

PSYCHIATRIC CONSULTATION SERVICE: SPECIAL GUIDELINES FOR PATIENTS WITH DEFINITE OR POSSIBLE HIGHLY CONTAGIOUS INFECTIOUS DISEASE

PURPOSE: To provide guidelines for the behavioral health care of patients with definite or possible highly contagious infectious disease, such as Covid, on the medical and surgical units of Yale New Haven Hospital.

BACKGROUND: Covid is an example of an infection that is dangerous and highly transmissible. In patients with definite or possible infection, direct personal clinical contact creates a possibility for disease spread and thus can pose risk to the patient, to other patients, and to hospital staff. This policy describes procedures for ensuring good behavioral care while minimizing such risks. Specific situations discussed here include provision of psychiatric consultation and afterhours coverage by MOD (Medical Officer on Duty), general issues in treatment and isolation, patients with self-harm risk, patients with psychosis, patients with delirium, patients with addiction issues including nicotine use, patients with anxiety, claustrophobia, or other impairment in coping in isolation conditions.

GUIDELINES:

1. **PSYCHIATRIC CONSULTATION.** Direct patient contact with behavioral health providers requires consideration of risk and benefit balance. For all COVID-positive and PUI (Person under investigation, i.e., Covid test pending) patients, use of telepsychiatry for completion of patient interview is preferred. This can be conducted via InTouch (the hospital video system available in many rooms) or Zoom (via unit-based or Psychiatry-owned tablets). If clinical reasons warrant an in-person examination of a COVID 19 positive or PUI patient, appropriate PPE should be requested from the specific unit where the patient is located.

E-consults (chart consults). Some consult questions can be answered without interviewing the patient. Reviewing the chart, rendering a recommendation, and documenting that in the patient's chart as requested by the primary team constitutes an E-consult. Documentation should be entered in Epic using the standard consultation template or using other note format, as appropriate. Documentation should note why remote means were employed to protect the patient. The decision to perform an e-consult must be made in agreement with the requesting team. See Appendices A and B.

2. **MOD CONSULTATION.** After hours, the Psychiatric Consultation Service is covered by the MOD who may be a resident in training. As with consultation during the regular day, the necessity for direct patient examination should be considered carefully. The initial step is discussion with the medical team regarding the nature of the clinical situation and consultation question. In all cases, the MOD Physician **MUST** discuss with the covering Attending Staff whether to proceed with direct patient examination. *In the event that there is a delay in reaching the assigned Attending Staff person, then [REDACTED] will serve as backup (the first preferably for patients at the YSC and the latter two preferentially for patients at SRC).*

3. **GENERAL CONSIDERATIONS.** Assessment and treatment of infection such as Covid, with needs for isolation rooming and personal protective equipment (PPE), can be anticipated to be challenging for all patients, even outside of the special circumstances below. Clear information, reassurance, and support must be provided to the patient. Careful attention to patient comfort, including treatment of pain, insomnia, or other issue, is essential. Access to telephone, tablet, or laptop allowing contact with social supports should be verified. Such modalities also will permit entertainment, video games, and other activities. Books or magazines or other items may be provided if clinically appropriate. The Clinical Nurse Specialists / Behavioral Nurse Specialists (CNS / BNS) should be involved by the psychiatric consultation team for aid with emotional support and behavioral plans.

Version of November 25, 2020.

4. **PATIENTS AT RISK OF SELF-HARM.** Patients with risk of harm to themselves may require monitoring for safety, such as by constant companion. For patients with contagious disease, need for monitoring must be assessed promptly and critically by the medical team. The Psychiatric Consultation Service will be available for discussion and aid at all times. Since placement of a constant companion represents risk of infection of the patient, companion, and other patients or staff who may be exposed to the companion, such monitoring should not be instituted for patients with minimal evidence of actual risk. The nature of the self-harm risk should be analyzed carefully, as interventions for acute suicidal intent would differ from those for elopement, non-compliance, or fall risk. Ordering a constant companion for an admitted patient should be a very carefully considered decision. Hospital policy does NOT require assessment by a psychiatrist for the discontinuation of a constant companion. Additional aspects of care for the patient with self-harm risk, as described more fully in other hospital policy documents, include removal of personal belongings, removal of unnecessary cords, tubing, medical equipment, and plastic trash bags, yellow gowning, and the use of safe eating utensils.

5. **REMOTE MONITORING.** In the absence of infectious risk, patients at suicidal risk are ordered a constant companion at arm's length distance from the patient. In the presence of infectious risk, remote monitoring is imperative. Only a minority of hospital rooms permit visual monitoring from outside the room through a glass panel (e.g., NP 9 and 10). Some hospital rooms allow video monitoring. Patients with self-harm risk and definite or possible (PUI) SARS-COV-2 should have a high priority for a video-equipped room. Patients at acute risk of suicide MUST be under constant observation, whether remote or direct.

6. **PSYCHOSIS.** Patients with psychosis and consequent reduced insight will present particular challenges. Efforts should be made to improve understanding and reinforce adherence. Psychotropic regimens should be reviewed carefully and optimized. In cases of acute non-adherence which might place the patient, other patients, or hospital staff at risk, administration of appropriate treatment may be required, as permitted by Connecticut law. This may include antipsychotic medications, antianxiety medications, or a combination thereof (e.g., haloperidol plus lorazepam). Other agents may be indicated depending on clinical context. For example, antipsychotic or antihistaminic medications may be safer than benzodiazepines or opioid agents in patients at risk of respiratory depression in pulmonary disease. Longer acting agents would reduce need for frequent dosing. Involuntary medication hearings are not required when there is acute risk to self or others. Behavior which endangers others in the hospital, such as non-compliance with hospital isolation, could represent such a risk to others.

7. **SUBSTANCE USE DISORDERS.** All patients should be assessed carefully for the presence of substance use, as withdrawal and cravings may increase risk of elopement and non-compliance. All patients must be screened for the use of cigarettes, vaping, or other nicotine products and should be offered the nicotine patch or other replacement options as appropriate. Alcohol withdrawal should be fully treated, using scheduled and/or symptom-triggered medications, using Epic ordersets, modified if needed for clinical circumstances. Scheduled and longer-acting medications may be more appropriate than symptom-triggered protocols requiring frequent contact for reassessment such as lorazepam by CIWA criteria. Loading protocols and anticonvulsant protocols may help decrease the need for repeated dosing and the associated patient contact. Treatment of opioid withdrawal should also be treated with methadone or non-methadone protocols, available as Epic ordersets. Benzodiazepine withdrawal is not effectively treated using symptom-triggered protocols in some patients, and appropriately intense scheduled long-acting medication regimens are indicated (note that many patients who abuse street benzodiazepines are using 10 to 15 mg of clonazepam or alprazolam per day). Replacing a high potency agent with a low potency agent can increase the risk of seizure, and using a similar longer-acting high potency medication is suggested.

8. DELIRIUM/AGITATION. Appropriate treatment of delirium, confusion, and agitation is essential, both to permit safe care for the patient and for patient comfort. Possible etiologies of altered mental function should be carefully considered and treated. Medications which may exacerbate confusion should be discontinued as possible. Environmental factors should be optimized (consider using available smart phrases), and CNS/BNS staff consulted as needed. Medications for delirium/agitation should be considered: where agitation and non-compliance may result in acute risk to the patient and those around the patient, the balance of risk and benefit mandates early and adequate treatment. Low dose neuroleptic agents may improve restlessness and anxiety (e.g., haloperidol/risperidone 1 mg q 8 hours, quetiapine 25 mg q 6 hours, olanzapine 2.5 mg qHS), but all regimens will need to be titrated promptly to clinical effect. It is emphasized that scheduled and adequate dosing of long-acting agents will reduce the need for more frequent patient contact for drug administration.

9. IMPAIRED COPING. Claustrophobia, anxiety, personality disorders, or other factors could impair coping with the stress of isolation and needed treatments. It may be possible to offer support by telephone or other remote means. As noted, the CNS/BNS staff should be involved early in coordinating a response plan when the patient is in an area of the hospital covered by such staff. Treatment with low dose benzodiazepines or sedating neuroleptic agents, scheduled or prn, should be considered. Patients with dementia or impaired cognition may require more intensive care, both behavioral and pharmacological.

