

CONSULTATION LIAISON PSYCHIATRY COVID-19 SERVICE MANUAL

For use during the COVID-19 pandemic only

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CONTENTS

(hyperlinks below, hit “control” and click on link to go to each section)

[**COVID-19 Overview and Workflow Options**](#)

[**Directions for CL Service Leadership to Set Up Telemedicine**](#)

[**APPENDIX 1: Vidyo Processes**](#)

[**APPENDIX 2: Patient Instructions for Vidyo Direct to Device**](#)

[**APPENDIX 3: Documentation and Billing**](#)

[**APPENDIX 4: Sample Staff Rotation Schedule \(for larger consult services\)**](#)

[**APPENDIX 5. Cleaning and PPE**](#)

[**APPENDIX 6. Clinical Case Scenarios**](#)

[**APPENDIX 7: Weekends versus Weekdays \(Pittsburgh hospitals\)**](#)

The authors report no conflict of interest related to this work.

COVID-19 AND THE CL PSYCHIATRY SERVICE

Aims:

- Create a clinical plan for conducting consults with patients in isolation and infected with COVID-19 and others in the hospital to minimize patient and staff exposures
- Develop pathways for high-acuity/high-risk psychiatric consultations

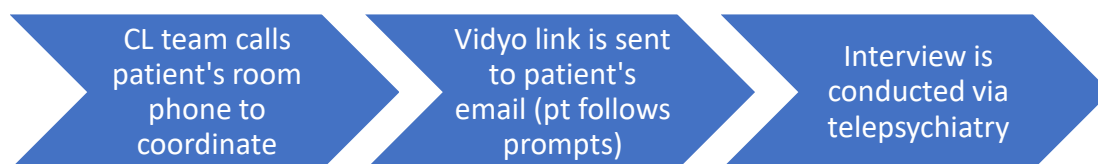
Logistics for Emergency Response:

- In line with UPMC system response
- Telepsychiatry to patient's personal device if possible using Vidyo link/invite
- If patient does not have a device, then tablets will be taken into the rooms by a tele-assistant (not a tele-presenter; this individual will not engage in history-taking or examination)
- If patient cannot engage with a device, then some circumstances may require in-person.
- Can also consider phone consultation to patient or to primary team

To this end, the supporting video-platform technology is Vidyo. To help prepare yourself for these rollouts, it is requested that all physicians and other clinicians take the following steps in preparation:

- Request a Vidyo Account (IMS request by clinic director)
- Download Vidyo to the PC or mobile device that you would plan to use
- NOTE: Based on early testing, use of a PC (UPMC issued) is recommended if you have options.

Workflow 1: Patient Device (Tablet or Smartphone) Used

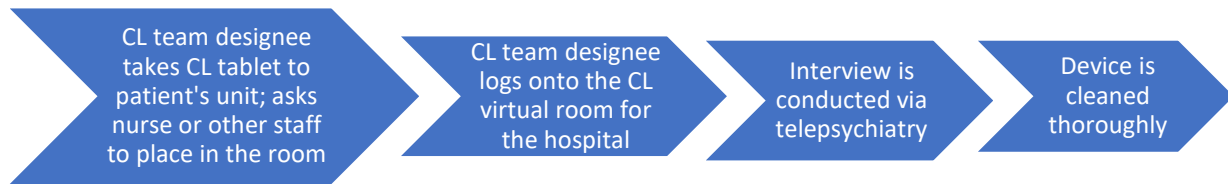


* Will need to use Vidyo chat room link sent through service account

* See [Appendix 1](#) for CL team's step-by-step

* See [Appendix 2](#) for patient step-by-step

Workflow 2: CL Tablet (used when patient doesn't have a tablet; in-house presence needed)



* CL team designee will log into the chat room and coordinate with CL nurse/resident/fellow and attending

* Cleaning protocols for devices as recommended by infection control: preferred cleaner is PDI purple top or alcohol wipes for screens

ALL NEW CONSULTS

- Please conduct consults through telepsychiatry (audio and video) using the Vidyo app.
- If patient does not have a device or the system doesn't work, please conduct telepsychiatry (audio and video) using service tablet.
- Attendings bill through Profee using the telemedicine modifier (not the drop-down).
- If the technology fails and the patient is low-risk medically and psychiatrically, consider an in-person consult.
- If the technology fails and the patient is high-risk medically and psychiatrically, consider a telephonic consult. Attendings will not bill.

