback):

- behavioral emergency response team MD (psychiatric code)
- Supervise CL Fellow's cases remotely
- AM and PM signout to overnight
- Manage CL List
- CL Phone triage and case assignments
- Proactive Rounding by phone
- Overflow cases or urgent consultation

Remote CL MD Responsibilities (clinical heavy lifting):

- TELE CL followups and new evaluations
- Prioritize caseload by acuity, schedule TELE CL evaluations with TELE CL RN
- Clear communication with assigned TELE CL RN
- Clinical documentation of all encounters in EPIC, incl type of encounter and involvement of TELE

CL RN

- Verbal and written psychiatric recommendations

TELE CL RN Responsibilities

- Facilitate CL MD's TELE consultations
- Liaison and support for bedside RNs
- Sanitizing CL IPAD between patients
- Clear communication with assigned MD(s)

Equipment: 2 (Two) TELE CL IPADS in shatter resistant case with screen protector, 2(two) rolling IPAD stand.

For NYU: We do not have any sacrificial lambs. Our Tele CL RN is not going into the room of any COVID patients. They set everything up on the IPAD ahead of time and wait for the bedside RN to go into the room at a time when she / he already needs to go in for meds / vitals / assessment etc. The ask of the bedside RN is to simply roll the IPAD on wheels into the room and face it towards the patient. Our TELE CL RN is in charge of cleaning / sanitizing. We are triaging consultations and reserving the Tele consultation for urgent questions like SI, etc. The IPAD is kept out of arms reach from the patient. Another option is to directly connect with the patient (if cognitively intact and not intubated) using the patient's own phone. See our description below:

Part 11: TELE CL RN Role

CL Service Goal During COVID: To continue providing NYU Langone Hospital with high level psychiatric consultation while minimizing risk of exposure to CL Psychiatry service members.

CL Service Priorities:

1. Maintain patient safety and deliver excellent clinical care
2. Support our medical and surgical colleagues who are caring for challenging patients
3. Avoid unnecessary exposure to COVID19 to minimize staff illness and preserve PPE

COVID Strategy for Patient Care:

Effective immediately, ALL Psychiatric consultations will be conducted via Telepsychiatry unless the patient meets one of the exclusions below:

Patients NOT appropriate for TELE CL: Acute agitation or behavioral emergency that precludes safe use of TeleMedicine.

TELE CL RN Responsibilities

- Facilitate CL MD's TELE consultations
- Liaison and support for bedside RNs
- Sanitizing CL IPAD between patients
- Clear communication with assigned MD(s)
- No documentation required for facilitating MD consultation. MD records presence of RN if applicable.

Equipment: 2 (Two) TELE CL IPADS in shatter resistant case with screen protector, 2 (two) rolling IPAD stand.

TELE CL RN Role Description:

1. Clinical Role: The TELE CL RN has the dual role of facilitating the MD consultation and supporting the bedside med-surge nurse. For new consultation requests, the TELE CL RN and remote CL MD review patient's chart. TELE CL RN goes to the floor to verify with the bedside RN that the patient is available and ready for TELE consultation. TELE CL RN inquires about level of cognition, presence of agitation, primary language, hearing or vision impairment. TELE CL RN communicates directly with the Offsite CL to discuss that patient is available, appropriate for TELE consultation, and facilitates MD TELE CL evaluation. Before and after each encounter, the TELE CL RN ensures that the IPAD is sanitized.
 - a. Isolation Procedure:

- o For COVID+ patients, the TELE CL RN instructs the bedside on connecting to the TELE visit but does not don PPE and does not go into the room (pre-connects the IPAD and bedside RN rolls it into the room). The TELE CL RN coordinates the time of consultation with the bedside RN to coincide with a time when he / she needs to enter the room for medications / vitals / assessment, etc to preserve PPE.

- o For non-COVID patients, the TELE CL RN wears a mask and gloves to facilitate the TELE CL encounter either using the patient's bedside tablet or the CL IPAD on wheels.

b. Observation Procedure:

- o TELE CL RN may stay with the patient for the duration of the consultation if the patient is NOT already on 1:1 / constant observation, if necessary, at the discretion of the TELE CL RN and Offsite CL MD. If staying in room, the TELE CL RN will assist with communication, redirection, and bedside exam under direct visual supervision of the Offsite CL MD. TELE CL RN will maintain a distance from patient of at least 6 feet unless clinically indicated.

IX. If the patient is already on CO or 1:1 with a PCT, the TELE CL RN may leave to assist with the next TELE consultation, if appropriate, and at the discretion of the CL team. In this situation, the PCT or bedside RN performing constant observation will be provided with the TELE CL RN contact information in case further assistance is required.

2. Staff Support Role: Given the increasing level of distress and challenging work environment for bedside RNs, the TELE CL RN has the opportunity to provide Psychological First Aid. All the TELE CL RNs have experience as psychiatric RNs and are fluent in supportive interventions. They will also remind RNs that psychiatry CL is available to assist with agitated patients or any challenging behaviors. They are also available as clinical resources for delirious or other challenging patients.

Jennifer Brandstetter, MD, 4/3/2020

This is a pivot on the topic but I am interested in the sitter policy for COVID+ patients. We are starting to have more patients here in Cleveland and planning policy is stating no sitters for COVID+. We have options including rooms with windows, we have 2 units with video monitoring. So far we haven't encountered a case that couldn't be accommodated but I anticipate we will.

Thanks for any input you have,

Eli Bader, MD, 4/3/2020

At Mount Sinai Chicago, we have decided to do a similar setup. Given the crisis situation, provider safety is paramount. We have a medical unit with isolation rooms with large bay windows in which we will move patients with or suspicious of having COVID who require observation for psychiatric reasons.

Cathy Crone, MD, 4/3/2020

They have been having the sitters right outside of the patient's room with door closed and a portable video monitor is placed in the patient's room. The sitter gowns up if something is happening that they have to go in. Our patient rooms have windows so the sitter can watch them this way. Apparently there was some sort of presumption that a sitter would be sitting in PPE in a patient's room for 12 hours but the director of sitters rightfully said this was not appropriate

Avram Mack, MD, 4/3/2020

For those who perform in-room observation of COVID+ patients they use appropriate PPE and then limit the time to 90 min per observer.

David Kroll, MD, 4/3/2020

It's also important to emphasize that the inoculation size of the exposure (i.e., the time of contact or "dose" of the virus) is increasingly understood to be correlated with mortality risk in healthcare providers. Medical teams at my institution are now being instructed to take their histories with inpatients over the phone, then go in very briefly to do the exam as quickly as possible and remain in the room for no more than 5 minutes. Considering that a psychiatric evaluation typically takes much longer than 5 minutes, I can't imagine that expecting a psychiatrist to do this all in person is consistent with what is being expected of other medical teams.

Priya Gopalan, MD, 4/3/2020

Such great discussions on this.

We more or less told people what we were doing (rather than asking permission). If needed, there are studies showing outcomes equivalency on telepsychiatry compared to in-person care for outpatient and other settings, if anyone gives pushback.

The argument that I have found to be the most effective is framing this as 1) staff preservation and 2) socially distancing our own service to try to protect patients. Hard to argue either.

We are following a rotation model similar to Dr. Caravella's, which we started this week. So far, it has worked well.

Kristin Beizai, MD, 4/3/2020

An issue we are having is that then the Med/Surg RN either has to stay in the room for the duration of the interview or go in/out 2X which increases use of PPE-

This is causing a lot of tension/distress

How are people handling then getting the equipment out of the room?

Blair Walker, MD, 4/3/2020

Wise words Wayne,

We are doing similar types of workarounds as well--we have windows too, now we have ipads, so we may tele through window to eyeball then pivot to bedside phone if we can and its a televideo visit rather than just telephone. Ive also done phone call while standing outside window, we have no visitors in our hostpial system (or very few exceptions) so confidentiality less of a concern and that works well too!