10. LEGAL HEARINGS. Probate court hearings regarding commitment and conservatorship are being conducted by telephone conference calls or Zoom conference. Involuntary medication hearings are to be conducted by Zoom conference. Note that the treatment team must be present for the hearing. For patients with definite or possible (PUI) infection, counsel for the patient will require assistance in communicating safely by remote means with his/her client.

11. DISCHARGE PLANNING FOR SARS-COV-2-positive PATIENTS TRANSFERRED FROM YPH. Social work staff from YPH will be available to collaborate on discharge plans for patients admitted to medical units, as these patients may not be able to return to psychiatric units.

12. PPE. Surgical masks should be worn in all clinical areas at all times. N-95 masks and full PPE should be used for contact with Covid or PUI or ED patients. Units should provide PPE for Covid or PUI patients if the clinician does not have PPE already.

ADDITIONAL REFERENCES

Yale New Haven Health Policy & Procedures: Restraint and seclusion, effective 3/14/18

Yale New Haven Health Policy & Procedures: Suicide Risk Screening, Assessment, and Precautions, effective 11/7/19

Yale New Haven Health Department of Pharmacy: Treatment of Acute Delirium in Adults in the Non-Intensive Care Units, revised 1/17

Link to protocols & guidelines are permanently housed on PBeH SharePoint site [visit this link](#).

APPENDICES

A: Yale New Haven Health SBAR: Consultative Services for all ED and Inpatients.

B: Consultation Smart Phrases

C: CPT Codes for Admitted Patients or Observation Patients

D: InTouch Manual

E: iPad with Zoom and FaceTime Video Conferencing for Patients

F: Accessing Patient and Team Phones

G: Legal Forms

H: Code Status Policy Update

I: Inpatient Psychiatry Admission Algorithm

APPENDIX A: YALE NEW HAVEN HEALTH SBAR: CONSULTATIVE SERVICES FOR ALL ED AND INPATIENTS

Consultative Services for both Inpatients and the ED: Update 6.19.2020

(Previously updated 3.18.2020, 3.30.2020, 4.22.2020)

Situation: During the COVID-19 pandemic, a chart review consultative process (eConsult) was initiated as communicated in previous SBARs. This initiative is meant to protect patients and healthcare providers and will also ensure proper stewardship of resources (PPE, etc.). Documentation and billing of those consults was originally done through a smartphrase and Y-Code (YIPEC).

Background: There is additional guidance from payers regarding inpatient consults performed through the eConsult pathway.

Assessment: It is recommended that eConsults be considered for COVID-19 positive patients when a face-to-face assessment is not deemed necessary and video communication is not possible. Consultants and referring providers will continue to jointly decide on whether a consult can be done via chart review only or requires a physical exam and/or direct communication with the patient.

Recommendation: It is recommended that face-to-face or video consults be performed and eConsults only be used when appropriate for COVID-19 positive patients. A new Epic workflow to order an inpatient eConsult will be available soon. Referring providers ordering an eConsult must obtain and document patient or family consent for this consultative service in the chart. **Billing for these consultative services is now dependent on whether the attending physician is at the same site as the patient or not.** A method to document location is now included in the SmartPhrase .consultCOVID19 .

1. The referring/requesting physician/provider will document patient or family consent in the chart
2. The consultant will document the question posed and advice given in an Epic note and verbally communicate these recommendations with the referring provider.
3. The consultant will add the following SmartPhrase at the bottom of their note/attestation to signify the consult was performed during the COVID-19 pandemic:

.consultCOVID19: "Due to COVID-19 restrictions, I was unable to physically examine or speak with the patient face-to-face. All recommendations are based on chart review and discussion with the primary team. Detailed recommendations were communicated to the primary team both verbally and through this written note. I spent * minutes providing medical consultative discussion and review. Provider location: ***"**

It is important that time spent and location of provider (on-site or at home/office) be documented for reimbursement.

4. The consultant will now report the appropriate CPT code based on the service provided and their location. **The YIPEC code should no longer be used.**
- If the consulting attending physician is **at the same hospital site** as the patient, whether a face-to-face, video, or an eConsult is performed, the F2F codes can be billed for new consults (**99251-99255**) or subsequent hospital visits (**99231-99233**) even though the service is through chart review.
 - If the consulting attending physician performs an eConsult (i.e., chart review only) and is NOT at the same hospital site as the patient – whether they are at home, in the ambulatory clinic, or at another hospital site (e.g., attending is at SRC but patient is at YSC), an interprofessional consultation (IPC) or eConsult code should be used.
 - If the **attending physician verbally communicates** with the referring provider, an IPC (**99446-9**) code should be used. These are time-based codes.
 - If the attending physician does NOT verbally communicate with the referring provider, and provides a **written report only**, the eConsult code (**99451**) should be used.

Note: 99446-99449 *The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion. If greater than 50% of the time for the service is devoted to data review and/or analysis, report CPT 99451.*

Interprofessional Consultations & eConsult Codes			
CPT Code	Time	Must Include:	Requirements
99446	5-10 min	verbal and written report to requesting provider	<ul style="list-style-type: none"> are reported by consultant when opinion and/or treatment advice is requested by patient's treating physician/QHP requires the consult request and reason for the consult be documented in the record requires consent from the patient/family documented in the patient's medical record may be reported for new or established patients may be reported for a new or exacerbated problem time spent must be documented < 5 min consult cannot be reported applicable if consultant performs chart review and discussion with primary team 99446-99449 requires the majority of service time (>50%) be devoted to consultative verbal or internet discussion
99447	11-20 min	verbal and written report to requesting provider	
99448	21-30 min	verbal and written report to requesting provider	
99449	≥31 min	verbal and written report to requesting provider	
99451	≥5 min	written report only to requesting provider	

APPENDIX B: CONSULTATION SMART PHRASES

For consultations performed without examination of the patient:

.consultCOVID19

Due to COVID-19 restrictions, I was unable to physically examine or speak with the patient face-to-face. All recommendations are based on chart review and discussion with the primary team. Detailed recommendations were communicated to the primary team both verbally and through this written note. I spent {Length of Consult:33100::"5-10 minutes","11-20 minutes","21-30 minutes","31 minutes or more"} minutes providing medical consultative discussion and review.

For consultations performed with telephone or audiovisual examination of the patient:

.psyipvideo

VIDEO TELEHEALTH VISIT: This clinician is part of the Telehealth program and is conducting this visit in a currently approved location. For this visit, the clinician and patient were present via an interactive audio and video telecommunications system that permits real-time communications. The clinician is appropriately licensed in the state of Connecticut to provide care for this visit. The visit type for this patient required modifications due to the COVID-19 outbreak.

APPENDIX C: CPT CODES FOR ADMITTED PATIENTS OR OBSERVATION PATIENTS

As of April 3, 2020, for consultations using remote technology, clinicians should use the usual CPT codes for new or follow up care for patients on admission or observation.

INITIAL CONSULTATION CODES

INITIAL INPATIENT CONSULTATION		99251	99252	99253	99254	99255
FLOOR TIME (estimated)		20'	40'	55'	80'	110'
OUTPATIENT CONSULTATION		99241	99242	99243	99244	99245
FLOOR TIME (estimated)		15'	30'	40'	60'	80'
ALL	HISTORY	HPI	Severity Timing Context Duration Associated symptoms Quality Modifying factors Location		≥1	≥4 (or status of 3 chronic diseases)
		ROS	Const Endo ENT Oph Psych Neurol GI GU Resp Card MS Derm Heme Imm	0	≥1	≥2
		PFSH	PMH, FH, SH	0	≥1	All 3
	EXAM		≥3 VS App Speech Lang Orient Affect TP Assoc TC Know Mem Conc I+J [Motor or G&S]	≥1	≥6	≥9
						All
	MDM 2 of 3	OPTIONS	Min	Min	Lim	Mult
		DATA	Min	Min	Lim	Mod
		RISK	Min	Min	Low	Mod

May bill Initial and Subsequent Care by time if Counseling and Coordination of Care > 50% total time: document issues addressed, time spend on counseling and coordination of care, total floor time.

PLEASE BE SURE TO USE **OUTPATIENT CONSULTATION** CODES FOR ALL INITIAL CONSULTATIONS IN **OBSERVATION STATUS** PATIENTS –

For example, use 99244 instead of 99254 for initial consultations. Observation codes are now available under “Observation” in the billing navigator.