ALL FOLLOW-UPS

- Please conduct follow-up using telepsychiatry (audio and video) using the Vidyo app.
- If patient does not have a device or the system doesn't work, attempt telepsychiatry (audio and video) using service tablet if clinically indicated.
- If the technology fails, okay to engage in a telephonic follow-up visit.

Please refer to [Appendix 3](#) for details.

Please start the encounter with the following:

“Due to coronavirus and trying to limit your contact to too many health care workers, the psychiatry consult service in the hospital has moved to doing televisits when possible. So, instead of conducting this visit in person, we have started conducting visits virtually. The app we use for this is called Vidyo and can be downloaded on your phone. This is a HIPAA compliant forum. Would you be comfortable conducting a visit today in this way.”

Directions for CL Service Leadership to Set Up Telemedicine

To operationalize the workflows above, you will need the following steps to be completed:

1. Request Vidyo access for all staff and faculty vis IMS
2. Request a service account through IMS (so that Vidyo video links may be sent without revealing individual emails)
3. Request virtual rooms for your team to use for each hospital (1-2 rooms per hospital)
4. Order 1-2 tablets per hospital (if there are not available devices on the units)
5. Order 1-2 carts per hospital
6. See if staff need tablets and/or want to set up on their personal devices
7. Make sure everyone has downloaded Vidyo and installed the app to all devices with the appropriate set-up
8. Once service account is obtained, log in through Outlook and share the service account calendar with your team members with edit access
9. Create a rotating in-house staff schedule to protect your work force in anticipation of shortages (see [Appendix 4](#) for a sample schedule)

APPENDIX 1: Vidyo Processes

Direct to device

- Sign in to Vidyo app using your individual account name and password.
- Create a Vidyo room (+button on the top right on the desktop app) and copy the link. (*see instructions attached for details).
- Call the patient's unit.
- Ask to connect to patient's landline.
- See if the patient has a tablet/device/cell phone and obtain email.
- Confirm that the patient has the Vidyo app downloaded.
- Sign into your individual Outlook email. Click on Calendars and open the Shared CLTelepsych service account calendar.
- Right click and create a "New Appointment" *under the shared calendar*. Click Add Invitees in the box that pops up and type in the patient's email. Copy the Vidyo visit link into the email and send.
- Ask patient to click on the link from their email on their device.
- Click on the link in Outlook from your device.
- Conduct the evaluation.

Using unit or service devices

- Sign in to Vidyo app using your individual account name and password.
- Call the patient's unit.
- Ask to connect to patient's landline and confirm that patient does not have an individual device.
- Call or text the designated tele-assistant (someone from the CL service or eventually someone designated on each unit) to coordinate visit.
 - Option 1: Create a Vidyo secure meeting invite and copy the link. Send the link to the tele-assistant's device via email.
 - Option 2: Log into a common room (see below for each hospital).
 - CLPUH1
 - CLPUH2
 - CLMUH1
 - CLMUH2
 - CLMWH
 - CLSMH
 - CLPAS
 - CLEast
 - CLSHY1
 - CLSHY2
- Conduct the evaluation.
- Clean the device using a PD Sani wipe, alcohol wipe, Clorox wipe, or other wipe with 70% alcohol content (do not submerge in any liquids).