Push back at your admin Avram--what a waste to have on psych doc overrun for a few weeks then completely out of commission or dare I say it sick and dying potentially. Remind them of rational and responsible use and protection of resources. Our going remote saves PPE and keeps psych docs who are hard to replace readily available remotely. I suspect you are dealing with a lot of understandably emotional administrators who are panicking and maybe dont have great doctor leadership way up high in the system to take charge, calm down and use rational rather than emotional mind. THis has been completely off the charts stressful for everyone so I hope they calm down and see reason. Ultimately they cant make you stay in house, Im betting they really value you if they are trying to get you to stay. Just SAY NO, I doubt they would fire you in current circumstances, esp if you explain the entire Psych C/Lwork force nationally has been pulling to remote--standards of care and all should help the argument.

We started with everyone panicking when I floated the remote idea that psych was going remote a week ago monday, but then things changed so fast that now they are going to remote in the critical docs from ICU down to ER etc to minimize PPE (thanks to the ipad donations we've gotten!!). SO now there's no pressure or concern about us doing it, all realize the expert workforce must be preserved. I assuage

them by explaining if absolutely need ill come in for a certain case (bc my group is willing to do that and are not in high risk categories, anyone who is will not be allowed to go in). The psychology of that makes them feel better!

Dev Thakur, MD, 4/3/2020

One thing we have discussed but haven't implemented yet -- and of course this only applies to patients who have the technology, but many do -- is calling the patient in the room and telling them to download Zoom, and then evaluating them via their own smartphone. This of course would involve documenting that informed consent regarding this process, including discussion of privacy limitations, was done.

Tom Blair, MD, 4/3/2020

HHS/OCR has specifically permitted FaceTime/Skype if used "in good faith" and failing other options --

<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19>

And yes, to colleagues who are being compelled to do everything in person -- that is very clearly inconsistent with the standard of care right now, and as much an ethics-and-liability issue for us hurting our patients and/or wasting PPE as it is a matter of our own safety.

And -- thank you everyone for all of the very helpful input and coordination. The mutual support is much needed right now.

Chris Ryan, MD, 4/3/2020

A few brief comments from Australia

1. Dev, we are doing the call the patient via their mobile or bedside phone and talk them through the Zoom process. That is working well. (Its pretty easy. I did it with a clearly psychomotor retarded woman with depression yesterday. Seemed to brighten her up!)

2. We have been told we can't use Zoom, FaceTime etc. Instead we have to use the approved, privacy protected, bespoke program that is coming (in the way it seems that Christmas is coming). We have said we will use it when it comes ... and have then continued to use Zoom etc while waiting. (We have not mentioned this second part. Never has the epigram "better to ask forgiveness than permission" been more true. (The administrators are all overwhelmed and too busy to notice what is happening on the ground. Anyway, if they want to fire me ... I'm sort of fine with that right now).

3. We have also been told we can't work from home until it is approved, and a proper form is signed off, or an occupational health and safety inspection of the home office occurs. We rapidly instituted a split roster where only half the team (we may soon go to a third of the team) is on site. I may have forgotten to go through all the appropriate processes on this. Better to ask forgiveness ...

We are still several weeks behind you but our thoughts are with you.

Dev Thakur, MD, 4/3/2020

Thanks for your comments, Chris. The home inspection sounds, honestly, most absurd. Physicians can't be trusted to have one clean, quiet, private space, with an internet connection? The inspection

requirement is infantilizing! I completely understand seeking forgiveness rather than permission in such a case.

Dahlia Saad Pendergrass, MD, 4/3/2020

We are trying to move towards more video monitoring for our patients who need 1:1 observation especially given what we now know about duration of exposure. Curious what you have all done to shift and whether there are clear guidelines/policy for who is/is not a candidate for video monitoring vs. in-person.

Meghan Sheehan, MD, 4/3/2020

Here are our current guidelines. That said, I can envision a surge severity in which this would not be practical. I think it's a fair approach for now.

Clarifying e-mail on the use of sitters for COVID coverage. The reasoning is three fold: preserve PPE, maximize resources, minimize safety concerns.

1. **COVID positives and rule outs** who need sitter coverage **SHOULD** always utilize video monitoring.
2. **COVID positives and rule outs** who cannot be monitored via video will have a Patient Care Tech (PCT) or extender from the flex pool assigned.
3. **COVID positive or rule outs** who are also a **1:1 high risk suicide precaution patient** will have a (PCT) or extender from the flex pool assigned. The RMC and Flex Pool group will do our best at choosing the most effective resource available, this may be a PCT or extender already on your unit. Here is guidance from TJC about slight modifications from protocol for this population:
 - a. TJC is not waiving any requirements to have high risk for suicide patients under continuous observation with the ability to immediately intervene though the use of 1:1 observation. The observer must always have full continuous view of the patient and be able to intervene without delay if necessary. It is permissible for an observer to be outside the room, but the 1:1 observer must be able to maintain full continuous view of the patient, with the door closed and be able to intervene without delay when necessary. The observer would have to maintain the appropriate PPE to ensure entry into the room without delay when necessary. If this is not possible, the 1:1 observer would have to remain in the room, with the door closed, donning the appropriate PPE with full continuous view of the patient and within a distance to be able to immediately intervene if necessary.

Essentially, the observer may sit outside a room with a window so that the high risk for suicide patient is in constant view of the observer. The observer would be required to be wearing PPE so that they could immediately intervene if necessary.

Rationale for proper sitter use and use of PCT and Extenders: PAT's cannot provide direct contact care for the patient. Under their current scope of practice a PAT can only monitor and redirect, for any cares they have to call for assistance meaning (PCT, RN) another person will then have to put on PPE to enter the room.

4. **General population (non-COVID)** requiring sitter, consider video first and place PAT as secondary choice if physical presence is required. If PAT is unavailable use PCT or extender.
5. **General population (non-COVID)** for **1:1 high risk suicide precaution patient** requiring sitter, place PAT as physical presence is required. If PAT is unavailable use PCT or extender.

We will do our absolute best to co-locate the **1:1 high risk suicide precaution patient** on 7UT where visibility from the outside is feasible. Teams should work with their providers/Psychiatry to ensure patients truly are considered “high risk for suicide” from the clinical perspective and not screening alone. If providers/Psychiatry do not believe they require 1:1 and are not “high risk”, this can be documented in the record and avoid unnecessary sitter use and expose risk.

Avram Mack, MD, 4/3/2020

It will be interesting to hear about other children’s hospitals as we care for patients of many types who normally have behavioral dyscontrol and sometimes need to be redirected or restrained.

Kelly Saran, MD, FRCPC, 4/3/2020

Dear Friends,

Our regional (BC) Centre for Disease Control just released some documents that may be helpful to you.

<http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/ethics>

Ethics

The information on this page is provided to inform health care workers of their ethical duty and to support health care organizations and teams in making challenging decisions.

Ethical decision-making

The ethical decision-making framework, and underlying principles and values, provides an interim process to support health care organizations and teams to make challenging decisions in a COVID-19 outbreak.

COVID-19 ethical decision-making framework

Duty of Care

The ethical analysis focuses on the duty of health care workers in circumstances where there is a risk of harm to their own person.

What is the ethical duty of health care workers to provide care during COVID-19 pandemic?

Stay safe!

Khyati Brahmbhatt, M.D, 4/3/2020

Hello Everyone,

I am very glad to have this resource and the collective wisdom of the group. A lot of what has been shared is similar to what we are seeing in pediatric settings too. Given the different realities of pediatrics I would agree that it would be interesting to see how this impact pediatric settings.

I am leading the collection of information and formation of a database of COVID-19 related patient parameters and service related parameters with the help of the Physically Ill child listserve of AACAP (CAP CL listserve within AACAP) and collaborators at NIH (Maryland Pao and Lisa Horowitz) . I have CCed them here.

