Access ALL Institute for Human Caring

COVID-19 Resources HERE

Institute for Human Caring
Providence St. Joseph Health

CATEGORY	NAME
CLINICAL GUIDES + RESOURCES	→ Guide for Physicians o Adapted from: CAPC COVID-19 Response Resources
ADVANCE DIRECTIVES	→ State-Specific Advance Directive Forms (including EZ Form) → Web2Print-EZ Form AD Order Info
(TDM) TRUSTED DECISION MAKER	(TDM) Trusted Decision Maker Resource Page → TDM for Non-Epic Ministries → FAQs - TDM and Preliminary AD → Epic Guide (1-page) - TDM and Preliminary AD → Epic TDM Workflow VIDEO → Decision Chart - TDM → Decision Chart - Surrogate Decision Maker
TELE PALLIATIVE CARE (PC)	TelePC Resource Page → Implementation Toolkit o **Implementation Quick Tips**: iPad Fact Sheet, Policy Fact Sheet o **For Caregivers:** DotPhrases, Workflow Guidelines o **For Patients & Families:** Patient FAQs, Patient At-home Instructions → Presentations → References
PALLIATIVE CARE REFERENCES	Palliative Care References Page → Articles, professional organization position statements, etc. → Palliative Care Disaster Plans
PSJH ETHICS GUIDES	→ PSJH Ethics Brief Guide → PSJH Ethics Extended Guide → Additional References
CAREGIVER SUPPORT	Caregiver Support Resource Page → Self Care, Death and Grief Resources (long and short versions)

COVID-Ready Communication Skills
Adapted from
COVID-Ready Communication Skills, a playbook of VitalTalk Tips

Institute for Human Caring
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Deciding — When things aren't going well, goals of care, code status

What they say	What you say
I want everything possible. I want to live.	I hear you clearly. We will continue to give you the best care we can. This is a tough situation. Could we step back for a moment so I can learn more about you? ***What do I need to know about you to do a better job taking care of you?***
I don't think my spouse would have wanted this.	Well, let's pause and talk about what s/he would have wanted. Can you tell me what has been most important in her/his life? ***What means the most to her/him and gives her/his life meaning?***
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. ***Can you say more about what you mean?***
I am not sure what my spouse wanted—we never spoke about it.	Many people find themselves in the same boat. This is a hard situation. To be honest, your spouse is very sick. If we need to put her/him on a breathing machine or do CPR, I do not think s/he will survive. This is hard for me to say, but the odds are just against us. ***My recommendation is that we accept that s/he will not live much longer and allow her/him to die peacefully.*** I imagine that may be hard to hear. What do you think?

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Resourcing in a Crisis — When limitations force you to choose, and even ration

What they say	What you say, and why
My grandmother needs the ICU! Or she is going to die!	I know this is a scary situation, and I am worried for your grandmother myself. ***This virus is so deadly that even if we could transfer her to the ICU, I am not sure she would make it.*** So we need to be prepared that she could die. We will do everything we can for her. **[C]***
Why can't my 90 year old grandmother go to the ICU?	This is a very difficult time and situation. **The truth is that whatever we do, it is very likely that your grandmother will die.** *I wish that wasn't the case, but it is.* ***There is a team of experienced doctors who are responsible for making very difficult decisions about using limited ICU beds during the pandemic. It is not up to me. They will be reviewing her case.*** It is possible that given your grandmother's condition, she may not be able to go to the ICU during this crisis situation. If that happens, I promise you that we will take good care of her for as long as she lives. **[C]***
Shouldn't I be in an intensive care unit?	The hospital is being forced to use special rules about treating patients in the ICU because we are trying to use our resources in a way that is fair for everyone. ***There is a team of experienced doctors who are responsible for making very difficult decisions about using limited ICU beds during the pandemic. It is not up to me.*** Unfortunately, your condition may not meet criteria for the ICU right now. ***If it were not for this public health crisis, we might be making a different decision. This is an extraordinary time.*** I wish I had more resources – we all do. **[C]***
Are you just discriminating against her because she is old?	I can see how it might seem like that. You really care about her. **No, we are not discriminating.** *We are trying to make the best decision for each individual patient, based solely on a person's medical condition and likelihood of benefiting from treatments.* *During this crisis, if there are not enough ICU beds or ventilators for every patient who needs them, we can rely on public health guidelines for how to give good and just care.* ***These guidelines were developed by people of multiple religions and ethnic backgrounds*** *and included* health care professionals, ethicists, spiritual leaders and lay people who considered all the pros and cons in *preparing for a public health crisis like this*. The guidelines we are using have been approved by the leadership of Providence and are consistent with state government guidelines. **[C]***

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You're treating us differently because of the color of our skin.	***I can imagine that you may have had negative experiences in the past with health care simply because of who you are.*** That is not fair, and I wish things had been different. But, honestly, this is not discrimination. We strongly believe that every person has dignity and worth. The situation today is that critical medical resources are stretched so thin that we are using guidelines that were developed by people in this community – including people of color – so that we can be fair. **[C]***
It sounds like you are rationing.	We are trying to use limited resources fairly. ***I wish we had more for every single person in this hospital, but we don't.*** **This situation affects us all.** **Many of us have colleagues, friends and family members who are ill and need care.** **[C]***
You're playing God. You can't do that.	I am sorry. I did not mean to give you that feeling. ***Across the city, every hospital is working together to try to use limited resources in a way that is fair for everyone. I realize that we don't have enough.*** I wish we had more. Please understand that we are all working as hard as possible. **[C]***
Can't you get 15 more ventilators from somewhere else?	Right now the hospital is operating over capacity. It is not possible for us to increase our capacity like that overnight. ***I realize that must be disappointing to hear.*** **[C]***
How can you just take them off a ventilator when their life depends on it?	I'm so sorry that her condition has gotten worse, even though we are doing everything we can. The hard fact is that h/she is dying even with our best efforts. We are in an extraordinary time, and we are following special guidelines that apply to everyone. We cannot continue to provide critical care to patients who are not getting better. Sadly, this means that we need to accept that s/he will die, and that we need to take her/him off the ventilator. I wish things were different. **[C]***
Who made this decision?	I can't imagine how frustrating this decision is. It was made by team made up of experienced doctors who are trying to spread out resources in the best way possible. I wish we had more for every person here. As their doctor, I do not participate in that process. I do promise as their doctor I will continue to provide the best care possible for them and ensure that their death is as comfortable as possible. **[C]***

[C] = For Communicating only during a crisis.
* While all clinicians may need to know how to respond to these questions, best practice would be for a physician member of the team to be the first person to discuss this with a patient or family.