APPENDIX 2: Patient Instructions for Vidyo Direct-to-Device

If you are assisting the patient in setting up the Vidyo chat, please instruct them to do the following:

1. Download VidyoMobile app
2. Launch the app
3. Click “Accept” when prompted for terms and conditions
4. Type in the portal name: “portal.video.upmc.com”
5. Don’t close the app. It should stay at a screen with “user name” and “password” – you don’t need to enter anything here
6. Go back to the email with the Vidyo link sent to you and click on the link
7. The link will prompt you as to how to open to app. Choose “Open with VidyoMobile”
8. Activate all microphones and speakers. Make sure the patient’s phone is muted

Video Platforms During Video Visits

As we’re all working together to transition to using **VIDYO** to complete video visits, we recognize that there may be some temporary challenges. UPMC Telemedicine IT is actively addressing all issues quickly. The preferred priority of platform at UPMC is **VIDYO** as it’s HIPAA compliant, capable of handling our system volumes, and can be used over the long term.

Should you experience problems with **Vidyo**, and it is clinically necessary to connect via video visit rather than telephone or in-person, you may use the following #2 options as a **temporary solution**:

Questions about acceptable video platform:
Contact Telepsychiatry Team at sabrina.george4@chp.edu

1st Choice (and our long term solution)

• **Vidyo**

2nd Choice/temporary options (not long term)

- Telephone only (when clinically appropriate)
- Microsoft Teams
- Apple Facetime (go to settings, phone, go to “show my caller ID”, turn this “off”)
- Google Duo
- Zoom
- Doxy.me <https://doxy.me/>

Do not use:

- ~~Facebook messenger, Facebook live~~
- ~~What’s App~~
- ~~Tiktok~~
- ~~Twitter~~
- ~~Snapchat~~



APPENDIX 3: Documentation and Billing

For TELEPSYCHIATRY (WITH VIDEO)

Use a regular BH Psychiatric Initial Consult Note

Choose Psychiatric Consult as the folder (“Type”)

Attestation Statement – Please include this as the first paragraph of your HPI or attendings may use this in their attestations:

- Patient at Medical Facility Visit: “Due to extenuating circumstances from COVID-19, consultation was provided via telemedicine from ‘*Location of patient (ex. UPMC NW)*’ using two-way, real-time interactive telecommunications technology between the patient and the provider. The interactive telecommunication technology included audio and video. Verbal consent has been received.”
- If an alternate platform other than Vidyo is used (e.g., Teams, Zoom), please use this attestation: “Due to extenuating circumstances from COVID-19, the patient agreed to use XXX for this telehealth visit and was advised that it may not be fully compliant with HIPAA.”

Attendings – bill through Profee with the telemedicine modifier checked off

For TELEPHONIC CONSULTS

Use a regular BH Psychiatric Initial Consult Note

Choose Psychiatric Consult as the folder (“Type”)

Attestation Statement – Please include as the first paragraph of your HPI or attendings may use this in their attestations:

- Telephone Only – “Due to extenuating circumstances from COVID-19, this consultation was provided via telemedicine from ‘*Location of patient (ex. UPMC NW)*’ using audio telecommunications technology between the patient and the provider. Verbal consent has been received.”

Attendings – please don’t bill these, but do not remove them from your Profee billing queue yet.

APPENDIX 4: Sample Staff Rotation Schedule

IN-HOUSE ROTATION - Oakland

Week 1:

Resident 1, Plescia (fellow); Nicole (psych RN) on Mondays; Ryan/Meredith (attendings)

Week 2:

Resident 2, Israel (fellow) ; Diane (psych RN) on Tuesdays; Priya M-T/Shelly W-F (attendings)

Week 3:

Resident 3, Pale (psych RN), Darcy (attending)

*Brenda can do transfers from remote

*Role of the in-house team is less for direct patient care (and will receive a modified case load) and more for tablet facilitation, commitments, and psychiatric emergencies

IN-HOUSE ROTATION – Community Hospital Pool 1 (SHY, East)

Week 1:

Teri, Altman (attending)

Week 2:

Gina, Gushchin (attending)

Week 3:

Michaelene (psych RN), Susan M/T/W/Th (psych RN), Nicole (psych RN), Faeder (except T) (attending)

*Role of the in-house team will vary by credential

- If an attending is in-house, then the RN/clinician will do the interview and information-gathering in the morning by telephone by home, present to the attending, and the attending will do a quick check-in either in-person or via televideo

- If a clinician is in-house, then the RN/clinician will do the interview and information-gathering in the morning by telephone at work and present to the attending. The clinician will then facilitate the tablet and “round” with the attending, with the aim of keeping the clinician in the patient’s room for a minimum amount of time

IN-HOUSE ROTATION – Community Hospital Pool 2 (SMH, PAS)

Week 1:

Donna(psych RN), Hudak/Good (attending)

Week 2:

Candace (psych RN), Ketterer T F/Gopalan M W Th (attendings)

Week 3:

Jerrad M/W/F (psych RN); Diane T/Th (psych RN), Fishman (except T) (attending), Gopalan T (attending)

*Role of the in-house team will vary by credential

- If an attending is in-house, then the RN/clinician will do the interview and information-gathering in the morning by telephone by home, present to the attending, and the attending will do a quick check-in either in-person or via televideo

- If a clinician is in-house, then the RN/clinician will do the interview and information-gathering in the morning by telephone at work and present to the attending. The clinician will then facilitate the tablet and "round" with the attending, with the aim of keeping the clinician in the patient's room for a minimum amount of time

APPENDIX 5. Cleaning and PPE

Cleaning of any tablets/cell phones that go into the patient room should include use of PD Sani wipes (purple top), Clorox wipes, or using a solution of at least 70% alcohol.

Up-to-date information on Personal Protective Equipment (PPE) is on the UPMC Infonet:

<https://infonet.upmc.com/BusinessTools/EmergencyPreparedness/Pages/COVID-19-PPE-Conservation-and-Cleaning.aspx>

Fit testing will occur on a “just in time” basis at the bedside to conserve PPE.

APPENDIX 6. Clinical Case Scenarios

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For patients who are positive COVID-19 Psychiatric admissions will only occur after a 2+ week period of quarantine and medical clearance.

	Clinical Approaches	Notes
Suicidal Patients	<p><u>Admission for Suicide Attempt</u></p> <ul style="list-style-type: none"> • Admission to isolation rooms with a door conducive to looking in if possible • Room checked thoroughly by security using personal protective equipment • No sharps, wires, strings should be left in the room • Preference to admit to room with a window to look in if available • Potential use of restraints if imminently lethal and less restrictive option is not available <p><u>Consult for SI not after an attempt</u></p> <ul style="list-style-type: none"> • Sitter at the door looking in if possible until psychiatric consult • Consult psychiatry, which will be conducted via telepsychiatry • Determination will be made by psychiatry as to if sitter is needed and search/securing belongings is necessary • If sitter and environmental management is needed, then call security and secure room. • As above for imminent lethality <p>*For refused tele consult, attempt in-person consult with PPE assistance from PUH nurse in donning/doffing.</p> <p>*Psychiatric admissions will only occur after a 2+ week period of quarantine and medical clearance</p>	Sitters workflows are still being worked out.
	<p>1 – Screen for acuity by conversation with physician ordering consult/staff concerned for homicidality</p> <p>2 – If suspected issue is delirium/MNCD/agitation, follow that workflow</p> <p>3 – Attempt c/s by telepsychiatry</p>	Sitters workflows are still being worked out.

