

Report from Brigham and Women's Hospital Consultation-Liaison Service

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Staffing

As of March 16, 2020, we began to make rapid changes to our staffing schedule. Being a very busy service (most consulted service in hospital, see about 9-12% of all admitted inpatients; carry about 65-80 patients on our list at any one time), we used to have 2-4 attendings and 3-7 trainees on per day. We decreased the number of in-house trainees first, followed by attendings. On March 23, 2020, we are at 1 attending, 1 C-L fellow and 1 psychiatry resident in-house with all other staff working from home (WFH). For those trainees and attendings at home, they are receiving tasks from our triage / administrative fellow (who is also WFH) including virtual consultations (see below), chart review, collateral information phone calls, etc. The in-house clinicians will focus on the most critical patient care that cannot be performed remotely (severe psychosis, complex capacity evaluations, etc). This decision was made for March 23, 2020 in the context of a "mask policy," where all staff, clinical and non-clinical, would need to wear a surgical mask (NOT N-95) anytime they were on-site in the hospital, even in non-clinical work areas.

These changes will hopefully aid in decreasing the amount of PPE being utilized by our service as well as prevent infection of staff and patients by decreasing the number of in-person patient visits.

Virtual Consultation

As of March 16, 2020, the Brigham and Women's Hospital (BWH) C-L Service started providing as much virtual consultation as was possible. This took 3 forms as described:

1. Telephone recommendations: For routine consultations, the service attempted to guide teams on management via telephone recommendations. This was possible for consults requesting information about resources, management of delirium, medication management in the context of medical illness (ex: can I stop medication X without tapering?), etc.
2. Telephonic contact with patient: Wherever possible, we attempted to connect with the patient by phone (every hospital room has a phone and occasionally the patient wanted to utilize his/her mobile phone). This worked less well in the ED where every room does not have a phone (particularly those that are designated "safe" rooms for agitated and risk for self-harm patients) and cellular service is particularly poor
3. Video virtual consultation: Rapidly, the ED identified "iPads on a stick" (iPads on an IV pole) to use for video virtual consultation. This is working well for approximately ½ of the patients we receive consults on in the ED. Severe psychosis, intoxication, etc make it difficult to utilize the iPads.

Billing

We are documenting each virtual encounter with appropriate headers to the notes, always writing that the consultation was performed in this manner due to the COVID-19 pandemic and then one of the following:

-the patient was not seen in-person, but thorough chart review was performed and recommendations were communicated to the team; this encounter is note billed

-the patient was evaluated via telephonic contact (obviously some items cannot be evaluated such as “appearance” in the MSE—this is indicated in the note); this encounter is billed as usual (as initial or follow up visit but with the modifier, GPH)

-the patient was evaluated via video virtual consultation; this encounter is billed as usual with the modifier, GT

Note

This is where the pre-existing relationships in the hospital, built over years, has been helpful. BWH has put an enormous amount of trust in us – they have confidence that we will do what is right for the patient, including switching to in-person care as needed/required.

The author denies any significant conflict of interest related to this report.