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Notifying — When you are telling someone over the phone

What they say	What you say
Yes I'm his daughter. I am 5 hours away.	I'm sorry to be having this conversation by phone. I am calling with serious news. Are you in a place where you can talk?
What is going on? Has something happened?	I am calling about your father. He died a short time ago. The cause was COVID19.
[Crying]	I am so sorry for your loss. [Silence][If you feel you must say something: Take your time. I am here.]
I knew this was coming, but I didn't realize it would happen this fast.	I can only imagine how shocking this must be. It is sad. [Silence] [Wait for them to restart]

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For more COVID-19 communication tips review the Center to Advance Palliative Care COVID Resources

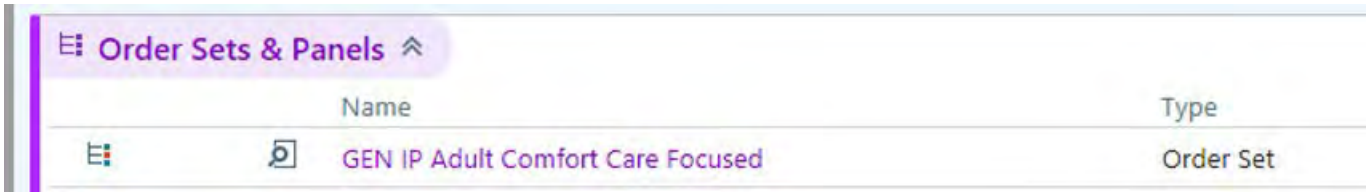
Download the VitalTalk Tips App (iOS or Android)

VITAL talk

Electronic Health Record Resources (EHR)

Comfort care order set exists in both the Epic and Meditech EHRs. These order sets contain commonly used medications and dosing for control of common symptoms. These can be accessed by:

1) **Epic** - From the orders navigator, search for the "GEN IP Adult Comfort Care Focused" order set



2) **Meditech** - From the order set menu, search for Comfort Care Adult SS (OC/HD), N Comfort Care End of Life (NorCal), or T Palliative Medicine (Texas).

Southern California example

Updated 3/19/20

Symptom Medications

COVID-19 Clinical Resource

Center to Advance Palliative Care℠ capc

Rescue Medications for Symptom Distress

Rescue medications are for symptoms that are unrelieved by regularly administered medications. Once acute symptoms are controlled, switch to standing (around the clock) regimen of the effective dosage, every 4 hours for morphine, every 6 hours for haloperidol, lorazepam, and metoclopramide. For more opioid prescribing guidance, see pain card.

Pain or Shortness of Breath or Cough:

ORAL or SUBLINGUAL:

Morphine liquid: 10 mg per 5 ml, take 2.5 ml every 30 minutes until relief. Increase to 5 ml if no relief from starting dosage.

Morphine tablets 15mg: ½ tablet PO every 30 minutes until relief. Increase to 1 tablet if no relief from starting dosage.

IV or SQ:

Morphine 5mg IV or SQ every 30 minutes until relief. Increase to 10 mg if no relief from starting dosage.

Nausea, Restlessness, Anxiety, Agitation, or Confusion:

ORAL or SUBLINGUAL:

Haloperidol liquid (Haldol): 2 mg per ml, Give ¼ ml to ½ ml by mouth or under tongue every hour until relief or calm.

Haloperidol tablets: 1 mg tablet, give half tablet every 1 hour until calm, increase to full tablet if no relief from starting dosage.

IV or SQ:

Haloperidol 2 mg/ml ¼ ml every hour until relief, increase to ½ ml if no relief from starting dosage.

Anxiety, Restlessness, or Agitation (not relieved by haloperidol):

ORAL or SUBLINGUAL:

Lorazepam liquid (Ativan): 2 mg per ml, Give ¼ to ½ ml by mouth or under tongue every hour until relaxed/calm, increase to 1ml if no relief from starting dosage.

Lorazepam tablets: 1 mg tablet, give ½ tablet every hour until calm, increase to 1 tablet if no relief.

IV or SQ:

Lorazepam 1 mg/ml, give ½ ml every hour until relief, increase to 1 ml if no relief from starting dose.

Symptom Control

Pain, dyspnea, cough:

ORAL or SL:

Morphine Sulfate: 15 mg ½-1 tablet every 4 hours AROUND THE CLOCK. (once we know what the average daily total requirement is to keep pain or dyspnea below a 5 out of 10, switch to a long acting pain medicine, see pain card).

IV or SQ:

Morphine 5 mg IV or SQ every 3 hours around the clock. Increase by 50% for pain unrelieved by starting dose.

Nausea:

ORAL or SUBLINGUAL:

Metoclopramide: 10 mg every 6 hours around the clock.
OR
Ondansetron: 4 mg every 8 hours, increase to 8 mg if no relief from starting dosage.

IV or SQ:

Metoclopramide 5 mg/ml, give 1 ml every 6 hours around the clock.
OR
Ondansetron: 0.15 mg/kg IV every 8 hours

****If using antiemetics for opioid-induced nausea give 30 minutes before morphine to prevent nausea - this should only be necessary for 3-4 days as nausea wears off with time.**

Preventing Constipation:

Miralax powder: 1-2 capfuls in water or juice or any liquid you like *every day*. If no daily bowel movement increase to 3 capfuls. Over the counter.
+
Dulcolax suppository: 1 or 2 per rectum *every morning* after breakfast. Over the counter.

Prescribing Opioids: A Reference Guide

Center to Advance Palliative Care™
capc

Starting Doses in the Opioid-Naïve Patient
START LOW AND TITRATE BASED ON RESPONSE

Drug Name	Oral Dose	Intravenous Dose
Morphine	7.5 mg (15 mg pill cut in half)	2 mg
Hydromorphone	1 mg (2 mg pill cut in half)	0.2 mg
Oxycodone	2.5 mg (5 mg pill cut in half)	—
Hydrocodone	5 mg	—

CAUTION: Prescribers should always consult the individual drug monographs for comprehensive information. Transdermal fentanyl should not be used in the opioid-naïve patient.