<p>Homicidal Patient</p>	<p>4 – For refused tele consult, attempt in-person consult with assistance from PUH nurse in donning/doffing OR provide curbside recommendations based on chart review.</p> <p>5 – For completed consult, use best clinical judgment given current circumstances/resources for frequency of follow-up</p> <p>6 – Low threshold to involve UPMC legal when circumstances do not allow for pre-CV19 standard of care when circumstances do not allow for pre-CV19 standard of care</p>	
<p>Agitated Patient</p>	<p>1 - Screen for acuity by conversation with physician ordering consult/staff concerned for agitation</p> <ul style="list-style-type: none"> • Characterize the type of agitation (oppositional behavior, verbal, aggression, etc.) • Obtain collateral via chart review • Assess acute safety risks (risk of aggression, risk of transmission of COVID-19) • Attempt to clarify differential diagnosis for agitation, including: <ul style="list-style-type: none"> ○ Unmet physical needs (pain, withdrawal, hunger, fatigue) ○ Psychosis ○ Delirium* ○ MCND* ○ Volitional <p>2 – Attempt consult by tele</p> <p>3 – For refused consult, have a low threshold to order and give PRN medication and/or restraints</p> <p>4 – Re-attempt consult daily or until reasonable concern has passed.</p> <p>5 – For completed consult, use best clinical judgment given current circumstances/resources</p> <p>6 – Low threshold to involve UPMC legal when circumstances do not allow for pre-CV19 standard of care</p> <p>*Follow relevant workflow</p>	<p>Same except for in-person attempts.</p> <p>May need to make recommendations based on collateral (chart review, family) and primary team’s assessment only.</p> <p>Document clinical reasoning carefully.</p>
<p>Delirious Patient</p>	<p>1 – Attempt telepsychiatry consult with minimum goal of at least doing a brief visual evaluation</p> <p>2 – High priority for gathering extensive collateral</p> <p>3 – In-person with PUH nurse assistance with donning/doffing only as necessary</p>	

<p>Patient with Major Neurocognitive Disorder (or other cognitive deficits)</p>	<p>1 – Attempt telepsychiatry consult with minimum goal of at least doing a brief visual evaluation</p> <p>2 – High priority for gathering extensive collateral</p> <p>3 – In-person with PUH nurse assistance with donning/doffing only as necessary; consider curbside recommendations</p>	<p>May need to make recommendations based on primary team impressions and collateral from family.</p> <p>Document clinical reasoning carefully.</p> <p>Physical examination will not be done.</p>
<p>Catatonic Patient (or other cases where physical examination is imperative)</p>	<ul style="list-style-type: none"> • In-person PUH nurse will assist CL team with donning and doffing to conduct in-person exam to include physical exam • Attempt to minimize duration of exam through chart review, extensive collateral from family, discussion of primary team’s exam. • Request nursing staff document PO intake and any agitation. • If Immobility present, nursing staff will ideally need to turn patient q2h if allowed • If agitation present then follow agitation guidelines including more liberal use of restraints • Will have to discuss ECT protocols with interventional psychiatry team for situations of malignant catatonia or use solely pharmacological management. Orphan’s Court is currently running 	<p>Consult will be conducted via telepsychiatry with device on a stand.</p> <p>May need to make recommendations based on primary team impressions, chart review, and collateral from family.</p> <p>Physical examination will not be done or can attempt to instruct nurse in brief motoric exam.</p>
<p>Ventilatory Dependence with Anxiety</p>	<ul style="list-style-type: none"> • Would first attempt telepsychiatry assessment via device on a stand 	<p>May need to make recommendations based on</p>