Use the following Y-Code for billing and RVU capture: YIPEC (Inpatient eConsult)

FOLLOW UP CONSULTATION CODES

SUBSEQUENT HOSPITAL CARE			99231	99232	99233
FLOOR TIME (estimated)			15'	25'	35'
SUBSEQUENT OUTPT CARE			99212	99213	99214
FLOOR TIME (estimated)			10'	15'	25'
2 of 3	HISTORY	HPI	Severity Timing Context Duration Associated symptoms Quality Modifying factors Location	≥1	≥4
		ROS	Const Endo ENT Oph Psych Neurol GI GU Resp Card MS Derm Heme Imm	0	≥1
		PFSH	PMH, FH, SH	0	≥1
	EXAM		≥3 VS App Speech Lang Orient Affect TP Assoc TC Know Mem Conc I+J Motor G&S	≥1	≥6
					≥9
	MDM	2 of 3	OPTIONS	Min	Mult
			DATA	Min	Mod
			RISK	Min	Mod
					High

May bill Initial and Subsequent Care by time if Counseling and Coordination of Care > 50% total time: document issues addressed, time spend on counseling and coordination of care, total floor time.

PLEASE BE SURE TO USE **SUBSEQUENT OUTPT CARE** CODES FOR ALL FOLLOW UP CONSULTATIONS IN **OBSERVATION STATUS** PATIENTS –

For example, use 99213 instead of 99232 for a Level 2 follow up visit (note change in last digit). 99212-14 actually require one level lower MDM than shown (straightforward, low, moderate complexity, respectively). Observation codes are now available under “Observation” in the billing navigator.

APPENDIX D: InTouch Manual

Inpatient Video Visits: Telehealth

SBAR

Situation

Inpatient telehealth (video visits, e-consults) remains available in many inpatient areas across YNHHS, and further expansion is planned. Utilization has been less than anticipated, however.

Background

Throughout the COVID19 pandemic, the ability to virtually enter the inpatient room has become a priority for nursing, providers and other clinical staff in order to expediate care, preserve PPE, stop the spread and safely social distance. Video visits allow for efficiency gains for providers, can facilitate extra 'face time' with patients without additional exposure risk or PPE use, and can enhance communication with patients and the overall patient experience.

Assessment

Inpatient telehealth is expected to be a permanent part of the inpatient environment, and is accessible to all clinical staff. Integrating this technology seamlessly into workflows, and finding specific use cases, will be integral to broader adoption and use across YNHHS.

Recommendation

Identify 'champions' to utilize inpatient telehealth, who can then identify use cases, populations, or areas of the inpatient space to facilitate broader adoption.

Clinical staff have the ability to request either in person or video visit when placing a consult order in Epic for all outfitted telehealth units. For video consults, the consulting providers will utilize the existing deployment of InTouch video carts to connect with the patient on the units. With this, phone consults should be minimized if not eliminated on select pilot locations outlined below. Providers will be able to log in using Single Sign On (SSO) instead of the existing generic unit-based access.

Further units will be outfitted for this capability over time.

Note: must notify the Care Team via Mobile Heart Beat (MHB) at least 30 minutes in advance to ensure the InTouch cart is available and positioned toward the patient.

Getting Started:



New User_Enterprise



Video Cart

Login_InTouch Health Deployment Steps_Fin

Helpful Tips

Order

Using the Consult Order the ordering provider will pick the most appropriate consult type. This preference will display to the consultant. Consultants will continue to use their discretion to adapt the consult type as clinically appropriate.

Process Inst: ** YSC/SRC only. STAT consults contact on call ** Type selection into "To" field
YNH Med Consult --> YSC Medicine Consult/Co-Mgmt Podiatry/IR;? Tx Medicine
YNH Trauma --> YSC Trauma/EGS Co-Mgmt
Fracture Hospitalist --> SRC Hip Fracture/High Risk Spine Co-Management
SRC Co-Management --> SRC Co-Mgmt (Podiatry, IR)
Medicine Resident --> SRC Medicine Consult/7 Tx Medicine

Consult: From: DESHPANDE, OHM MOHAN To: [Redacted]
Priority: Routine Discharge Dependent
Patient Location: YNH (YSC/SRC) BH(BC/MC)/GH/LMH/WH
Consult type: Hip/Spine Med Consult Transfer Evaluation Pod/IR Co-Mgmt
Reason for Consult?
Callback Cell Phone:
What type of consult is most appropriate for this patient? (Consultant may alter as clinically appropriate)
In person Remote/Telemedicine E-Consult/Chart review recommendation
Instructions for contacting the appropriate consultant:
Connect Center: Please contact the consultant NOW
Is this order for an ED patient? YES
Comments: If consult to SRC resident is URGENT between 11pm-7AM, directly call the Consult Resident Dynamic Role.

Signing-In to InTouch

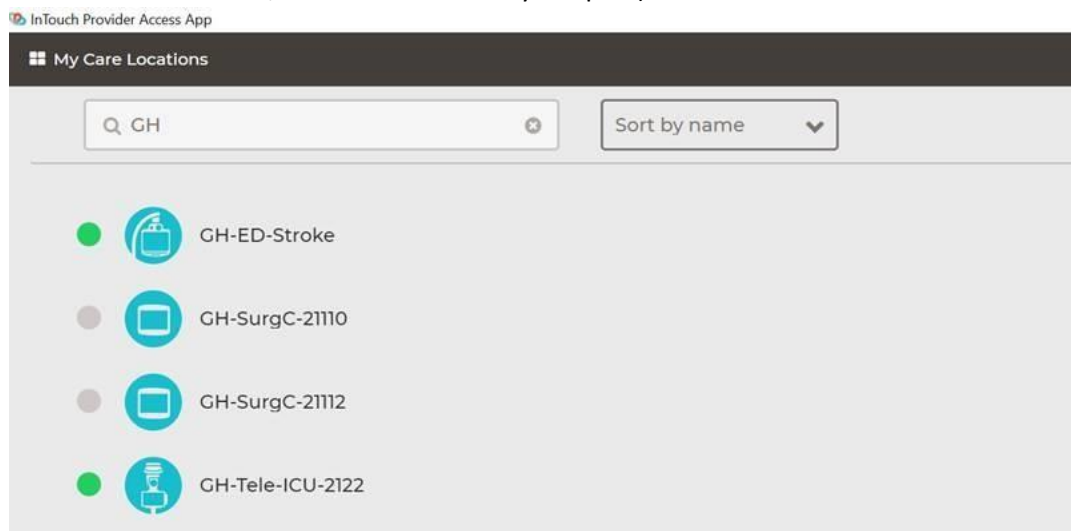
Care Team Members

– Will utilize their existing Epic user ID and password to log into the InTouch system

Nursing – Continue to utilize the generic username provided above and the password

([Redacted]) provided to each unit

In order to narrow the Intouch cart list, search using the Delivery Network abbreviation (GH for Greenwich, BH for Bridgeport, YSC for York Street Campus, SRC for Saint Raphael Campus, LMH for Lawrence & Memorial, and WH for Westerly Hospital)



Technology

Nursing - Ensure the InTouch cart is plugged into an outlet and facing the patient. See attached "Video Cart Deployment Steps".

Care Team Member – If using InTouch cart, please notify RN ahead of time to ensure the cart is plugged in and facing the patient