Equianalgesic Conversion Table

Drug Name	Equianalgesic Dose		Oral to Parenteral Ratio
	Oral (mg)	Parenteral (mg)	
Morphine	25	10	5:2
Hydromorphone	5	2	5:2
Oxycodone	20	n/a	n/a
Hydrocodone	25	n/a	n/a
Oxymorphone	10	1	10:1

Potency ratios:
→ oral morphine: oral hydromorphone is 5:1
→ oral morphine: oral oxycodone is 1.25:1
→ oral morphine: IV hydromorphone is 12.5:1
→ transdermal fentanyl 25mcg/hr: oral morphine 50mg/24hr

Oral hydromorphone is 5 times as potent (mg per mg) **as oral morphine**

This conversion table is adapted from: McPherson ML. Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd ed. American Society of Health-System Pharmacists, Bethesda, Maryland, 2018.

Common Dosing Strengths and Availabilities

Formulation	Strength
Morphine Sulfate	IR 15 mg, 30 mg
Morphine Sulfate Oral Solutions	10 mg/5 ml, 20 mg/5 ml Also available in a highly concentrated 20mg/ml solution
Morphine Sulfate ER	15 mg, 30 mg, 60 mg, 100 mg, 200 mg
Oxycodone IR	5 mg, 10 mg, 15 mg, 20 mg, 30 mg
Oxycodone Oral Solutions	5 mg/5ml and 20 mg/ml
Oxycodone ER	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
Hydromorphone	2 mg, 4 mg, 8 mg
Hydromorphone ER	8 mg, 12 mg, 16 mg, 32 mg
Oxymorphone IR	5 mg, 10 mg
Oxymorphone ER	5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg
Fentanyl Patch	12 mcg/hour, 25 mcg/hour, 50 mcg/hour, 75 mcg/hour, 100 mcg/hour
Methadone	5 mg, 10 mg
Methadone Oral Solutions	5 mg/5 ml, 10 mg/5 ml, 10 mg/ml
Buprenorphine Transdermal System	5 mcg/hour, 10 mcg/hour, 15 mcg/hour, 20 mcg/hour

Institute for Human Caring
Providence St. Joseph Health

TELEHEALTH FACT SHEET

Introduction

With the COVID-19 emergency rapidly evolving, and tele-health emerging as a crucial response strategy, the Institute for Human Caring has synthesized key information around the latest tele-health guidelines and billing/coding protocols into one digestible resource for your reference.

This is a living document that will be updated as new information becomes available.

New Regulations

- **Telehealth visits are now considered the same as an in-person visit.** Tele-health visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

- **You do not need to have a pre-established relationship with a patient.** Normally you need to have an established relationship with a patient to bill for telehealth services, but HHS will not be auditing this during the COVID-19 response.

- **You can conduct tele-health appointments from anywhere.** The new waiver eliminates the need for caregivers to be at a medical facility or physician's office; patients can receive tele-health service from their homes or any setting of care.

- **HIPAA compliance standards have been suspended for platforms like Facetime and Skype.** Although the **Zoom** platform remains strongly preferred, penalties for HIPAA violations will be waived for health care providers serving patients in good faith through everyday communications technologies, such as **FaceTime** or **Skype**, regardless of whether the patient has symptoms/diagnosis of COVID-19. **Telephonic communication**, while not ideal, is also allowed.

- **Caregivers should enable encryption and privacy modes as much as possible.** Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should **NOT** be used.

- **For disinfecting tablets and other electronic devices, always disinfect to the strongest recommendation based on the patient's diagnoses.** For COVID-19, PDI Super Sani Cloths (or equivalent non-abrasive, non-bleach wipes) have been approved by Infection and Prevention.

Last Updated April 1, 2020

Billing/Coding

- Medicare will pay the same amount for tele-health services as an in-person visit.
- Tele-health does not change out-of-pocket costs for Medicare patients, but there is flexibility to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs (e.g.; Medicare or Medicaid).
- There are three main types of virtual services caregivers can provide to Medicare patients: **Medicare telehealth visits, virtual check-ins and e-visits**.

See below for a summary of telehealth services and the corresponding billing codes:

TYPE OF SERVICE	WHAT IS SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For *new or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check-in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evalutation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Resources

MEDICARE TELEMEDICINE HEALT

3.17.20 COVID 19 Telehealth Waiver FAC

Medicare_telehealth_code_list_for_cy_2019_

Last Updated April 1, 2020

Level of Service

TeleHealth Consult			Minutes
Level 1	G0425	Inpt/ed teleconsult	30
Level 2	G0426	Inpt/ed teleconsult	50
Level 3	G0427	Inpt/ed teleconsult	70
Level 1	G0406	Inpt/tele follow up	15
Level 2	G0407	Inpt/tele follow up	25
Level 3	G0408	Inpt/tele follow up	35

Modifiers

-95 can be used for telemedicine services rendered via real-time interactive video telecommunications equipment

-25 can be used for a significant, separately identifiable E&M service above and beyond the other service provided

Additional E/M codes

Visit	CPT Code	Short Description	Threshold Time
Prolonged Services (Acute with Patient)			
1st Hr	99356	Prolonged service inpatient	31-75 mins
Addl 1/2	99357	Prolonged service inpatient	76-105 mins
Prolonged Services (Non-patient Facing)			
1st Hr	99358	Prolong service w/o contact	31-75 mins
Addl 1/2	99359	Prolong serv w/o contact add	76-105 mins
Prolonged Services (Emergency Dept, Observation, Out Patient with Patient)			
1st Hr	99354	Prolonged e&m/psyctx serv o/p	31-75 mins
Addl 1/2	99355	Prolonged e&m/psyctx serv o/p	76-105 mins
Advance Care Planning			
1st 1/2 Hr	99497	Advanced care plan first 30 min	16-45 mins
Addl 1/2	99498	Advanced care plan addl 30 min	46-75 mins

*The following codes should be used for an **inter-professional telephone/Internet/EHR** assessment and management service provided by a consultative physician. You must include a verbal and written report to the patient's treating/requesting physician or other QHP.*

Visit	CPT	Short Description	Threshold Time
Inter-professional Internet/EHR Collaboration			
5-10 Min	99446	Intrprof ph/Intrnet/EHR	5 mins
11-20 min	99447	Intrprof ph/Intrnet/EHR	11 mins
21-30 min	99448	Intrprof ph/Intrnet/EHR	21 mins
>31 min	99449	Intrprof ph/Intrnet/EHR	31 mins

Last Updated April 1, 2020

Updated 3/23/2020 by David Delgado

PC iPad Information

General iPad Information:

Cleaning: **For disinfecting tablets and other electronic devices,** always disinfect to the strongest recommendation based on the patient's diagnoses. For COVID-19, PDI Super Sani Cloths (or equivalent non-abrasive, non-bleach wipes) have been approved by Infection and Prevention.