Interfering with Wean	<ul style="list-style-type: none"> • Attempt to minimize duration of exam through chart review, collateral from family, and impression from primary team. • Rule out other potential factors including withdrawal, untreated pain, akathisia, other medication side effects, delirium • Utilize scheduled and prn medications, and SBTs as guided by evidence to facilitate weans and ventilator availability. • Consider more liberal use of restraints to prevent agitation or self-extubation and potential infection spread • Know indications for M95 or PAPR • In-person PUH nurse will assist CL team with donning and doffing to conduct in-person exam when necessary 	<p>primary team impressions, chart review, and collateral from family.</p> <p>Physical exam will not be done</p> <p>Establish and closely coordinate with point person on CCM team</p>
Anxiety and/or Trauma-Related Disorder specific to COVID-19	<ul style="list-style-type: none"> • Consult to psychiatry, which will be conducted via telepsychiatry only • Education on measures being taken by the institution • Screen for anxiety and acute stress reaction symptoms • Limit media exposure • Restore control to patients when possible • Consider psychosocial stressors: financial, stigma, isolation/boredom • Enhance communication/connectedness (e.g., connect to family/friends) <p>Source: https://www.cstsonline.org/resources/resource-master-list/coronavirus-and-emerging-infectious-disease-outbreaks-response</p>	
Capacity	<p>1- Screen for acuity by conversation with physician ordering consult/staff.</p> <ul style="list-style-type: none"> • Clarify the capacity question and urgency of this question. • Attempt to clarify with primary team reasons for patient’s lack of capacity. <ul style="list-style-type: none"> ○ Delirium – ask if primary team has screened for this and encourage them to do so. ○ Anxiety ○ Agitation ○ Volitional ○ Psychosocial stressors • Obtain collateral via chart review <p>2 – Attempt consult by telepsychiatry</p>	

3 – For refused tele consult, attempt to guide primary team as best as possible until patient is agreeable to consult

Specific Capacity Scenarios:

- **Capacity to refuse recommended medical intervention:**
 - Work with primary team to assess urgency of the intervention and consequences of refusal.
 - Work with primary team and/or telepsychiatry to assess differential for refusal reason (particularly delirium).
 - Have a low threshold for patient lacking capacity and using medications and/or restraints.
- **Capacity to leave AMA:**
 - Assess for lack of capacity (psychosis, delirium, etc) as you normally would
 - Consider psychosocial stressors and address these as indicated
 - If patient lacks capacity due to psychiatric or cognitive (i.e., delirium MNCD) reason, may detain as per normal protocols
 - If patient has the capacity to leave AMA but poses significant infection risk to others, call security/local law enforcement and call legal team

APPENDIX 7: Weekends versus Weekdays (Pittsburgh hospitals)

WEEKDAY WORKFLOW

ALL NEW CONSULTS

- Explore telepsychiatry as the first option to patient's device
 - If patient doesn't have a device, see if a family member does
- If direct to patient's device does not work, attempt telepsychiatry to a CL service tablet
 - Designate one person to take the tablet to the room
 - Try to minimize exposures by leaving the tablet in the room
 - If desired, may have one person stay in the room with the tablet, but only reserve this for acutely psychiatrically ill patients
- If this is not feasible or desirable (e.g., infected or symptomatic patient), consider phone encounters
- If neither is possible, provide an "e-consult" or "curbside consult" based on chart review
- In-person encounters should be limited due to risk of exposures; only reserve this for acutely psychiatrically ill patients

ALL FOLLOW-UPS

- Explore telepsychiatry as the first option
- If this is not feasible, revert to phone or in-person encounters
 - In-person encounters should be limited due to risk of exposures; only reserve this for acutely psychiatrically ill patients

WEEKEND WORKFLOW

ALL NEW CONSULTS

- Explore telepsychiatry as the first option to patient's device
 - If patient doesn't have a device, see if a family member does
- If this is not feasible, revert to phone encounters
- If neither is possible, provide an "e-consult" or "curbside consult" based on chart review
- If a patient requires telepsychiatry via tablet over the weekend, then these will be done once on Sunday if clinically possible to minimize the number of times the physician needs to come to the hospital
- Patients without devices will be have a telepsychiatry trial through a tablet where appropriate on the following Monday
- In-person encounters should be limited due to risk of exposures; only reserve this for acutely psychiatrically ill patients

ALL FOLLOW-UPS

- Explore telepsychiatry as the first option
- If this is not feasible, utilize phone encounters
- If phone calls are not possible, then see if e-consult (i.e., recommendations based on chart review) is feasible