If there is an interest in collaborating on a similar database for adult CL settings - would love to discuss this further.

Hope you are all getting some rest and keeping well.

Take Care

Gita Ramamurthy, MD, 4/3/2020

In our hospital, we have arranged to have 1:1 sitters observe the patients from outside the glass except for rare circumstances in which patient is so likely to attempt suicide in their room, the sitter needs to be within arm's distance from them. (So far, I've never had a case so severe that such an acutely suicidal patient wasn't sedated). If the patient has COVID-19, the sitter has easy access to an N95 mask if they need to rush in while calling out to staff.

David Kroll, MD, 4/4/2020

Dahlia—right now (as far as I know) we have not resumed video monitoring for suicidal patients despite the current crisis, after the joint commission came out discouraging the practice last year. However, I can offer a little insight because the Brigham and Women's protocol for it we published last year is still the only published virtual suicide monitoring protocol I'm aware of:

<https://www.ncbi.nlm.nih.gov/pubmed/30665667>

Basically, TJC's position is that video monitoring can't be used for "high risk" suicidal patients, unless as a backup, but can be used for "low risk" suicidal patients. They did not explicitly define what constitutes a high risk versus a low risk patient, however. Some institutions have protocols that use the CSSRS to determine high-risk versus low-risk, although I don't think any of those protocols are published. In our protocol, we separated patients by impulsivity risk rather than suicide risk and found that it is "feasible" to use video monitoring as a stand-alone practice in low-impulsivity patients (proving efficacy would be very difficult from a practical standpoint), but so far TJC has not adopted that language. And because TJC's instructions are vague, our hospital decided to discontinue the whole program for the time being.

So a couple of thoughts about being in compliance with TJC on this, if you do choose to use video monitoring:

1. For most indications other than suicide, there is no problem. This includes delirium, substance abuse, falls, etc.
2. Video monitoring can still be used as a "backup"—I think this means that if you have an observer outside the room and video monitoring in the room this would probably be fine, although this would still be open to interpretation
3. "low risk" suicide patients are still considered ok per TJC, but there is no clear definition of a "low risk" suicide patient

Dahlia Saad Pendergrass, MD, 4/4/2020

This is extremely helpful, thank you! Video monitoring for delirious patients, substance abuse and fall risk alone would be a huge protection for many of our PCA's.

As for the suicide risk patients, especially the low suicide risk patients, the idea of using the CSSRS is a great one. Do you know if there is a different stance on VM from right outside the door vs. a separate area on the floor eg. Behind the nursing station?

It just seems to me that a PCA, fully ready in PPE (gowned, gloved, w mask, and shield in place) and sitting right outside the door watching a video feed on the workstation on wheels (WOW), would be equivalent to one present in the room. This is especially so if they are wedged into a far corner of the room and distracted by fear of getting sick.

In addition, the WOW can be turned to ensure privacy ... and current visitor restrictions make the issue even less of a concern.

In all cases, this is very helpful ... thank you!

Chris Ryan, MD, 4/4/2020

Since “high risk” and “low risk” in this context mean exactly nothing, or rather, to use a more precise phrasing, there are no clinical or demographic features (or combination of features) of inpatients in psychiatric crisis that can be used to usefully classify them by their likelihood of future suicide, then the TJC’s position (as you state it) seems meaningless. In addition, of course, the position could not have factored in considerations relating to the risks associated with COVID-19.

I’m in Australia. We don’t have to worry ourselves with the TJC’s position. However, given its content and the current situation, I suspect it should be given scant regard.

(re assertions on risk assessment, see for example: Ryan C, Nielssen O, Paton M, Large M. Clinical decisions in psychiatry should not be based on risk assessment. *Australasian Psychiatry* 2010; 18: 398-403; Large MM, Ryan CJ, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? *British Medical Journal* 2017; 359: j4627)

David Kroll, MD, 4/5/2020

I think it would be very difficult to ding you for placing a PCA outside the door, although keep in mind that most video monitoring platforms use a centralized telesitter to watch multiple feeds at once (so the PCA in this case might be outside the door, in addition to the centralized sitter).

One concept that I have seen come up at mock TJC audits (but not clearly at actual TJC audits) is the idea that the sitter should be at “arm’s length” from the patient at all times. I have never seen this documented in any TJC guidelines, and there’s no evidence basis to support it (in fact, I think it runs counter to the sitter’s purpose, which is to observe and not to try and intervene since they are not trained to do so), but some individuals policies will refer to it. It’s not something we do at my institution.

Cathy Crone, MD, 4/5/2020

Not sure if this would be helpful but it came from my hospital system’s COVID updates:

Telesitter Guidance

The Joint Commission provides the following telesitting recommendations for COVID-19 patients requiring observation:

- If outside of the room, the 1:1 observer must be able to maintain full continuous view of the patient, with the door closed, and be able to intervene without delay (after donning PPE) when necessary.
- If this is not possible, the 1:1 observer would have to remain in the room, with the door closed, donning the appropriate PPE with full continuous view of the patient and within a distance to be able to immediately intervene if necessary.
- If using video technology, please be sure the live feed is not recording and the monitor is close enough to allow the observer to intervene without delay after donning PPE.
- Toileting and other activities unable to be visualized will require the observer to don PPE and remain alongside the patient.

Melissa Smith, MD, 4/8/20

Is anybody still seeing routine consults in person? Or is everyone going to tele regardless of PUI or Covid + status

Julie R. Owen, MD, 4/8/20

Melissa, I am an embedded psychiatrist in our academic medical center's ED. I am still seeing all consults in person.

Blair Walker, MD, 4/8/20

Melissa—we have a hybrid model in our teaching hospital here in Austin— we rapidly deployed iPads for tele, but are available in person if needed, and I've continued to go in as Chief even just for a few hours a day multiple times a week to check in with each unit, say hi and see a couple patients often that the learners have seen first via iPad. Still pulling back to mostly tele though where we can—this being said, we've not hit anywhere near a surge yet, but the numbers are increasing every day...I am also not planning to actually enter any covid rooms as we have windows and phones etc though I've just redone fit texting and don/dogging training bc you never know...

Avram Mack, MD, 4/8/20

I can't understand why no one has developed robots To do the "final yard"!

Michele Wang, MD, 4/9/20

I actually have a similar question. At my hospital they got some extra iPads and are allocating them to different services for tele. My understanding is that it's only for covid/rule out covid patients at this point. We are running into some difficulty because the RN/staff don't want to set the equipment up for psych (maybe because our interviews are longer?) although it doesn't seem like other consult services are getting the same type of pushback. I was wondering how this was being handled at other hospitals. Also I heard that the iPad stands are sold out. Does anyone have other creative telehealth methods? Is there a rule that the Rn/staff need to be in the room during the interview? Or can they leave?

Kanak Masodkar, MD, 4/9/20

Yes seeing in person. I am solo psychiatrist doing CL and ER.

Priya Gopalan, MD, 4/20

This hybrid is what we are doing in Pittsburgh, as well.

Cathy Crone, MD, 4/9/20

We are doing various forms of distance or telemedicine consults on as many cases as possible not just PUI or COVID. Realistically we realized we are potential vectors given that we are in so many spots in the hospital and the issue of asymptomatic cases

Raymond Young, MD, 4/9/20

We do not expect any staff to be in the room during the interview. If the Ipad are how other services are seeing patients, does the nurse bring in the Ipad and retrieve it? Is there the possibility of a unified protocol across departments so psychiatry is not treated differently?

At two of our hospitals we are seeing non COVID patients in person. For patients that are PUI's or COVID+ we are utilizing telemedicine when we are able and if necessary onsite assessments. At one hospital (Emory St. Joseph) we have been using telemedicine for all consults since 2017.