Documentation

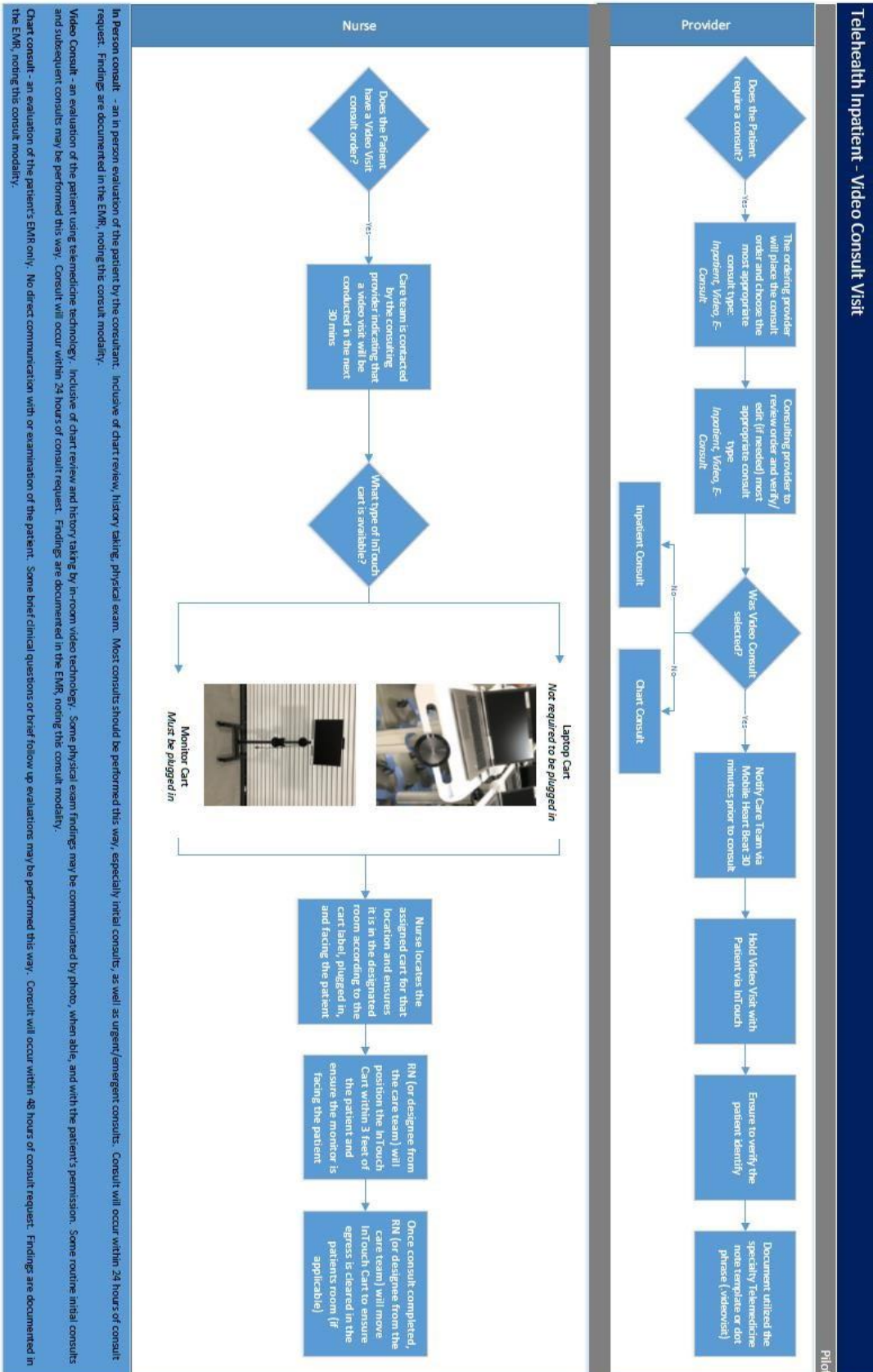
Care Team Member should utilize the **.visittype smartphrase** to document what type of visit was performed.

**This has already been added to most IP consult note templates.*

If using the Consult Navigator, mark what type of visit you have performed

The screenshot displays a software interface for managing consultations. On the left is a vertical sidebar with the title 'Consult' and several menu items: 'TREATMENT TEAM' (with a sub-item 'Treatment Team'), 'CONSULT TYPE' (with a sub-item 'Consult Type' which is highlighted), 'NOTES' (with a sub-item 'Consult Notes'), 'ORDERS' (with a sub-item 'Complete Orders'), and 'CHARGES'. The main content area is titled 'Consult Type - Consult Type'. It features a 'Time taken:' field with the value '1635' and a clock icon, and a date field with the value '7/21/2020' and a calendar icon. Below these is a 'Values By' field with a plus icon and a 'Create Note' link. A dropdown menu labeled 'Consult Type' is open, showing three options: 'In Person' (which is selected and highlighted with a blue border), 'Video Visit', and 'E-consult/chart review only'. At the bottom of the main area are three buttons: 'Restore' (with a double left arrow icon), 'Close' (with a green checkmark icon), and 'Cancel' (with a red X icon).

Inpatient Telehealth Standard Workflow



Inpatient Telehealth Standards of Practice and FAQ for Clinicians

Inpatient telehealth has proven to be an invaluable mechanism for clinical staff to provide high quality patient care and communication, while also facilitating efficiency, diminishing staff safety exposures, and preserving PPE. Telehealth does not replace in person, bedside evaluation of patients. However, both patients and providers have made it clear that telehealth should be an option, when clinically appropriate, to deliver the best care possible. **YNHHS and Yale Medicine support the ongoing use of telehealth for the provision of care to augment existing standard practices in the inpatient setting.**

Inpatient Telehealth Guidelines

- Who may use inpatient telehealth?

Any member of the inpatient care team has access to inpatient telehealth, including in room video technology. This includes trainees and students.

In room video technology is available at all YNHHS inpatient delivery networks, and in most inpatient care spaces, but is not yet comprehensively available. Check with the unit leadership about availability if you are unsure if video technology is available or not where you are. Ultimately, YNHHS plans to have this available comprehensively for inpatients.

- Why should I use inpatient telehealth?

Telehealth technology is not intended to replace in person, bedside care in the inpatient setting. But it can augment inpatient care for both patients and clinical staff.

Benefits to performing an inpatient video visit or consultation may include:

- Safe and secure patient communication from wherever you are
- Flexible access and scheduling to meet dynamic needs of inpatient providers
- Opportunity for patients, families and providers to interact more efficiently

- When should Telehealth be used?

Clear communication with patients on what to expect during a video evaluation is necessary for a positive patient experience. Of note, to protect our patient's privacy, cameras and microphones in patient rooms remain off until needed by the care team.

Primary Medical/Surgical Team:

When Telehealth is appropriate:

- **In general, subsequent care should be performed in person daily**, except under rare circumstances where a video visit may suffice (i.e. clinically stable patient awaiting discharge).
- After an in-person evaluation has been performed on a calendar day, subsequent communication or evaluation may be completed by video as clinically appropriate.

When Telehealth is **not** appropriate:

- **In person patient communication, evaluation, and physical exam are the standard of care.**
- **All H & Ps must be performed in person.**
- **E-Consult/Chart review alone is not acceptable for care by the primary team.**
- **Discharge evaluation must be performed in person.**
- **Death pronouncement must be performed in person.**

Consulting Teams:

When Telehealth is appropriate:

- **Initial Consults may be requested by the primary team to be in person, by video visit, or as E-consult/chart review only.** The primary team may indicate that multiple modalities are appropriate for that patient. The **consultant may use their discretion** as to what type of evaluation is performed, based on the clinical question posed.
- **Most subsequent or follow up consults should be performed in person.** However, some subsequent consults may be performed by video or e-consult as clinically appropriate. Communication with the primary team is imperative, regardless of the modality utilized.

When Telehealth is **not** appropriate:

- **Most initial consults should be performed in person,** unless explicitly requested otherwise.
- **E-consults alone should be used infrequently,** and for specific, defined clinical questions.

Note: Each department is encouraged to develop internal practices and standards for triaging consult questions to in person evaluation vs video evaluation vs e-consult.

• How do I use inpatient telehealth?

Technology:

- For video visits, the only approved and secure platforms for inpatient care are:
 - InTouch
 - Zoom (via YNHHS account only)
 - Vidyo Connect
- There are myriad other video conferencing technologies available (i.e. Facetime, etc). These platforms are not currently approved for use in the inpatient setting unless you have specifically been granted approval for use by the telehealth executive committee.
- Refer to specific Tips sheets for each platform, and how to use them in your clinical setting.

Documentation:

- Visits performed using video technology or by e-consult must be **CLEARLY** identified.
- Be sure to **clearly identify what type of visit was performed** by using the consult navigator, .visittype smartphrase, or other identifier

- **Video visits must include the .videovisitinpatient smartphrase**, which denotes patient consent, and patient/provider physical locations. These are required by CMS and insurers.
- **E-consults must include the .consultCOVID19 smartphrase which includes documentation of consent by the patient/guardian**, and identifies if verbal or written communication with the primary team was performed, as well as the provider's physical location.

Billing:

Video Visits:

- If the **provider is in the same location/building as the patient**, then regular face to face billing codes are used for consults (99251-99255) and subsequent care (99231-99233).
- If the **provider is NOT in the same location/building as the patient**, then the GT Modifier must be added to indicate that the service was provided by telehealth E-Consults:
 - 99446-99449 should be used when the patient/provider are in different physical locations, and both verbal AND written report has been given to the consult requestor. Codes are delineated by time spent on medical consultative discussion, chart review, and/or review of the medical record.
 - 99451 is used when only a written report is submitted without verbal communication.