- Disinfect both tablet and chords and them air dry per manufacturer's recommendations
- See the document below for a EPA list of all COVID-19 killing products

EPA list of COVID killing Products.pdf

Connectivity: For iPads ordered through Providence, connectivity should be set up for you by the regional IS team. For all other iPads, tablets and devices, work with your local IS support to ensure connectivity to local Wi-Fi networks.

Using your own device: Federal exceptions during this crisis response has relaxed some policies surrounding use of personal devices. For the most up-to-date information about using your own device, please check with your local IS team.

iPad Isolation Request:

What you need to know:

Providence has streamlined the ability to order iPads for use with isolated patients. In order to help caregivers with this process, Providence Information Services has created a central site to provide as much information as possible.

Main links:

Ordering Page and Additional Instructions	Ordering, info for patients, caregivers, and other instructions: https://providence4.sharepoint.com/sites/IsolationiPads
Cleaning of iPads	https://providence4.sharepoint.com/sites/IsolationiPads/Shared%20Documents/2019%20-%20I-Pad%20Cleaning%20Instructions.pdf?csf=1&e=HMhWfM&cid=b0b8ec32-deff-4107-a0f0-c8e6ea2a18ab
Instructions for setting up video chat	Facetime: https://providence4.sharepoint.com/sites/IsolationiPads/Shared%20Documents/2020%20-%20i-Pad%20Instructions%20-%20FACETME.Final.pdf?csf=1&e=THf6a4&cid=4f54d0be-5a89-4e83-abc0-c546413a3fa1

TELE-PC DOTPHRASE: Initial Consult Documentation

Virtual Visit Initial Visit Documentation Template

You may use this DotPhrase for documentation of consultation visits between the PC team providers and patients conducted over telemedicine platforms. This contains the required telehealth documentation for the visit. The content must be used at the start of the visit (informed consent; confirming patient location), and contains spots to enter start and end time of visit, etc.

For Epic, a DotPhrase can be entered. For non-Epic users, or in the case the DotPhrase does not work, copy and paste the text below.

Text starts below the dotted line.

This exam was initially conducted via a secure 128-bit AES encrypted bidirectional video session.

Service was provided face-to-face with the patient via interactive videoconferencing

Video start time: ***
Video end time: ***

Total time (in minutes) including non-face-to-face time (i.e. reviewing records, documentation, etc.…)**:** ***

Patient Consent

1. You have chosen to receive care through the use of telemedicine. Telemedicine enables health care providers at different locations to provide safe, effective, and convenient care through the use of technology. As with any health care service, there are risks associated with the use of telemedicine, including equipment failure, poor image resolution, and information security issues.

2. Do you understand the risks and benefits of telemedicine as I have explained them to you? ***

3. Have your questions regarding telemedicine been answered? ***

4. Do you consent to the use of telemedicine in your medical care today? ***

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Disclaimer

Due to the nature of the COVID-19 outbreak and efforts to conserve personal protective equipment, this patient was evaluated virtually. A chart review of the providers' notes, discussion with pertinent providers, and patient lab work and studies were reviewed. At this time, the physical exam was limited to what could be visually observed via the virtual encounter. Face-to-face visits and physical examinations of isolated patients have been limited only to patients for whom it is required for medical decision making.

This documentation is adherent to CMS expansions of telehealth benefits under the Coronavirus Preparedness and Response Supplemental Appropriations Act and Section 1135 waiver authority.

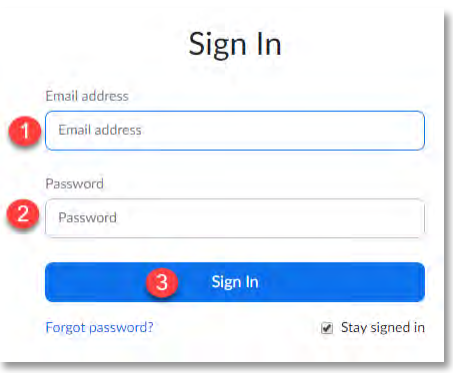
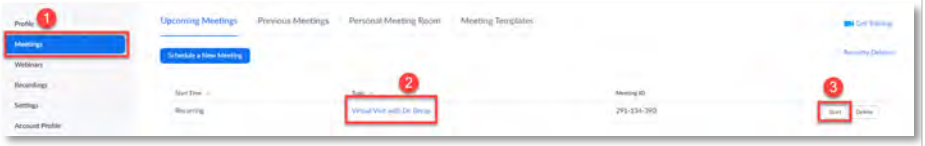
telehealth Powered by Providence St. Joseph Health

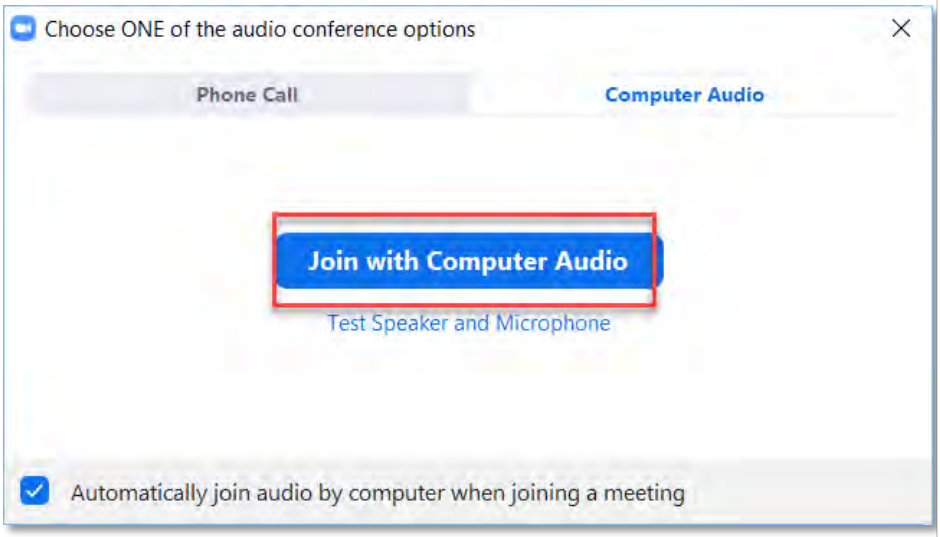
Step-by-Step Guide for Crisis Virtual Visits