Jennifer Brandstetter, MD, 4/9/20

We have been seeing consults in person unless COVID+/PUI but generally maintaining 6 feet when seeing except for needed exam

For COVID/PIU we are using zoom/phone if possible, but there have been a few where we have needed to go in and see with full PPE

Jon Levenson, MD, 4/9/20

Worth noting that in the past few weeks I have had two oncology consults who were in hospital for oncologic treatment (one who had an elective surg onc procedure and the other a chemotherapy admission) both of whom spiked a fever later during their hospitalization and then tested covid+. So perhaps it is best to think of and approach all consult cases as potentially covid + which argues, I think, for a telepsych consultation model whenever possible.

Jennifer Brandstetter, MD, 4/9/20

Yes, it is a concern, especially because testing is still limited in Ohio. We are looking what our options are to move to more telepsych but this is how we have been managing for now. Hoping we can increase testing as well as technology access for more telepsych

Brian Skehan, MD, 4/9/20

We have moved to all telepsychiatry with the exception of emergent crises and even some of those are triaged by phone if the primary team is available. We have tried to schedule consults with the primary nurse and have them bring the equipment in to the room at a time they have to enter for other needs (i.e. medications or food delivery) to limit PPE use. We are scheduling all routine consults (regardless of COVID+ or PUI) via tele as well to limit the amount of time in the room with patients as our evaluations tend to take longer. Time spent in close proximity seems to increase exposure risk and we want to limit our transmission to non-covid pts. Also, as others have mentioned, we are anticipating that even some of our non-PUIs may be asymptomatic or presymptomatic but want to avoid using PPE such as N-95s when they aren't necessary or warranted.

Very similar to Dr. Caravella's protocol below although we do not have the same amount of support staff so need to be more strategic with triage to chart review/teleconsult/in person consult

Melissa Smith, MD, 4/9/20

I know ERs have patient coordinators who usually meet patients to get ID, insurance, etc.

Any thoughts on piloting a project where we get the coordinator or patient advocate to ask if the patient has a phone, if they're able to download zoom or use FaceTime and also consent to tele? It might be a way to increase availability of tele and safety if the patient is able use their own phone. The limiting factor will be chargers to actually keep the phones charged..... but maybe also a way to screen for equipment needed like chargers.

Is any hospital doing this type of thing now? An opt in from day 1 vs waiting for the need for a teleapt later.

Work arounds for the chargers-

There tend to be lots of chargers in lost and found. I'm not sure about distributing random potential fomites though- maybe they can disinfect and put in a "clean" container .

Also, lots of people in the community want to know how to help. Maybe even having a phone charger drive for patients could be an initiative?

This may allow more telepsych even if an iPad on wheels not available.

Obviously, this wouldn't be appropriate for every patient if they're too delirious or psychotic to have their phone. Also, a long charger cord is a no no in an actively suicidal patient too potentially, but they could still be screened in the ED for the phone/ charger, zoom downloaded if wanted and then if their SI resolves and it's safe, give them their phone and the charger later.

I'm just thinking of how to increase tele availability without the delay of obtaining iPads or laptops.

Megan Press, MD, 4/9/20

We were asked to see a patient 3 days ago who was in the hospital for non-respiratory complaints. We did a tele-interview as is our current practice for all consults now. 2 days later, he returned for cough and was admitted COVID+. Assume everyone has it. Including us.

I would also add that tele and in-person aren't mutually exclusive. If you feel that you need to eyeball someone to answer the consult question, consider completing the majority of the interview by phone or video. Then go eyeball them. 3 minutes in the room is better than 60.

Stephen Kramer, MD, 4/9/20

wondering what people's experience thus far has been with psychiatrists becoming covid positive and/or sick while working in the hospital seeing patients. In our hospital quite a number of residents and attendings have become covid positive and also ill. We had been trying to implement tele psych with mixed results and a fair amount of resistance from the rest of the hospital

Kelly Saran, MD, 4/9/20

Advocating (at our site, your site, every hospital) for a connected smart device (iPad, tablet) in every hospital room in the same way there is the standard of a telephone in every room.

David Van Norstrand, MD, PhD, 4/9/20

At Lahey in Boston we are doing a mix, as it seems most people are. For the two EDs we cover, we instituted I pads and now do all evals remotely using the app Vidyo. For the hospital, it is a mix of phone versus in person since we haven't gotten our hands on any ipads. I've also started to rarely (if I'm confident in my recs after chart review and team discussion) utilize the 99446-99449 interprofessional consultation codes for "curbsides" which is a time-related code.

To your other question about patient phones: we have formalized a protocol where the patient downloads Vidyo to their phone and we send the link to their phone from a "dummy" Lahey account which allows us to interview using their phone. But given our volume of older patients, particularly with delirium and flip phones, we haven't been able to do proof of principle yet.....

My question to the group is what conversations have been like with the front line teams about this move towards virtual evals. I've heard from hospitalist staff that given the move towards virtual evals they're feeling somewhat abandoned on the front lines, and I'm curious how you've engaged in that, even though we would agree in principle that conserving PPE for the staff (we're running low on gowns) and conserving an available consult team (ie if we get sick they're out of luck for consults) are key reasons to do it. (I ask in part as I'm tasked to lead a virtual staff support group next week.)

Stacey Heit, MD, 4/9/20

Our psychiatric staff is 100% telemedicine. We got push-back from nursing about taking iPads into the rooms, so we are using our hospital's "supplemental" staff (such as surgical techs who are otherwise not able to work right now), to be the Ipad transporters. We also have LPC's and LCSW's at the hospital, but

they are working from offices and also using supplemental staff to transport iPads for their assessments. Our hospital has provided us with 2 designated iPads.

Seema Quraishi, MD, 4/9/20

I assess as much as possible by phone calls to nursing, internal medicine, etc. to determine if the consult absolutely requires an evaluation while the patient is in the hospital. If so, then I will ask staff to take the iPad to the room for non-PUI and non-Covid patients. I have not yet had to ask staff to go into a Covid+ room and am not sure what I will do when that comes up. May have them hold iPad to window or from doorway. I have a high bar for what I will consider a psychiatric emergency.

Here at Mount Sinai Beth Israel in New York, we have run into similar difficulties with the set-up of the patient facing iPad. Our approach to ALL consults regardless of COVID/PUI status is to perform a curbside, tele-psych, or telephone interview - in that order. Each COVID unit has their own tele-health machine which uses InTouch as a platform. In the event that staff on patient facing side unable to set up or machine is unavailable, we bring our own C-L patient facing iPad on wheels. We have a rotating schedule for one designee on each C-L team to don/doff PPE and place the unit in the patient's room. The schedule rotates each week between one resident, fellow, or attending on each of three teams. The designee will take our iPad into the room, wait outside, and then return to retrieve the tablet when interview is done. Our official guidelines and workflow are in the member resources section.

Eli Bader, MD, 4/9/20

At the Sinai Health system in Chicago (Mount Sinai Hospital and Holy Cross Hospital) we have one telepsych device on wheels that is available and utilized at the CL provider's discretion. Floor staff (whomever is available) is enlisted to coordinate minimal exposure and evaluations are timed (as much as possible) to coincide with rounds. The CL provider brings the device to the unit and initiates the call from their own device. The floor staff does not have to remain with the device, and once the encounter ends, it's retrieved when convenient for the floor staff (again, whomever is going to see the patient next). This does cause some delays, but it's been tentatively accepted by most units.