Primary Team		H & P	Subsequent care	Discharge
	In person	99221-99223	99231-99233	99238-99239
	Video*	NA	99231-99233	NA
	E Consult	NA	NA	NA
Consultant		Initial Consult	Subsequent care	
	In Person	99251-99255	99231-99233	
	Video*	99251-99255	99231-99233	
	E Consult	99446-99449, 99451	99446-99449, 99451	

***NOTE:** If patient and provider are in different location, use Modifier GT.

Reimbursement/RVUs:

- Currently, video visits are reimbursed and carry the same RVUs as Face to Face visits.
- E-Consults are reimbursed at a lower rate, and have lower RVU generation, as noted in the table.

CPT code	Reported by	Concluded with	Time required	How time is spent	2019 wRVUs	2019 RVUs ^a
▲99446	Consultant	Verbal and written report to requestor	5-10 mins	Review pertinent medical records, lab/imaging studies, medication profile, etc. and medical consultative verbal or internet discussion ^b	0.35	0.51
▲99447	Consultant	Verbal and written report to requestor	11-20 mins	Review pertinent medical records, lab/imaging studies, medication profile, etc. and medical consultative verbal or internet discussion ^b	0.70	1.01
▲99448	Consultant	Verbal and written report to requestor	21-30 mins	Review pertinent medical records, lab/imaging studies, medication profile, etc. and medical consultative verbal or internet discussion ^b	1.05	1.52
▲99449	Consultant	Verbal and written report to requestor	≥ 31 mins	Review pertinent medical records, lab/imaging studies, medication profile, etc. and medical consultative verbal or internet discussion ^b	1.40	2.02
●99451	Consultant	Written report to treating/requesting physician/QHP	≥ 5 mins	Review pertinent medical records, lab/imaging studies, medication profile, etc. and medical consultative verbal or internet discussion	0.70	1.04
●99452	Treating/requesting physician/QHP	N/A	≥ 16mins ^c	Preparing for the consult and/or the actual time spent communicating with the consultant	0.70	1.04

^a The facility and non-facility relative value units (RVUs) are identical

^b For codes 99446-99449, more than 50% of the service time must be consultative time and not time used to review data. Do not report codes 99446-99449 if data review time is greater than 50% of the total service time.

^c Code 99452 can be reported in addition to non-direct prolonged services (99358-99359) if appropriate (see CPT manual)

• new code

▲ code with a revised descriptor

Shaded boxes note some major differences.

wRVU: work relative value unit

What evidence is there for Telehealth?

Published evidence for the use of telehealth and telemedicine in specific areas existed prior to COVID, but with wide spread adoption of telehealth into all areas in response to the pandemic **there is a growing body of literature to support the use of telehealth more broadly in the inpatient setting:**

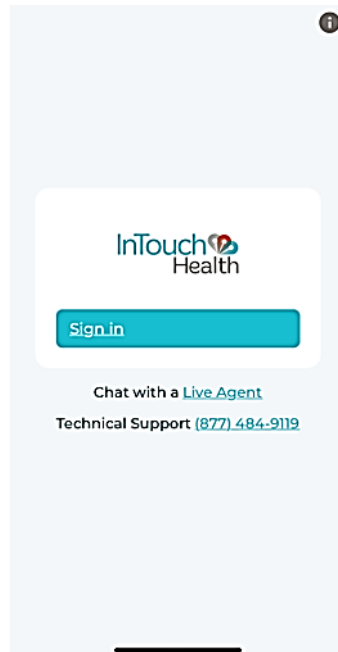
1. Gabel C.K., Nguyen E., Karmouta R., Liu K.J., Zhou G., Alloo A., et al. Use of teledermatology by dermatology hospitalists is effective in the diagnosis and management of inpatient disease. J Am Acad Dermatol. 2020(pagination):ate of Pubaton: 07 May 2020.
2. Humphreys J., Schoenherr L., Elia G., Saks N.T., Brown C., Barbour S., et al. Rapid Implementation of Inpatient Telepalliative Medicine Consultations During COVID-19 Pandemic. J Pain Symptom Manage. 2020(pagination):ate of Pubaton: 2020.
3. Jones M.S., Goley A.L., Alexander B.E., Keller S.B., Caldwell M.M., Buse JB. Inpatient Transition to Virtual Care During COVID-19 Pandemic. Diabetes Technology and Therapeutics. 2020 01 Jun 2020;22(6):444-8.
4. Kalin M.L., Garlow S.J., Thertus K., Peterson MJ. Rapid Implementation of Telehealth in Hospital Psychiatry in Response to COVID-19. Am J Psychiatry. 2020 01 Jul 2020;177(7):636-7.
5. Keller J.J., Johnson J.P., Latour E. Inpatient teledermatology: Diagnostic and therapeutic concordance among a hospitalist, dermatologist, and teledermatologist using store-and-forward teledermatology. J Am Acad Dermatol. 2020 May 2020;82(5):1262-7.
6. Monkowski D., Rhodes L.V., Templer S., Kromer S., Hartner J., Pianucci K., et al. A retrospective cohort study to assess the impact of an inpatient infectious disease telemedicine consultation service on hospital and patient outcomes. Clinical Infectious Diseases. 2020 01 Mar 2020;70(5):763-70.
7. Mustafa S.S., Staicu M.L., Yang L., Baumeister T., Vadmalai K., Ramsey A. Inpatient Electronic Consultations (E-consults) in Allergy/Immunology. The journal of allergy and clinical immunology. In practice. 2020(pagination): Date of Publication: 22 Jun 2020.


Rev 10.19.202

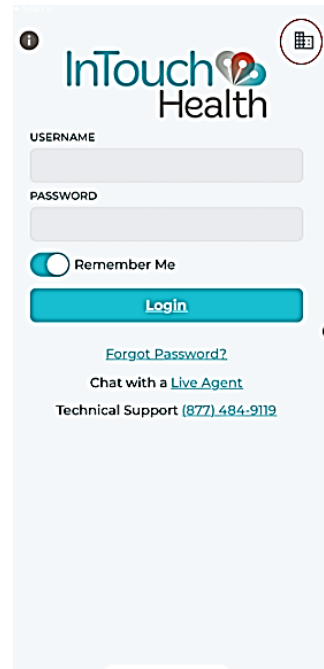
InTouch New Login


You can now use you YNHH credentials to login to InTouch for ALL YNHH units.

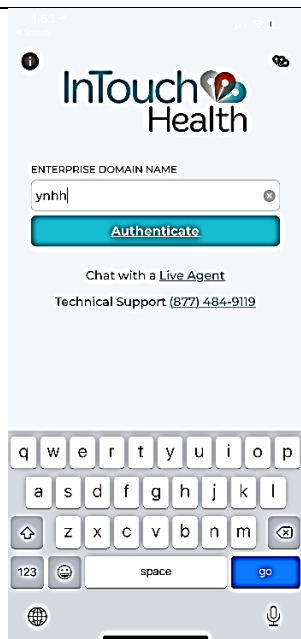
1. open the App, click “sign in”



2. Click the  icon (circled red).



3. Type “”



4. Type in your YNHH credentials







InTouch tips

1. You can scroll up or down to find the specific room number where the patient is located.
2. You can also find a room by scrolling up and typing it in the search bar.



InTouch carts are not on all inpatient medicine settings but are set up in specific locations.

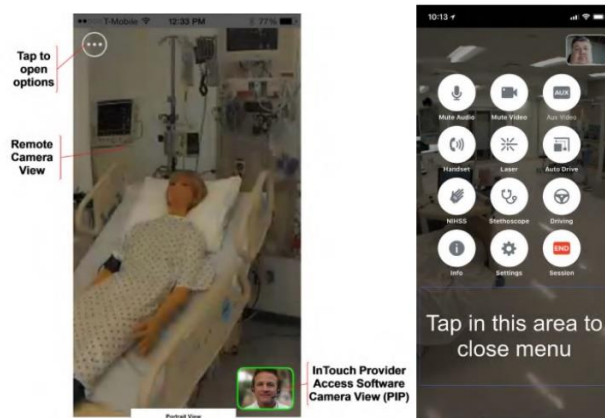
3. Call the Unit BA/patient nurse (see APPENDIX for hints on reaching patient nurse via MHB) to verify patient can be seen using InTouch cart, and if the InTouch Name is correct (some units may have moved the carts).
4. The color icon next to the room number indicates its status.