FOR: PROVIDERS

RECOMMENDED EQUIPMENT FOR PROVIDERS	
Due to the speed of deployment, individual clinics are responsible for procuring the equipment necessary for virtual visits. Alternatively, providers may be able to use their current work laptop or personal device (see below). PSJH Physician Enterprise leadership has recommended procuring from vendors directly such as Amazon, Staples or other online merchants due to the backlog of requests for necessary clinical supplies the PSJH supply chain team is currently handling.	
Desktop Computer	Desktop computers can be used with an external monitor that uses a webcam for video. A webcam with an integrated microphone/speaker is preferred for the best audio, however a simple Webcam used in combination with an external microphone/speaker can also be used. Specifications for those are below.
Laptop	Any laptop with an integrated camera, microphone and speaker that connects to the Internet can be used and is a good solution for providers at home. A personal laptop can be used if the provider follows PSJH standards for personal computers and can connect to the EMR for documentation. This is a good solution if a webcam is not available.
Tablets and Smart Phones	PSJH Information Services has approved the use of these devices (PSJH-issued or personal) for telehealth visits. The Zoom app will need to be downloaded to the tablet or smart phone from the App store. See the tip sheet in the Appendix of this document.

NOTE: Technical support information for Epic, Desktop/Device and ZOOM is at the end of this document.

GETTING STARTED	
Log into the computer where you'll be conducting the virtual visit.	
Log into Epic to document the virtual visit.	
Open your web browser (Chrome works best) and type in: psjhealth.zoom.us	
Click the **SIGN IN** button at the bottom right of the screen. ①Enter your PSJH e-mail address and ②password used for the Zoom license, ③click SIGN IN	 
①Click **MEETINGS** in the left column. ②Find your link, called "Virtual Visit with <Dr. Your Name>" ③Click **START** at the far right NOTE: DO NOT click delete, which is next to start	

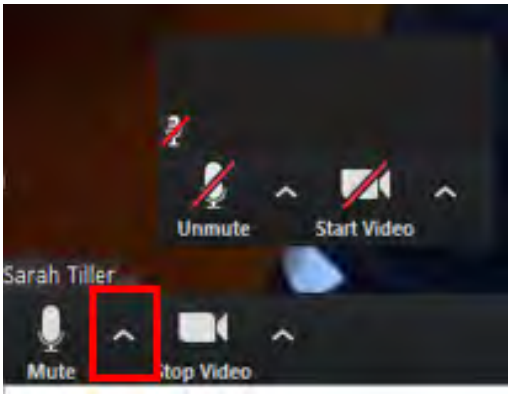
Click **JOIN WITH COMPUTER AUDIO**	

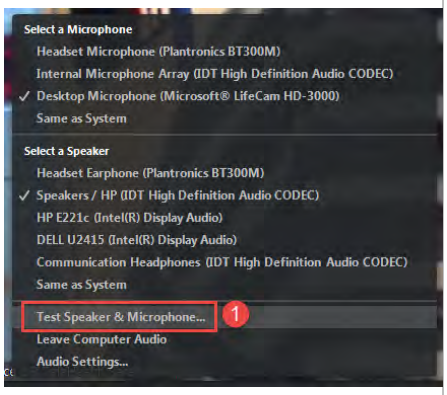
TEST YOUR SPEAKERS AND MICROPHONE

Click the ARROW next to the mic icon

①Click on TEST SPEAKER & MIC [screens]