Rachel Caravella, MD, 4/9/20

Regarding colleagues feeling like we might be absent:

At NYU, we decided to implement proactive, virtual rounding at the same time as our TeleCL protocol went live. Our CL fellow and PGY2 resident reach out to the medical directors of the hardest hit units (~8 units) daily by phone or however the medical director requests the contact. We strive for consistency and predictability. We simply ask how it's going on the unit and if there are any patients they are concerned about from a psychiatric perspective. From there, sometimes a conversation develops and sometimes they identify patients. This allows us to maintain some of the liaison relationships, take the pulse of the staff daily, remind them that we are virtually present and still accessible. Clinically, we can identify patients at risk for agitation (elopement, violence, delirium, etc) which teams appreciate. In addition, our Tele CL RNs consist of redeployed psych RNs from our inpt psych unit that has been experiencing low census. The Tele CL RNs' role has expanded to include "on the ground" psychological first aid to their med surge bedside RN counterparts. They are enthusiastic about using their therapeutic skillsets to contribute in this way. They checkin with their colleagues when they bring the iPads around.

These two interventions have seemed to really help colleagues feel that we are present. We are adapting with each day and trying to keep up as best as we can with the needs of the patients, the staff, and ourselves.

Jennifer Knight, MD, 4/9/20

Logistical question – where are folks storing these ipads in between uses? Is who is accountable for them if no CL folks are present, or do the CL folks come on campus to move the ipads around??

Colin Harrington, MD, 4/9/20

We here at Brown / RIH are engaging visual contact thru windowed rooms, phone visits, and iPad Zoom visits. While making all efforts to minimize unnecessary contact and risk - we continue to see patients face-to-face as indicated. The face-to-face cases serve as a reminder of the importance, relevance and therapeutic value of our regular work.

Allison Deutch, MD, 4/9/20

At NYU's Main Campus we always have a single attending in-house. We rotate weekly so there is never more than one CL psychiatrist in the office but always someone present for cases that require in-person consultation (these days, that seems to involve only behavioral emergencies). We do have a lot of support staff so both of our iPads are in use during the day, cleaned with an alcohol-based sanitizing wipe after each patient use and before they are stored for the evening in our office (requires badge swipe access to enter). At our downtown location, finding a place to store the iPad was a bit more challenging but were able to identify a location through the help of nursing leadership.

Gita Ramamurthy, MD, 4/9/20

I am interested to know what you are doing for screening COVID19 among psych inpatients admitted to the psych unit. Given that these patients are not sequestered to a room, but rather are walking about (and often ignoring the 6 foot rule), we would like to rule out covid19 as much as possible. However, testing is limited. Testing sensitivity is also not optimal - 70% I believe, which means false negative is not uncommon

Right now, our policy is
test everyone with resp/GI symptoms once
test pt recovered from COVID19 with 7 days asymptomatic twice
Ideal policy: (to me)
test everyone once even if asymptomatic
test everyone with resp/GI symptoms twice
test pt recovered from COVID19 with 7 days asymptomatic twice
I'd like to know what other hospitals are doing?

Dustin DeMoss, D.O., M.S., 4/9/20

Our process is to check temperatures before they step onto our psych ER floor and 3 times per day on in-pt units. If an incompetent person has 2 or more readings above 99.0 AND 1 or more COVID symptoms (or other related risk factors), we direct admit to our medical hospital for COVID r/o. For immunocompromised people, its 2 or more COVID symptoms.

Alba Pergjika, MD MPH, 4/9/20

It's been very helpful to read everyone's experience, and my question is about signing consents and documents with telehealth visits.

We are a Children's hospital and need parental consent and forms signed prior to inpatient psychiatric admission. We've had a couple of situations where the child has tested COVID negative but the parents

have cough/fever (uncertain COVID testing and clinical status). We're being mindful of bringing symptomatic parents into the hospital just for signatures. We're able to obtain verbal consent from parents but I don't think the laws have relaxed on verbal = written consent. Has anyone else faced this situation and what solutions have you arrived at? Thank you in advance.

Colin Harrington, MD, 4/9/20

Currently:

- All rooms converted to single on our units
- Scheduled time on unit for smaller numbers with spacing
- Masks, droplet precautions and room restriction pending testing for Sx patients
- Transfer to medicine for COVID positive patients – with CL managing
- Discussing masks for all – evolving – ligature issues
- Hospital as a system discussing testing ALL patients admitted to any unit as kits become more available
- Hospital surge plans also include converting 2 of our 3 psych units to medical units as needed
- A challenging balancing act re care of psychiatric patients (COVID pos or neg) alongside the surge

From CL side:

- Most recent DOH policy appears to be mandating 2 neg tests before d/c back to community facilities – regardless of asymptomatic status or completion of 14 day quarantine (challenging for some chronically ill patients who are largely recompensated but who refuse the latter swab)
- Fast moving policy changes

Gita Ramamurthy MD, 4/9/20

Dear Dr Pergjika, I'm finding myself curious about software like docusign - ie electronic signatures to replace in person signatures, but I dont know what our county mental health dept will think of it.

Michelle To, MD, 4/10/20

I am so glad we are talking about this!

Our inpatient unit started universal surveillance testing for all inpatient psych admits. It was a bit of an uphill battle but the Washington Post [article](#) about the medical disaster that happened in a South Korean psych hospital helped make the case to our leadership. We were able to successfully test all 46 patients in one day, with 100% compliance. We have a rapid 2 hr test (with limited capacity) and a slower 24 hr test. We reserve the rapid test for patients waiting for an open bed and use the slower test when the patient is expected to wait in the ED because of no open beds.

This all started two days ago, and we have now encountered our first patient on CL who needs transfer to psych but is refusing the test based on delusions. We consulted ethics about whether it is OK to test over objection. The answer was yes if the patient lacks capacity, and probably yes if the patient refuses and does have capacity. We felt he clearly lacked capacity, and proceeded with administering sedating meds and then swabbing the patient.

It's still a work in progress. We are definitely concerned about the safety risks imposed upon nursing staff who administer the test and need to develop protocols to mitigate that risk, eg. calling on standby assist from additional MH nursing staff.

We'll need to develop general policies about testing over objection especially as many nursing homes are requiring negative tests even after patients complete a 14 day quarantine.

Alba Pergjika, MD, 4/10/20

Dear Dr. Ramamurthy

Great suggestion. I should have prefaced that our hospital currently does not support docuSign, which we have been asking for.

Gita Ramamurthy MD, 4/10/20

In our hospital (upstate NY), the int med teams are getting verbal consents witnessed by nursing.

Thanks, Gita

Ethical Issues (3/28/20)

Mary Ann Cohen, MD, 3/28/20

While being inundated by patient, trainee, student, family, and friend questions about COVID-19, I have thought and tried to find ways to provide support and at the same time educate as best I can and am pleased to share. What I have found:

In addition to the ACP, NEJM and CDC, there are two videos that are helpful.

1. A talk to family and friends by Dr. David Price, ID specialist at Weill Cornell Medical Center - superb for patients as well as all of us

<https://vimeo.com/399733860>

2. American College of Physicians Web Page

3. NEJM March 27, 2020 issue - see below

I received a question that is disturbing to me as a C-L psychiatrist with a special interest in bioethics and here it is - a question on allocation of scarce resources that I thought I would never see again as we did in the early 1960s at a time when there were only two dialysis units in the United States and values were put on human lives.

Here is the question from a member of our SIG: "Wanted your advice on how to talk to patients and family that will not receive life saving treatment for COVID 19. We are preparing for the surge of patients this week and I will be the designated member of the Committee to discuss that event if it happens. We certainly hope it does not happens but need to be prepared for the worst."

Peter A. Shapiro, M.D., 3/28/20

This is a horrific scenario that was discussed by Ezekiel Emanuel in a NEJM paper last week, widely cited in the news media. There should be a separation between the administrative and therapeutic roles. The person who has to deliver this news to a patient and family should not be the same person who is providing therapeutic support. There should be clear-cut policies laid out a priori that guide decision-making about individual cases. Family and patients should be made aware of these policies in advance of the worst case scenario coming to a head for a specific patient. The staff person who has to be informing a patient or family of a triage determination to limit care will likely need emotional support him- or her-self.