	Green — Patient Access Device is Ready
	Blue — Patient Access Device is Busy
	Gray — Patient Access Device is Offline or Status is Unavailable
	Three Blue Connected — MultiPRESENCE is Available

5. **Starting a session:** When the color to the left of the room number is green, click on a room and you will be “in session” with the patient. The patient does not have to click on a screen.

iPhone Dashboard

The iPhone Dashboard has three different areas: the Remote Camera view (video from the Patient Access Device camera), the InTouch Provider Access Software Camera View (PIP) (video from the iPhone front-facing camera), and the Tool Bar.



6. Controlling the view

Gesture Based Video Control

When using the InTouch Provider Access Software, the Patient Access Device camera's pan, tilt, and zoom features are controlled by a series of gestures. In many cases you are controlling the head motion of the Patient Access Device, not just the camera.

NOTES:

- Be Patient! Remember that gesture commands are traveling over an Internet connection to the Patient Access Device, then causing a head or camera motion, and finally the video returns over an Internet connection to be displayed on the InTouch Provider Access Software. Bandwidth limitations and interruptions may cause significant delay (seconds) in viewing the results of your commands.
- If using an iPad, tap the Quick Help button in the Info Menu for the Gesture help screen overlay.

Spread (Zoom In)

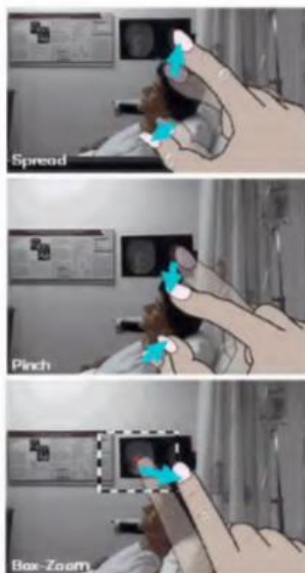
Gently press with two fingers and spread them apart until you zoom in to the desired level. The zoomed video will take a second to appear after you remove your fingers from the display. Remember that both fingers must remain in contact within the Remote Display view (either full screen or normal).

Pinch (Zoom Out)

Gently press with two fingers and pinch them together until you zoom out to the desired level. The zoomed video will take a second to appear after you remove your fingers from the display. Remember that both fingers must remain in contact within the Remote Display view (either full screen or normal).

Box-Zoom (Zoom In)

Gently press and drag with a single finger to make a zoom box. Start with your finger in the center of the view you would like to see close up, then drag until the zoom box includes all that you want to see. The Box-Zoom outline



will follow as you move your finger, and when released the zoomed video will take a second to appear.

Tap (Point-to-See)

Gently press and release with a single finger. Use a tap to select a button in a tool bar or dialog box. When you tap in the live Remote Camera view (Point-to-See), the Patient Access Device will center and focus on that point in the Remote Camera view. When in session on an InTouch Xpress, or other Patient Access Device without head motion, the camera view will not re-center if the zoom setting is full screen.

Double-tap (Zoom Out)

Gently and quickly press and release twice with a single finger. When you double-tap in the live Remote Camera view, the Patient Access Device will return to full view from any zoom level while remaining focused on the same spot.

Triple-tap (Zoom Out and Center Head)

Gently and quickly press and release three times with a single finger. When you triple-tap in the live Remote Camera view, the Patient Access Device will return to full view from any zoom level and return to its home head position. The home head position is typically level and facing straight forward.

APPENDIX E: iPad with Zoom and FaceTime Video Conferencing for Patients

iPad: Utilizing Zoom (page 1) or FaceTime (page 3) to support patient/family video conferencing (including Mom/Baby)

Note: This device should be treated just like a “patient visitor” and respect patient confidentiality & patient care while video-conferencing is in use.

Infection prevention recommendations for proper cleaning between patient uses related to COVID-19
Use the hospital approved disinfecting wipes to thoroughly wipe down the entire case that the device is in. The iPad device should remain in the case. Follow the disinfecting wipe manufacture instructions.

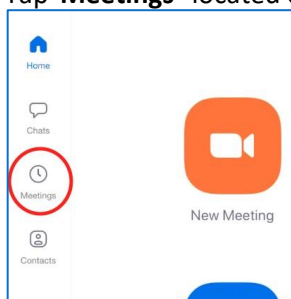
- **Special Note:** If the device was to go from one unit to another unit, remove the device from the case, wipe down both the case and the iPad down thoroughly with the hospital approved disinfecting wipe, let the device dry completely and reapply the case.

Initiating a Zoom Meeting from the iPad:

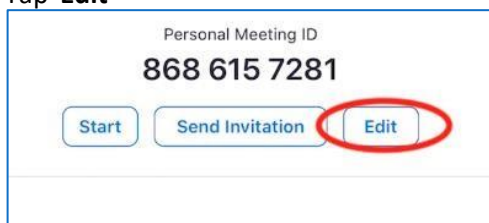
1. To Initiate a Zoom Meeting, select the **Zoom** Icon



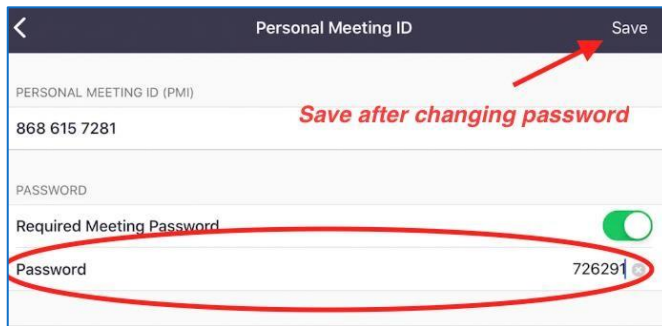
2. Tap **Meetings** located on the left side of the screen



3. Tap **Edit**



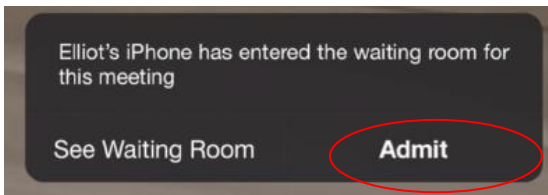
4. Tap on **Password** and change the meeting password to the patient's room & bed number



5. Provide the Meeting ID and the password you created to the patient's family and tap **Start** to begin the meeting.

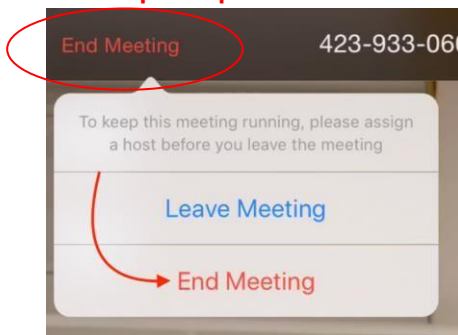


6. Wait for the family to join, when they join, you will need to **Admit** them into the meeting by tapping **Admit**. The meeting will begin once the family has been admitted.



7. Once the visit is complete, tap the screen, then tap "**End Meeting**" in the upper right-hand corner of the screen, then tap "**End Meeting**" in the drop down.

This step is important as it ends the call for all participants.



Instructions for the Family to Connect to the Zoom Meeting:

1. Go to the Apple app store or Google Play Store and download the Zoom Cloud Meetings app.
2. Open the app and tap join a meeting. (Note for apple users: You will need to allow access to Microphone and Camera)



Please contact the ITS Service Desk with any technical issues.

3. Enter the **Meeting ID & Password** provided by the staff and tap, **Join a Meeting**. You will need to wait for the staff member to admit you to the meeting.

Initiating FaceTime Meeting from the iPad:

Note: the hospital iPad can only make outgoing Facetime calls, it cannot receive incoming calls from family & friends.

What is Facetime?

Facetime is an application that works on Apple devices that allows users to make audio and video calls.

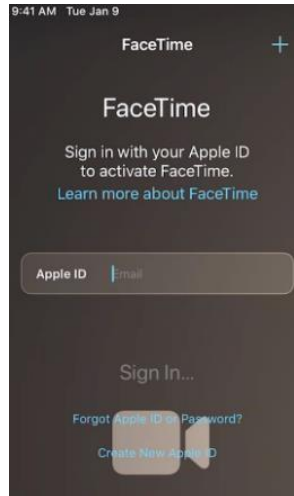


What Devices does it work on?