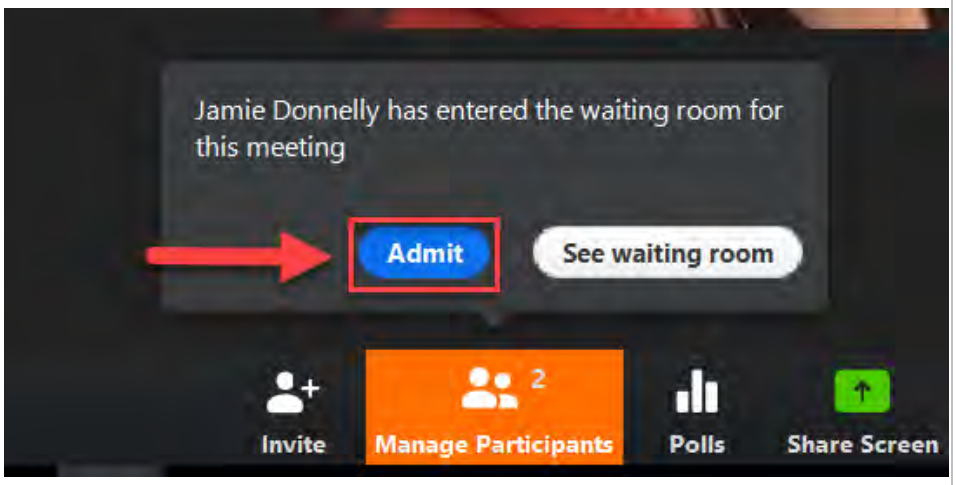
Follow instructions on-screen

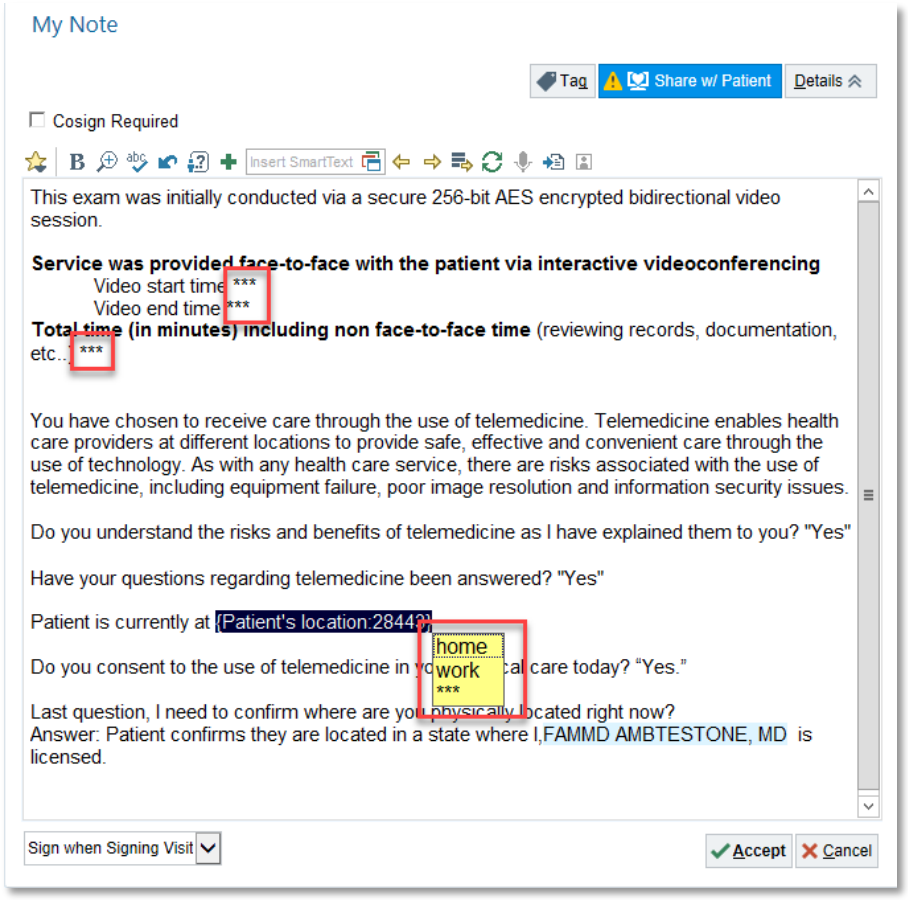
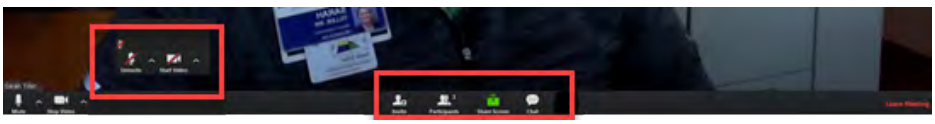


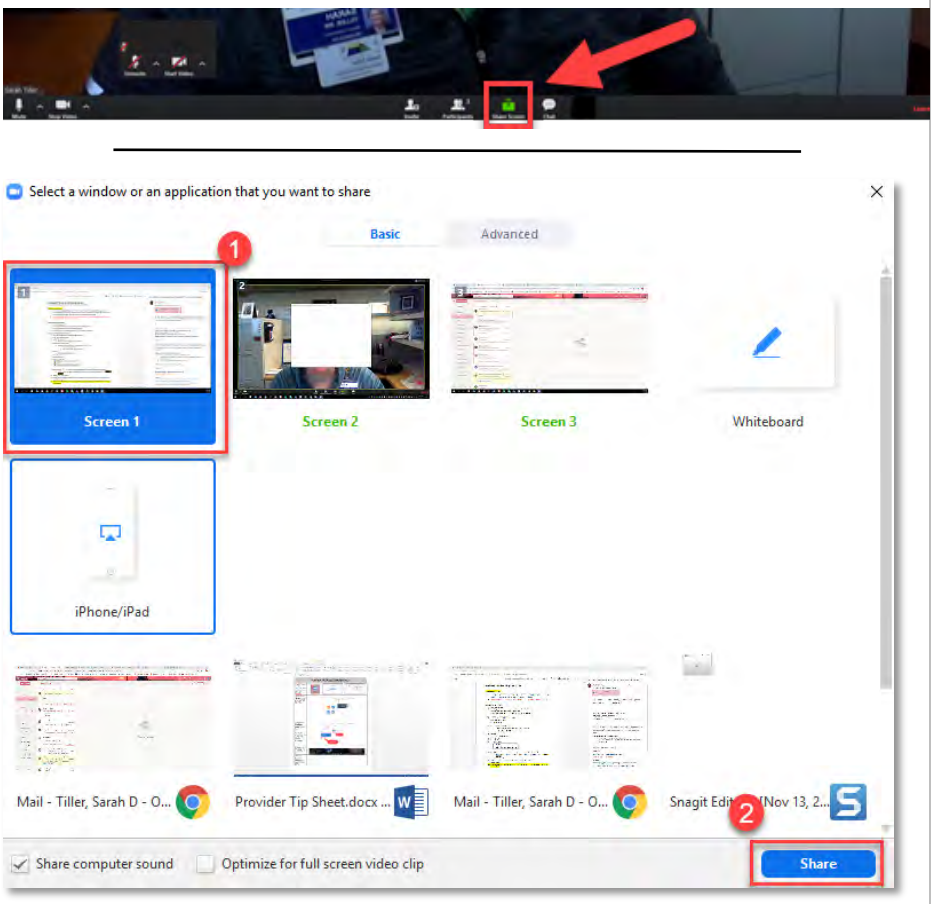
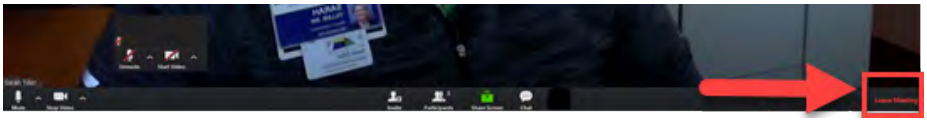


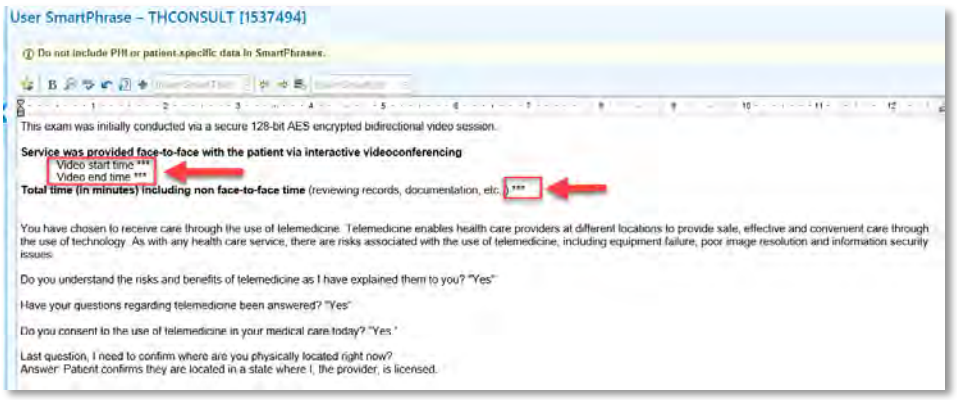
START THE VISIT

Admit the patient from the waiting room



Introduce yourself to the patient, and show your PSJH badge to the camera.	
Verify that the patient consents to the telehealth visit, and is located in the state you are licensed in. NOTE: In your Epic note, use the system SmartPhrase .THCONSULT and you'll see content for you to use at the outset of the visit [screen]	
Use your toolbar to manage your meeting settings PRN [screen]	

To share your screen with the patient (optional) a. Click SHARE button at the bottom center of your screen b. Select share screen, or share the program or document you're using c. Click the BLUE SHARE BUTTON in the bottom right corner	
When done sharing, click the **RED STOP SHARE** button	
Click **LEAVE MEETING** when the visit is complete	

BILLING AND DOCUMENTATION	
In the .THCONSULT note, fill out the video start/stop time and total time NOTE: Total time should match the LOS you bill for.	
Add LOS NOTE: Modifiers will be added automatically on the back end.	