Lisa Rosenthal, MD, 3/28/20

At Northwestern a committee has been formed of 12 diverse leaders to create guidelines for allocation of care and decide on individual cases in a blinded review. In addition, there are twice daily multidisciplinary Covid rounds involving palliative care and multiple other teams to assist with family and patient communication.

However, we have not yet hit surge, so it is not clear if these preparations will be adequate. We have multiple back up teams including the CL team, to step in and support front line providers as possible. I completely agree that an individual should not have to determine allocation of care and communicate that decision to the patient and family.

A palliative care group has created these scripted responses, which I find fairly helpful. The very horrible scenarios are included about 2/3 of the way down the page.

<https://www.vitaltalk.org/wp-content/uploads/COVID-Guide-English-1.pdf>

We are still trying to figure out how we will help all of our healthcare providers in the moment as well as in the aftermath of these traumatic events. It seems to me that the epidemic of burnout is now also going to be a pandemic.

Loretta Y. Howitt, MD, 3/28/20

There is an excellent JAMA live stream interview with Dr. Douglas White who has been doing this work for a lifetime, Pittsburgh guidelines are easy to find on Ccm.pitt.edu

Mary Ann Cohen, MD, 3/28/20

Thank you to Loretta, Peter and Lisa.

Appreciate your comments and here are some of my thoughts:

1. Using a C-L model, have a virtual meeting with all the important players: infectious disease, pulmonology, intensive care, emergency care, internal medicine, risk management, administration, medical student education, bioethics chair
2. Lead a discussion of what resources are available and what a reasonable time line is
3. Plan for a second meeting with a representative of local or state government - councilperson, state representative, health commissioner
4. Determine whether resources are accessible and available and when you will have them
5. Ensure that open lines of communication are available for all departments and systems involved
6. Educate on all shifts
7. Do not create a policy or a method that may serve to reify and give permission for the "worst" to happen - plan for a realistic future when respirators, eye shield, protective gear, and ventilators are available in adequate supplies for all
8. Once adequacy for meeting the needs is established, then you may be able to plan for future better disaster readiness in the same way that NYU Langone may have had to when they realized that having an emergency generator below ground led to flooding and loss of power in a hurricane and Mount Sinai had to find better ways to cover surgery than having one overworked intern taking care of 34 post operative patients leading to the death a healthy young man died post-operatively after he provided a part of his liver to his brother.
9. Provide the necessary support and care for patients while at the same time teaching patients and to advocate for themselves while you provide a role model for the advocacy so desperately needed in the market driven world of business models as surrogate for medical care
10. Do not settle for rationing of scarce resources in advance or that may serve as a self-fulfilling prophecy

Meghan Sheehan, MD, 3/28/20

We will have a panel of 5 making the decisions 24/7. I will serve in one of the ethics positions. The 5 are comprised of critical care, 2nd physician/ethics, RT, pharmacy, and nursing.

We are working on scripting for these conversations.

In addition we are considering moving to a presumed DNR/DNI.

Finally, we are working on a concept I'm calling "Altruistic Deferment" of care. I'm thinking of it as an addition to DNR/DNI, and as a part of advanced care planning. The idea would be to have an option for patients who would normally choose medical interventions such as mechanical ventilation, but, in the setting of scarcity of resources, they would prefer to pass the use of that resource on to others, for the chance of betterment of care for others.

There could be ethical concerns, like if the person wanted to specify a recipient (wife lower on list but wants to give to her over next person). Or only wanting to give to a kid.... I think it would need to just be a blind opt out system in a time of scarcity.

Any places looking at doing something similar?

Anyone know of historical precedent?

Agitation (3/29/20 – 4/10/20)

Michelle To, MD, 3/29/20

For those of you working in hard hit areas, can you please share your experiences with treating agitation and delirium in patients with COVID19?

Kavitha Raja, MD, 3/30/20

We have had a lot of patients who are coming off weeks of mechanical ventilation from COVID pneumonia and having a hard time weaning even with low O2 requirements. Considering many other comorbid conditions, I have tried managing the anxiety/ agitation/ delirium with low dose antipsychotics (Zyprexa/ Seroquel primarily), SSRI (Zoloft mostly), low dose Ativan (when they have been on long term benzos during sedation), Gabapentin and Tenex. Most folks have been on Precedex prior to these trials and many have AKI and prolonged Qtc. Any expertise on this area would be greatly appreciated.

Margo Funk, MD, 3/30/20

I haven't yet seen any COVID+ patients or ECGs yet, but have been hearing about the QTc prolongation. Things I would want to know:

- 1) is QTc actually prolonged when corrected using a non-Bazett formula?
- 2) is there a BBB present from ventricular conduction delay/V-pacing "prolonging" the QT due to wide QRS? (if yes, repolarization may not be prolonged and warrants alternative measure of risk)
- 3) are there other modifiable risk factors that can be changed to mitigate risk?
- 4) consider IV haloperidol?

Maureen Hackett, MD, 3/30/20

My reading from a Chinese published protocol dated 4 March indicates CNS involvement including cerebral hyperemia and degeneration of some neurons. I am going to check the reference list when I can get to my computer and download this if it is not already there. Anyway, have you considered Valproate or is there too much hepatic or bone marrow injury?

Gita Ramamurthy, MD, 3/30/20

Dear Dr Raja, I haven't treated anyone with COVID19 yet. I have found depakote to sometimes be helpful in patients coming off ventilator if they have wide QTc. If liver is ok, its an option (just watch the NH3)

Marianne Jhee, MD, 3/30/20

I had a patient who was COVID19+, and became very agitated and aggressive. Treated with hydroxychloroquine. He responded well to haldol (initially given IV then transitioned to PO). Monitored QTC carefully bc of the hydroxychloroquine, and it stayed <500. Primary team did a sudden taper down on the haldol (not our recommendation) with some worsening behavior, so he's on a much slower taper now. Unclear if hydroxychloroquine contributed to agitation, but unlikely the sole source of delirium since he had already completed the hydroxychloroquine course when he's started acting up again. He has underlying unspecified neurocognitive disorder, no known h/o previous behavioral disturbance

Kelly Saran, MD, FRCPC

Re: Haldol, valproate discussion ... I wonder if the group below is onto something (very preliminary work I understand) as Damir Huremovic (thank you) pointed out ... his message reposted below.

On Behalf Of Damir Huremovic

I was doing a review earlier this week and ran into this interesting in vitro work (with, naturally, a huge translational question mark).

A group of scientists ventured to examine the way COVID-19 proteins interact with our receptors and to see which existing drugs can be used to curb the intracellular replication of the virus. They looked at a lot of them, identified about 70. Among them? Valproate and Haldol. It is a lengthy read, but give it a try.

<https://www.biorxiv.org/content/10.1101/2020.03.22.002386v1>



[A SARS-CoV-2-Human
Protein-Protein Interaction
Map Reveals Drug Targets and
Potential Drug-Repurposing |
bioRxiv](https://www.biorxiv.org/content/10.1101/2020.03.22.002386v1)

An outbreak of the novel coronavirus SARS-CoV-2, the causative agent of COVID-19 respiratory disease, has infected over 290,000 people since the end of 2019, killed over 12,000, and caused worldwide social and economic disruption. There are currently no antiviral drugs with proven efficacy nor are there vaccines for its prevention.

www.biorxiv.org

Valproate blocks HDAC2 (histone deacetylase 2), which was found to be affected by viral proteins nsp5 and E. The role of HDAC2 is largely putative and implicated in cell progression. Haloperidol is an extremely pronounced sigma1 antagonist and sigma2 agonist. Viral protein Nsp6 interacts with sigma1, while viral protein orf9 interacts with sigma2. Sigma1 are considered as chaperone receptors, responsible for protein unfolding in cells and possibly associated with stress response. Sigma2 has been implicated in programmed cell death (apoptosis).

While I don't think Haldol will be instrumental in 'curing' this illness, I find this feature an interesting 'added value' to its use when indicated for patients with both COVID-19 pathology and delirium or other acute behavioral disturbances.