- Patients are distributed iPads that are already signed in with generic YNHH.org facetime accounts. These devices can only call out to other facetime users.
- Patients' Family & Friends will have to enable facetime on their Apple device to receive calls from patients. Here are Facetime's minimum software requirements:
 - Mobile Devices (iPhone, iPad, iPod Touch) must be on iOS 7 or later
 - Mac computers must be on Mac OSX 10.9 or later

How Do I Set up Facetime?

- **Patients:** The FaceTime application should already be configured prior to use. If you see this screen asking you to "Sign in with your Apple ID" after opening the app, contact a staff member for help.



- **Staff Members:** If the FaceTime application is not already signed in, please log the device in for the patient. Your unit manager should have a list of Apple IDs and passwords for patient iPad FaceTime use.
 - The Apple ID that should be used is the device's name, which is shown on the lock screen (see right), + @ynhh.org.

For example, the Apple ID for patientzm0002 would be:

.

- To find the password, reference the Apple ID/Password list. If your manager does not have a copy of this list, contact the Service Desk and inform them you're setting up an iPad for patient to-family FaceTime consult. If you provide them with the iPad name, they should be able to provide you with the correct password.

NOTE: DO NOT USE PERSONAL APPLE IDs ON THESE DEVICES

Yale
NewHaven
Health

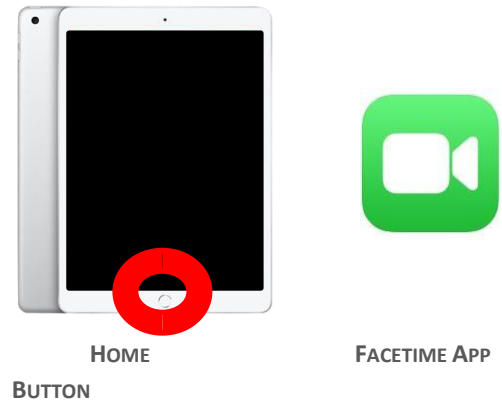
Please clean device before use

Provide this information → PATIENTZM0002


How Do I Make a FaceTime Call?

Step 1: Open The FaceTime App

- Open the iPad by pressing the home button.
- Tap on the green Facetime App.



Step 2: Find the person you are trying to facetime

- Tap the plus button  and type the person's phone number or email address (Figure 1)

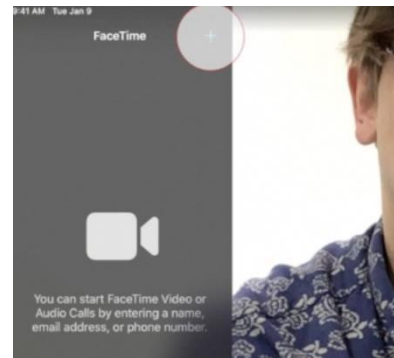




FIGURE 1

Step 3: Start the FaceTime call

- After entering the recipient's Apple ID or phone number, tap the "return key". (Figure 2)
- The Audio  and Video  buttons should turn green. (Figure 3)
- If the buttons do not turn green, try the following:
 - Make sure the Apple ID or phone number you

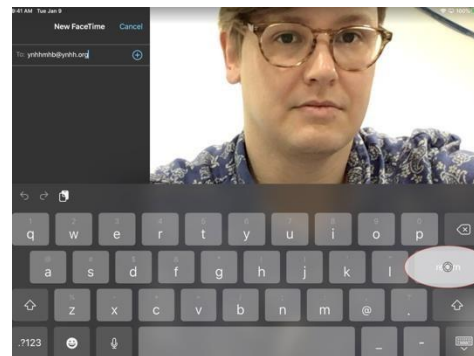



FIGURE 2

once by their iPhone cell number. Some users only have one method enabled.



entered is correct. ○ Try to call the user once by their Apple ID and

- Next, tap Audio or Video  to start the FaceTime call (Figure 3).
 - Audio will start an audio only FaceTime call.
 - Video will start a video FaceTime call.

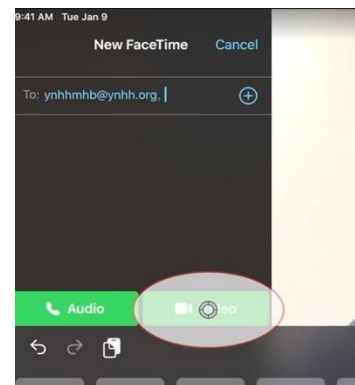


FIGURE 3

Step 5: The Call will connect once the recipient answers

- The recipient's device will ring.
- They will see the ynhh.org Apple ID in their caller ID on their mobile device (Figure 4).

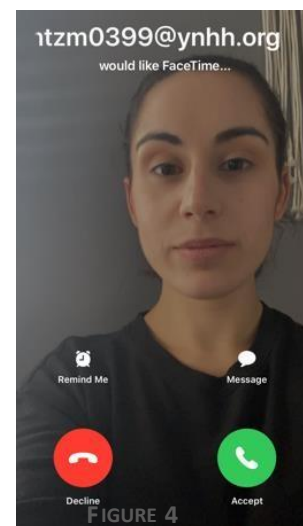


FIGURE 4

Step 6: The Call Is now live

- Once the recipient answers, the call will connect, and they will be shown on the screen. (Figure 5)
- You can bring up the FaceTime options menu by tapping anywhere on the screen.

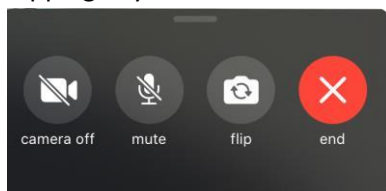


FIGURE 5

- When you are finished, tap the “end” button to disconnect from the call.

How do I clear the Call History?

After each patient use, the call history must be deleted for privacy concerns. YNHH staff members should erase the calls prior to letting a new patient use the iPad by following the steps below:

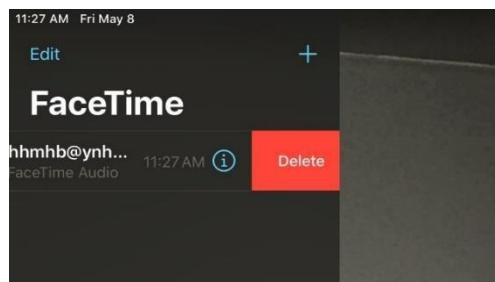
- Swipe to delete single contacts (see Figure 6 to the right)

□ Multiple contacts can also be deleted:

- Tap the “edit” button (Figure 6)
- Select the conversations that need to be deleted (see Figure 7)
- Tap the delete button at the bottom (see Figure 7)

(see Figure 7)

FIGURE 6



For Assistance:

- If you are a patient, ask a staff member for help.
- If you are a staff member, contact the ITS Service Desk.
- Users that are not patients or staff can reference www.apple.com/facetime for help with FaceTime setup and support.

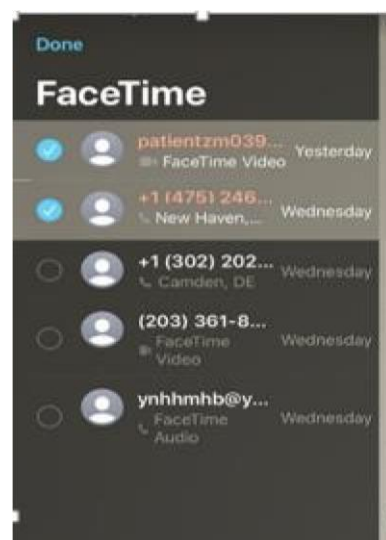


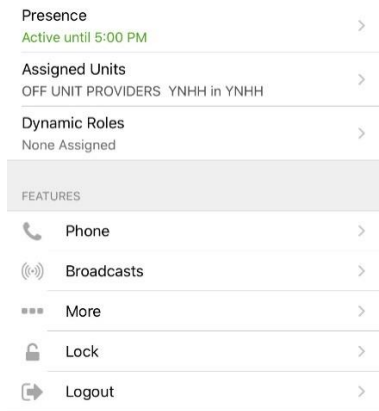
FIGURE 7

APPENDIX F: ACCESSING PATIENT AND TEAM PHONES

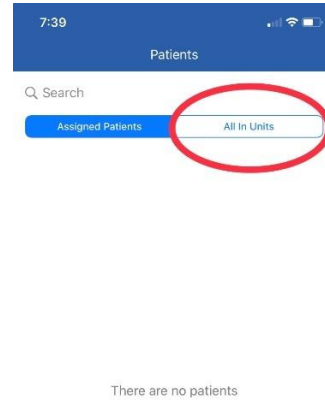
Accessing Patient's Bedside Phone & Covering Team phone from MHB