TROUBLESHOOTING: HOW TO ACCESS SUPPORT	
EPIC	If you have questions or issues related to Epic and/or using the Crisis Virtual Visit, contact the Epic Health Desk at 855-415-8188, except for Alaska which is 844-922-7548 (844-92-AskIT) or contact your local ambulatory informatics team.
Computer/Device Support	If you have questions about your PSJH-issued computer, contact the IS Service Desk at 844-922-7548 (844-92-AskIT). IS also will support personally owned devices in a limited way which includes assistance with installation of Office 365, Citrix and multi-factor authentication. However, providers will need to install and setup their own network connection at home, as well as the Zoom app on their personal iPad/tablet or smart phone if they are using a personal mobile device for virtual visits.
Zoom	We are recommending at least one, but ideally several, individuals at the clinic serve as Zoom "super users" to support clinicians, staff and patients with virtual visits. They are the first line of support. If the Zoom super user is unavailable or not able to address the issue, please contact the Providence Zoom Support line at: **1-844-943-1076. This phone number is for PSJH clinics and providers only – please do not distribute it to patients**. The clinic is responsible to support all patient questions. The Providence Zoom support team has access to resources and second tier support to escalate to if needed and is available daily from 7am-8pm.

END

Institute for Human Caring
Providence St. Joseph Health

CAREGIVER SELF-CARE

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water and not get wet."

- Rachel Naomi Remen, *Kitchen Table Wisdom* 1996

Goal: Provide support, decrease isolation, offer a safe place to express feelings and create opportunities for death rituals.

Serial Grief: Occurs when there is insufficient time to process multiple losses. Also known as cumulative grief.

Compassion Fatigue: Form of exhaustion resulting from prolonged exposure to caring for sick or traumatized patients. *Taber's Cyclopedic Medical Dictionary.*


Zen garden, Trinity Care, Torrance, Calif.

Rituals for staff: Techniques for coping with human suffering and death:

- Moment of silence at time of death
- Pause at the end of shift to remember those who died
- Utilize existing resources, i.e., reflection gardens on hospital campus'
- Debrief after death with co-workers, maintaining a safe physical distance (name of patient and one personal thing about them that you were able to garner i.e., John loved gardening)
- Remembrance tree: create a paper tree in the nurse's lounge. Provide an opportunity for caregivers to attach "leaves" with patient's first name to the tree
- Staff say aloud the name of the patient who died followed by chimes

Self-Care: Achieving work-life balance – transitioning from work to home and shedding the professional role

- Listen to music to and from work – the daily news will be there when you get to your destination
- Leave your badge in your car
- Put away your stethoscope
- Change out of your work clothes and into something comfortable
- Exercise and diversions – take a walk, practice yoga or visit this helpful resource for wellness activities [CLICK HERE]

- Engage in spiritual/religious activities such as prayer, meditation, reading scripture, poetry, mantras, and journaling
- Seek support from others:
    - Family/friends
    - Faith community/leaders
    - Spiritual care/chaplain
    - Manager
    - Providence Resource Page [CLICK HERE]

There is a lot of research around all of these topics. We acknowledge that these are unprecedented times and you may not have the time to take advantage of all of these ideas. Today, if you are at a place where you can only do two things, we recommend that you:

1. Pause during your shift and acknowledge the patients for whom you have cared and have died and
2. Practice shedding your professional role when you get home – do one thing from the list of transitioning from work to home

References:

1. "Helping Nurses Cope With Grief and Compassion Fatigue: An Educational Intervention", Clinical Journal of Oncology Nursing, 2014, Volume 18, Number 4.
2. "Compassion Fatigue in Palliative Care Nursing: A Concept Analysis", Journal of Hospice and Palliative Nursing, 2019 Feb; 21(1): 21–28.

Institute for Human Caring
Providence St. Joseph Health

COVID-19: Caregiver Support

Self-Care, Death and Grief Resources

Table of Contents

Dear Caregiver,

There is a lot of research around compassion fatigue, self-care and grief. We acknowledge these are unprecedented times and you may not have time to take advantage of all these resources.

Today, if you are at a place where you can only do two things, we recommend that you:

1. Pause during your shift and acknowledge the patients for whom you have cared and have died and
2. Practice shedding your professional role when you get home – do one thing from the list of transitioning from work to home.

Sincerely,

Providence Institute for Human Caring

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water and not get wet."

Rachel Naomi Remen
Kitchen Table Wisdom

CAREGIVER SUPPORT			
Goal	Provide support, decrease isolation, offer a safe place to express feelings and create opportunity for death rituals		
Serial Grief	Occurs when there is insufficient time to process multiple losses. Also known as cumulative grief.		
Compassion Fatigue	Form of exhaustion resulting from prolonged exposure to caring for sick or traumatized patients. *Reference: Taber's Cyclopedic Medical Dictionary*		
Rituals for Clinicians	→ Moment of silence at time of death → Pause at the end of shift to remember those who have died → Utilize existing resources, i.e., reflection gardens on hospital campuses → Debrief after death with co-workers, maintaining a safe distance (name of patient and one personal thing about them that you were able to garner, i.e., John loved gardening) → Remembrance tree: create a paper tree in the nurse's lounge. Provide an opportunity for caregivers to attach "leaves" with patient's first name to the tree → Staff say aloud the name of the patient who died followed by chimes		
Self-Care	Achieving Work-Life Balance	How to help transition from work to home – shedding the professional role → Listen to music to and from work → Leave badge in car → Put away stethoscope → Change out of work clothes and into comfortable clothes → Exercise and diversions: Walking, yoga or other activities	[CLICK HERE] Wellness Link - Walking and Yoga [CLICK HERE] Providence COVID-19 Resources