Of note, some other medications that act as sigma1 agonists (potentially 'unfavorable' for COVID-19?) are donepezil (a lot of elderly patients are on it), dextromethorphan (our favorite OTC cough

medication), and fluvoxamine (probably to this day one of Italy's favorite SSRIs). Other SSRIs also have some sigma1 agonist activity (namely citalopram and escitalopram), while sertraline has a more-complicated, dose-dependent relationship (higher doses push it into antagonism). I am not sure what to make of sigma agonism in this current situation.

Another medication of interest, quite promising, is hydroxychloroquine (HCQ). It has a long track record and is fairly safe to use. It does, however, come with psychiatric side-effects, most of which are dose-dependent. Side-effects include irritability, moodswings, possible depression and suicidality, and outright delirium/psychosis. Again, these side-effects are not very frequent. HCQ does prolong QTc.

I am not aware of any significant neuropsychiatric side-effects of remdesivir. I am talking to a researcher doing a case series and they are not aware of anything significant so far.

I hope you find this useful or at least interesting.

Lisa J Rosenthal, MD, FACLP, 4/6/2020

I am hoping to resurrect Dr To's question below.

Has anyone found particularly helpful strategies, particularly in the ICU, for the high level of agitation these patients are having?

Rachel Anne Caravella, MD 4/6/2020

We have been using much more Depakote than usual and at higher doses. Previously, we would use Depakote 125mg – 250mg PRN and up to TID for most patients with delirium without psychiatric histories. Now, we are using anti-manic dosing 15-25mg / kg and in combination with antipsychotics – typically olanzapine or haloperidol.

Clinically, we are seeing an increase in level of agitation, aggressive behaviors, disinhibition.

Michelle To, 4/6/2020

Thanks Lisa for resurrecting this question. We are seeing pretty severe agitation in our elderly patients. I had one COVID+ patient refractory to multiple doses IM Haldol and Ativan that was given in an attempt to sedate him for a CT head.

I'm learning more about using clonidine around the clock to produce calm sedation, to help wean patients off ventilators, or simply to regulate their sleep/wake cycle when given HS. It's an analgesic and anti-emetic agent as well. And can be given as a transdermal patch as well. Here's a nice review: <https://emcrit.org/pulmcrit/ketadex/>

[this link also posted on ACLP Links page]

Philip R. Muskin, MD, 4/6/2020

What about Precedex?

Allison Deutch 4/6/2020

We also use precedex but for patients who are septic and dropping their pressures, or for patients who are not in an ICU setting (ie: those who may have oxygen requirements but who are not vented), we are limited in our ability to use precedex.

I love the idea of using clonidine but have been wary to start with a patch - do you find that patients are tolerant of this? I typically start with oral standing dose then convert to a patch once I demonstrate that patient's BPs can withstand it.

Sharvari Shivaneekar, 4/7/2020

Thanks all for the useful suggestions. Has anyone had experience using ketamine for severe agitation?

Gita Ramamurthy, MD, 4/7/2020

Hi, Allison, doesn't clonidine also drop bp? Or is it less than precedex?

Allison Deutch 4/7/2020

Yes it does! But in our hospital, you can only use precedex in the ICU so it's not an option for our non-icu patients. A previous poster said they use the clonidine patch as an alternative to precedex and my question was about tolerability. I am always reluctant to start a patch without knowing what patients BPs will do. Just wondering if i'm being overly cautious?

Christine Skotzko, 4/7/2020

Clonidine patch can be very helpful,
We use clinically throughout the facility
Pts with hypovolemia are more at risk of hypotension.

Joel J Wallack, MD, 4/7/2020

As many patients are now getting hydroxychloroquine, obviously concern for worsening Qtc prolongation is an issue in choice of sedation. Depakote may be a safe alternative to SGA's for moderate agitation.

Philip R. Muskin, MD, 4/7/2020

Orally both aripiprazole and lurazidone are okay re QTc but neither has a parental formulation.

Vicente Liz, 4/7/2020

We've found the mix of Depakote/Depakene and Namenda to be very useful in these cases. The max for Depakote, depending on their LFTs, is 30 mg/Kg.

Charles Hebert, MD, 4/7/2020

I practice in Chicago at Rush -- our hospital has seen around 1000 Covid positive pts (not all of which are in ICU, however, and not all of which have required CL consultation). Our ICU's are actively using ketamine as well as other interventions for sedation. It's really a work in progress -- a lot of patients are asynchronous with the vent and some of the sedation is being used more for this rather than sedation in the general sense. It's become challenging since the number of needed infusions significantly contributes to volume overload which unfortunately only worsens respiratory parameters. That said, ketamine has been a useful adjunct in some cases.

Jennifer Knight, MD, 4/8/20

Great question. We have actually done a bit of research in this area, some of which I presented at ACLP in 2018. That abstract was a Dlin Fischer finalist, so I am attaching that application here to be able to share more details with folks who might be interested. The full manuscript is currently under review.

We initially hypothesized that tocilizumab would improve quality of life symptoms, however it in fact was associated with worse patient reported outcomes on most of the domains we assessed. In CAR-T patients, toci is associate with worse neurologic symptoms, if anything, but definitely does not help. We think this may be in part due to toci not crossing the blood brain barrier, yet antagonizing peripheral receptors, resulting in an increase in IL-6 effectively communicating with the brain. Happy to share more or discuss further with any interested parties.

[Associated document posted to ACLP Covid-19 resources page]

Catherine Daniels, MD, 4/9/20

I have run into an issue at our hospital - where the hospitalists are reflexively discontinuing antipsychotics on COVID patients being treated with hydroxychloroquine and Azithromycin due to concern about QTc prolongation.

I think that a more reasonable approach would be 1. Looking at other risk factors for QTc prolongation in a given case (ie previous heart disease, K+, Mg++ levels, age, gender, etc) 2. Monitoring the QTc in patients on this combination 3. Strongly consider keeping patients on multiple QTc prolonging drugs on Telemetry monitoring 4. Assessing the indication for the antipsychotic.

If based on the above factors (and maybe there are more to consider!) the benefit of the antipsychotic is felt to outweigh the risk, it would be reasonable to continue the antipsychotic.

Thoughts??

Margo Funk, MD, 4/9/20

Agree with all 4 of your thoughts!

Jennifer Brandstetter, MD, 4/9/20

I agree, sometimes the need for the antipsychotic is greater than the risk of QTc prolongation, especially since this is something we can monitor

Chris Sola, MD, 4/9/20

I agree with everything you said, and would note that Mayo Clinic has published some guidelines for the addition/use of hydroxychloroquine that might be helpful.

The news story:

<https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-provides-urgent-guidance-approach-to-identify-patients-at-risk-of-drug-induced-sudden-cardiac-death-from-use-of-off-label-covid-19-treatments/>

The prepublished article:

https://mayoclinicproceedings.org/pb/assets/raw/Health%20Advance/journals/jmcp/jmcp_covid19.pdf

Maybe helpful?

Eli Bader, 4/9/20

To add a new thought, one could consider aripiprazole, as an alternative, as it's less QTc prolonging.

Chris Sola, 4/9/20

Perhaps if considering which antipsychotic to introduce in a naive patient, I might consider it.

I would be very hesitant to switch from a stable antipsychotic to aripiprazole just for this *potential* benefit.

Chandan Khandai, MD, 4/9/20

Dr. Funk led a workforce on the APA C-L Council that created a resource document for psychotropics and QTc prolongation, that could be of use for further guidance:

<https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents>

Some additional thoughts, in addition to the ones already posted: at University of Illinois at Chicago (UIC), we give a general recommendation to keep K>4 and Mg>2 to reduce risk of TdP.

Catherine Daniels, MD, 4/10/20

The patient who prompted the question is a man with schizophrenia tenuously maintained on Risperidone.