1. Log-in to MHB

2. Click on "patient" icon.



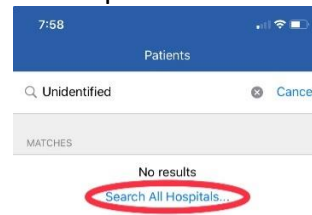
3. Click on "All In Units"



4. Type the patient's name or MR # in the



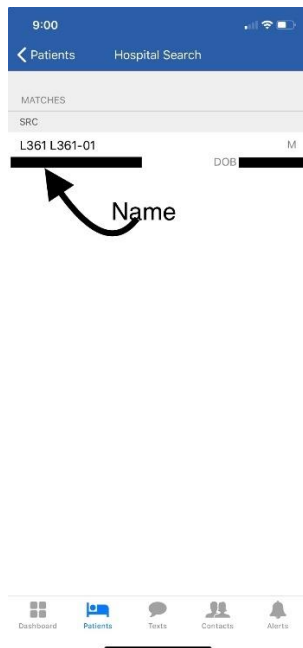
5. If you don't see the patient click on "search All Hospitals..."



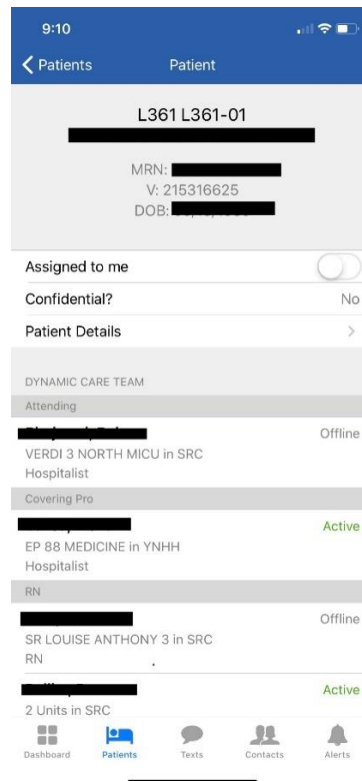
search bar.



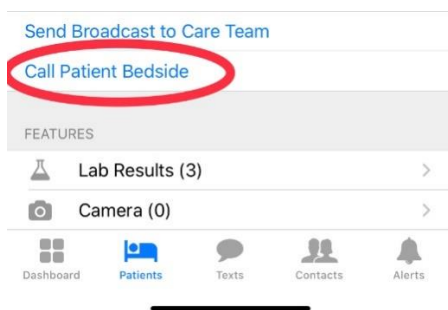
6. Click on the specific patient



7. You will access the patient's info and covering team



8. Scroll all the way to the bottom of the page and you will find the patient's Bedside phone



APPENDIX G: LEGAL FORMS

Legal forms may be found by going to the YNHH Intranet, selecting “Resources,” selecting “Departments and Communities,” selecting “Legal and Risk Management,” selecting “Policies and forms.” Available forms include conservatorship, voluntary and involuntary commitment, Physician’s Emergency Certificate, Probable Cause Hearing Request, etc.

The direct link is [here](#)

APPENDIX H: CODE STATUS POLICY UPDATE

The special resuscitation protocol put in place during last spring's wave has been reactivated as of November 18, 2020, with two minor changes. The policy allows two physicians, together, to change code status to DNR for patients with low survivability of an in-hospital code. The two changes are as follows:

- This version of the protocol supports only do-not-resuscitate status, not do-not-intubate.*
- Emergency Medicine physicians can invoke this protocol only for patients with suspected or confirmed COVID-19, which aligns it with the inpatient protocol. The previous version allowed its use for any patient with low survivability of an in-hospital code.*

Protocol re Code Status and CPR

YNHHS respects, protects and supports each patient's rights, including the right to take part in decisions about care and treatment.² Accordingly, clinical teams will make every effort to discuss matters of code status with patients and/or surrogates as early as possible upon admission or presentation to the emergency department. In some circumstances, aggressive resuscitation efforts are unlikely to benefit the patient and may be traumatic and painful without a likelihood of changing chances of survival. In cases where aggressive resuscitation efforts are not recommended by the clinical team, clear information will be provided to patients and/or surrogates and attempts made to obtain assent to assignment of a code status of "Do Not Resuscitate" (DNR)³ when clinically appropriate.

There may be circumstances where the assent of the patient/and or surrogate is not or cannot be obtained but in the opinion of the two physicians changing the code status is appropriate because, in light of the patient's medical status, in the event the patient degrades to the point where aggressive resuscitation efforts would be needed, such patient would at that time be in a terminal condition as disease progression at that point would be irreversible and reasonably likely to lead to death. In such circumstances, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status and documentation of such efforts must be included in the medical record. If assent cannot be obtained and transfer is not available,⁴ during the effective time of this Protocol, the following will apply:

1. **Critically Ill Patients with COVID-19.** The benefit of providing cardiopulmonary resuscitation (CPR) to critically ill patients with COVID-19 is likely to be low in most cases. CPR also exposes healthcare workers to high risk of infectious transmission. In addition, for certain of these patients, intubation may be dangerous or futile. For these reasons, attending physicians may, without the prior authority of the patient or surrogate, assign code status of DNR to critically ill COVID-19 positive patients where, in the good faith, best medical judgment of two attending physicians, it is determined to be clinically appropriate and that aggressive resuscitation is unlikely to benefit the patient because in the event such efforts were required, the patient would be in a terminal condition with an extremely low likelihood of survival to hospital discharge. Prior to changing the patient's code status, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status

and documentation of such efforts must be included in the medical record.

2. **Critically Ill Patients with suspected or confirmed COVID-19 in the Emergency Department.** Attending physicians may, without the prior authority of the patient or surrogate, assign code status of DNR to patients in the emergency department who are suspected or confirmed to have COVID-19, where, in the good faith, best medical judgment of two attending physicians, it is deemed to be clinically appropriate and that aggressive resuscitation is unlikely to benefit the patient because in the event such efforts were required, the patient would be in a terminal condition with an extremely low likelihood of survival to hospital discharge. Prior to changing the patient's code status, the clinical team must make a good faith effort to consult with and consider the wishes of the patient and/or surrogate regarding the change in code status and documentation of such efforts must be included in the medical record.

Treating physicians may reverse DNR code status that is assigned without patient or surrogate assent if a patient's condition has improved and the physician determines that the change in code is clinically appropriate. Treating physicians may also reverse DNR code status that is assigned without patient or surrogate assent if they believe cardiac arrest is due to a reversible cause that will not require prolonged cardiopulmonary resuscitation. Typical examples might include VT/VF arrest in the setting of electrolyte abnormalities or acute coronary syndrome.

APPENDIX I: Inpatient Psychiatry Admission Algorithm

Updated: 11/25/2020

Inpatient Psychiatry Admission Algorithm

Transfer type	Admission / Transfer criteria	Comments
<ul style="list-style-type: none"> • PES -> Inp. Psych • External -> Inp. Psych 	1. <ul style="list-style-type: none"> a) Negative test during current ED episode OR <ul style="list-style-type: none"> b) Negative test <48hrs prior (external) AND <ul style="list-style-type: none"> 2. No COVID symptoms 	• Note • due to the congregate care setting of inpatient psychiatry, these guidelines <u>exceed</u> the current standards provided by CDC (revised 10/21) and YNHHS (revised 10/26)
<ul style="list-style-type: none"> • COVID+ Medicine -> Inp. Psych 	1. <ul style="list-style-type: none"> a) > 10 days since initial positive test AND b) Asymptomatic for >=3 days (no fever, SOB) OR <ul style="list-style-type: none"> 2. <ul style="list-style-type: none"> a) Initial COVID+ test > than 10 days ago AND b) 1 negative test AND b) >3 days without fever 	• Note these guidelines were developed in concert with YNHHS Infection Prevention.
<ul style="list-style-type: none"> • COVID negative -> Inp. Psych 	1. A negative test within 72 hours prior to transfer from inpatient medicine 2. No COVID symptoms	• Note • these guidelines exceed the current standards provided by CDC and YNHHS.