		→ Spiritual/religious activities, i.e., prayer, meditation, reading scripture, poetry, mantras, and journaling Support from Others: → Manager → Family/Friends → Faith Community/Leaders → Spiritual care/chaplain → Employee Assistance Program	[CLICK HERE] Houck et al, 2014 [CLICK HERE] Cross 2019

ADULT & CHILDREN GRIEF RESOURCES			
CATEGORY	**TOPIC**	**DESCRIPTION & DETAILS**	**ATTACHMENTS**
Children	Children and Death Bibliography for Parents and Children	In this attachment, the following topics are covered: → Books for Children → Books for Parents → Death of a Parent → Death of a Grandparent	[CLICK HERE]
Children	Children Grief resources for WA, OR, Los Angeles	Regional specific resources: **Seattle, WA:** https://healingcenterseattle.org/ **Portland, OR and online:** Dougy Center: www.dougy.org **Los Angeles area and online** **Our House** https://www.ourhouse-grief.org/ **Providence Trinity Hospice** https://www.providence.org/locations/trinitycare-hospice-torrance	
General	Providence Bereavement Services by Region	**Alaska** https://alaska.providence.org/services/h/hospice **Los Angeles: Trinity Hospice**	N/A

		https://www.providence.org/locations/trinitycare-hospice-torrance **Lubbock, Texas** https://www.covenanthealth.org/hospice-of-lubbock/bereavement-support/ **Montana** https://montana.providence.org/locations-directory/p/palliative-care/services **Northern CA: Collabria Care** https://collabriacare.org/caregiver-resources/grief-support/ **Orange County: St. Joseph Health, Hospice** https://www.providence.org/locations/st-joseph-hospice-anaheim/resources/grief-support-services **Oregon** https://oregon.providence.org/our-services/p/providence-hospice-bereavement-services/ **Washington** https://washington.providence.org/services-directory/services/h/hospice-grief-support	
Children	Children and Death Developmental Stages	In this attachment, the following topics are covered: → Development Stages → Your Other Children → Age Related Responses to Death and Grief	[CLICK HERE]
Children	Children and Grief	Helping Children Cope with Grief by Alan D. Wolfelt, Ph.D.	[CLICK HERE]
Children	Grief During COVID-19:	When Your World is Already Upside Down: Supporting Grieving Children and Teens During the COVID-19 Global Health Crisis	[CLICK HERE]

ADULT SPECIFIC GRIEF RESOURCES			
CATEGORY	**TOPIC**	**DESCRIPTION & DETAILS**	**ATTACHMENTS**
Adult	Coping with Stress During Infectious Disease Outbreaks	This fact sheet provides tips for coping with stress during an infectious disease outbreak. It describes common signs of stress and how to recognize when to get help. Publication ID: SMA14-4885 Publication Date: October 2014	[CLICK HERE]

GENERAL FUNERAL RESOURCES: COVID-19			
CATEGORY	**TOPIC**	**DESCRIPTION & DETAILS**	**ATTACHMENTS**
Funeral Resources	Social Distancing and Mourning	How the coronavirus is affecting funerals and memorial gatherings	[CLICK HERE] eCondolences
Funeral Resources	How to Express Condolences	There are a number of unprecedented measures taking place as a result of the COVID-19 coronavirus that will restrict and limit certain gatherings, which includes funerals, burials and memorial gatherings	[CLICK HERE] eCondolences
Funeral Resources	Grief & Mourning	The breadth and length of time the restrictions will remain are still unknown, but the practices of social/physical distancing are in effect across the United States causing changes to funeral, burial, and memorial gatherings. This additional consideration or change in practices introduces a new type of grief.	[CLICK HERE] eCondolences
Funeral Resources	A New Grief: Staying Connected to Help	In addition to the ordinary grief mourners experience at a time of loss, newly imposed coronavirus requirements force us to modify or cancel public funerals, burials, and shivas and introduces an additional trauma and component to the grieving process.	[CLICK HERE] eCondolences

Additional Resources	iMortuary: Funeral & Planning Resources	iMortuary strives to help consumers find funeral homes and cremation providers in their area. Search thousands of funeral homes with the click of a button or browse by city and state to find the provider that best suits your needs.	[CLICK HERE]
Additional Resources	GriefShare	GriefShare seminars and support groups are led by people who understand what you are going through and want to help. You'll gain access to GriefShare resources to help you recover from your loss and look forward to rebuilding your life.	[CLICK HERE]
Additional Resources	Anticipatory Grief	Anticipatory grief, or grief that occurs before death, is common among people who are facing the eventual death of a loved one or their own death.	[CLICK HERE]
Additional Resources	National Hospice and Palliative Care Organization (NHPCO)	As the leading organization representing hospice and palliative care providers, NHPCO works to expand access to a proven person-centered model for health care—one that provides patients and their loved ones with comfort, peace and dignity during life's most intimate and vulnerable experiences.	[CLICK HERE]

HOW TO CARE FOR PATIENTS DYING ALONE IN THE HOSPITAL

CATEGORY	DESCRIPTION & DETAILS
"Each human should die in the sight of a loving face." Mother Teresa	Whenever possible offer to have someone present with the person who is actively dying. Not every person wants someone present, but most people say they do. We acknowledge that these are unprecedented times and we may not be able to honor patient and family wishes to be physically in the same room as the person who is dying.
How Can We Be a Witness How Can We Help Patients, and Families?	Using a Tablet: • Provide a tablet in patient's room for video chat (e.g., FaceTime or Skype, etc.) - Help family say goodbye

	• Think through with patients "The Four Things that Matter Most" by Ira Byock: - "Please forgive me," "I forgive you," "Thank you," and "I love you" [CLICK HERE] If a Tablet is Not Available, Consider: • Recording messages from patient to family and family to patient • Having the family write a letter that is read to the patient (refer to "The Four Things that Matter Most")
Ask the Family:	Find out from the family what they think the patient would want at the end of life • Cultural rituals – we may not be able to accommodate but ask • Music • Prayer, meditation, scripture reading, favorite poem • Catholic – Sacraments: Prayers for the sick • Photos of family • What matters to them – religious/spiritual beliefs, rituals, practices • Life review – It may be valuable to remember and pay most attention to good times. Consider asking: What were the times that you were most happy? • Get to Know Me Poster (If the patient is not responsive, ask the family to complete with help from hospital staff)
How to Be Present When Someone Is Dying	• Create a safe space • Active listening • Make eye contact • Lean in (if permitted in the room and with appropriate PPE) • Therapeutic silence: share the silence • Touch: With appropriate PPE and comfort level *(Note: Explore use of mobile technology)*