I know that the NYU Group had mentioned using Depakote for agitated delirium in patients with QTc prolongation, and this is certainly an approach that we have used here (Westchester Medical Center, just north of NYC), often with success.

Margo C. Funk, MD, MA, 4/10/20

For the collective radar. Just did first e-psychiatry QTc consult for patient who had been on hydroxychloroquine for 5 days. Please note that the half-life of hydroxychloroquine is 32-50 hours. It will stay around, just like amiodarone.

Gita Ramamurthy, MD, 4/10/2020

thanks, Margo...out of curiosity, are people running into wide qtc from covid19 pts with cardiac damage from the virus?

Chandan Khandai, MD, 4/10/20

At University of Illinois at Chicago (UIC) we've had a number of consults from the outpatient side on managing comorbid asthma and anxiety, especially with difficulty differentiating their anxiety from respiratory sx's. From the internal medicine standpoint, they've noted a lot of their COVID+ patients who then went downhill initially had dyspnea.

Any thoughts on managing anxiety in an asthmatic patient, and helping them differentiate between anxiety and general medical dyspnea? Most clinics are in lockdown, and psychotherapy already had a huge waitlist before COVID-19, so self-help options, behavioral strategies, apps, etc. would be particularly helpful.

Philip R. Muskin, MD, MA, 4/10/20

In a general way anxiety responds to a small dose of a benzodiazepine, even with asthma. Respiratory failure does not respond. The dose should be small so it does not decrease the respiratory rate.

Staff Wellbeing (4/3/20 to 4/8/20)

Nourhan Mohamed, MD, 4/3/2020

Messaging from Ontario, Canada – we haven't had a surge yet, but it's coming very soon.

Our fellow colleagues (internists, intensivists, nurses) are starting to reach out to us for support around the care they are providing to COVID+ patients.

Main issues are anxiety around contracting illness, fear of being forced to make decisions that lead to "moral injury".

Other than the supports you have through your leadership structures (e.g. wellness committees), I am wondering if others can share what formal supports they have in place or are engaged in that have been helpful during this stressful time.

Jennifer Brandstetter, MD, 4/3/2020

We have set up formal support program through the Employee Assistance Program for staff, as well as department faculty is volunteering to be available to staff if need appointment to address acute sx.

There is a page on the digital workspace with resources as well as a support tline to help connect caregivers. Department faculty is volunteering to provide services to caregivers in need. We are also as a CL team rounding on units to provide support and keep a sense of the needs, stress level

Richard Stall, MD, 4/7/20

I am trying to establish psychological support at our hospital. I was wondering what other sites were doing to support front line health care staff?

Has anyone established a "Code Lavender" response?

Magdalena Spariosu, MD, 4/7/20

Hi Richard,

I work in a hospital in NJ. We established a very robust support for our employees. Our CL psychiatrists and psychologists are rounding on the units, and provide education regarding available resources and assess the needs of hospital employees. In addition to that we established a phone hotline for employees with ability to provide immediate intervention and provide needed referral.

Dahlia Saad-Pendergrass, MD, 4/7/20

We are doing something similar at the Institute of Living/Hartford Hospital. This is separate from EAP, of course.

For Hartford Hospital, two of our CL DOCS are rounding on the units and having spontaneous conversations - the goal being support, normalization of fear/other reactions and education re: other available supports. One of them has made herself available by tigerconnect for chats or questions confidentially.

We also started a daily hour-long ZOOM drop-in group with times that vary to capture participants from various shifts. We posted flyers all over the hospital in nursing, and tech (respiratory, phlebotomy, medical transport etc) areas.

For our medical staff (hospitalists mainly but really all are welcome) the Professionals IOP program attending and clinicians are going to do a twice a week virtual group ... with the normal structure and

composition of a group rather than drop-in format. The thought was that the medical staff may feel more comfortable attending if group leaders were not their day-to-day CL colleagues.

If we pick up on needs that require further intervention or there are concerns from any of the other hospitals in the Hartford Healthcare network, a referral is made to our COVID support referral email which is then triaged by one of the IOL senior psychologists who has a crew of psychologists, psychiatrists and social workers from the IOL who have volunteered time/sessions Via telepsych.

(Our very early impression is that rounding on the units and speaking with individual nurses and nurse managers to let them know that there is someone available by tigerconnect has yielded the highest response in terms of utilization and some good feedback. This may change as the group offerings gain ground/ staff become more familiar)

Good luck out there!

Dahlia Saad Pendergrass

The Institute of Living/Hartford Hospital

Charles Hebert, MD, 4/7/20

Hi Richard,

At Rush (I'm in Chicago) we have done something similar and are performing formal daily wellness rounds. We have teams constructed of a psychologist, psychiatrist/psych APN and a chaplain (usually the one assigned to a given unit) and are rounding on the floors on a daily basis. We have several such teams and they are embedded on particular floors (we felt this would increase continuity and staff would eventually come to know us). We have several non-critical care Covid units and also several ICU's, of course. I've been rounding in the ICU's with my colleagues. We typically do so in the afternoon around 3p (mornings are a no-go since staff are occupied with rounds etc). We have found that different units have different needs and also different means of reacting/coping to stress. As time has progressed, staff have moved from the "we're fine" position to opening up and being more candid about what they are facing, especially as regards moral distress around losses/deaths.

Our chief wellness officer has spearheaded this effort across our hospital system, which includes main campus as well as a few satellite hospitals in other areas of town. Essential to this effort is a "wellness consult service." We have a 24/7 pager that is NOT managed by our EAP since they are off-site. The pager is carried by a Rush behavioral health employee (i.e., someone who is in the trenches and knows what is happening in the hospital rather than an outsider) and can be activated by a staff member in extremis but we've also encouraged its use by nursing unit directors, attending staff, and others who feel that the unit or floor may need special attention for ALL staff to boost morale, in which case we try to advise regarding possible interventions. It's worked well so far and we've fielded a variety of calls. We've also established "wellness rooms" on each of our respective floors that are outfitted with snacks, fruit, and bottled water (the water is very popular with busy staff!). This has also been helpful since it allows staff a place to go and grab a breath before heading back into the fray.

We're also making an effort to support those at home -- we have many staff who are away because of active symptoms or are otherwise isolation. We're working towards designing some outreach efforts (read: virtual) to make sure they do not feel "forgotten" while they are at home but are still a part of the fight!

If anyone is at all considering a similar initiative, I'd be glad to confer. We are constantly revising our system and manner of approach, but we've found that embedded wellness rounds on each of our Covid

units has been a valuable "link" between the ground level and incident command. We've been able to relay many concerns we've identified to leadership and they've appropriately acted on them.

Cheers to all of you and be safe --

-- clh

Nikki Allen, MD, 4/7/20

This is such an important topic! At Columbia Presbyterian we have set up a dedicated hotline for zoom calls for both faculty and housestaff spearheaded by our housestaff mental health division. Within CL specifically we have set up specific attendings to liaise to each unit given the structure of our hospital has changed with covid.

Charles, when your teams do wellness rounds in the afternoon, do you approach individuals, or do the floors know to expect you at a certain time and you all meet as a group?

Emily Gifford Holmes, MD, 4/8/20

At Indiana University we are establishing a new set of Team Member services available to any hospital employee. The Team Member can call a number that connects them to our virtual Behavioral Health Hub 24/7. The Hub then triages the team member to a variety of services that could include EAP, chaplaincy services, or referral to our department's new Team Member clinic. This clinic will offer 6 free sessions of psychological first aid, skills for psychological recovery, or crisis management. If a team member needs more services he/she can be referred to our general mental health clinic or to a specialist in trauma or grief, depending on the need. There are also some efforts to create peer-to-peer support services, but those are still in the works. We're especially hoping to make sure that team members in quarantine and on COVID units are aware of our resources.