Report from NYU Langone Health CL Psychiatry Service

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Observations in the first Two Weeks of COVID-19

As of March 25, 2020, NYU was treating approximately 200 patients with COVID-19, 66 of which were in critical condition requiring ICU admission. NYU went from 1 unit as the designated “COVID-19” unit, to multiple different types of COVID-19 units: two triage COVID-19 units, two COVID-19 ICUs, and several units for “stable” COVID-19 patients (for those patients not requiring supplemental oxygen or respiratory support). Our proposal to convert to TELE CL for COVID19 came from a desire to continue providing high level psychiatric consultations with face-to-face assessments while limiting provider exposure and use of PPE. Transitioning to TELE CL also allows the majority of our MDs to work from home, minimizing their exposure to the general hospital and decreasing provider-to-provider contact. The proposal was embraced by the Department of Psychiatry leadership who, in turn, advocated to the Department of Nursing for help filling the newly conceived role of the TELE CL RN. Our first TELE CL RN joined our team 9 days ago. We purchased 3 IPads from a local Staples and 2 IPad cases with a rolling IPad stand from Amazon. The CL service retained 2 IPads and the remaining IPad was designated for the Emergency Department. With these materials and our new TELE CL RN, we were able to quickly implement TELE CL throughout the medical center. Our protocol is revised every few days to reflect the evolving nature of the COVID-19 crisis as well as changes in workflow (typically arrived at through trial and error).

In the two weeks that NYU has been treating patients with COVID-19, our CL Psychiatry service has noticed a sharp decline in the number of new psychiatric consultations requested. For comparison, our daily census in February ranged from approximately 35-50 active CL cases; today our list has only 11 active CL cases. In the first few days of COVID-19, we observed that we were only being called for severe agitation, typically when agitation became so severe that isolation precautions were threatened. Each time we responded to a behavioral emergency, we observed an increasing level of distress in our physician and nursing colleagues. It quickly became clear that our colleagues in the ED, ICU and General Medicine were highly focused on ABCs (Airway, Breathing, and Circulation) and rightly so. The combination of decreasing consultation requests with increasing distress in our colleagues, lead to the rapid implementation of a proactive model of consultation.

Proactive consultation is a relatively new model for our service and our current CL fellow, Dr. Michael Yee, is spearheading this effort. We are just beginning to develop a workflow. To begin, we contacted the Medical Directors of each COVID-19 unit, introduced our new TELE CL

model, and offered daily check-ins to identify patients at risk for agitation or psychiatric symptoms. Each unit requested a different form of check-in: quick text message, phone call, virtually joining interdisciplinary rounds, or in person interdisciplinary rounds. We developed a search string of keywords for chart review and based on our findings, offer one of three interventions: full psychiatric consultation with patient interview via TELE, liaison-only "mini" consultation (full chart review, discussion with primary team, and written general recommendations), or brief phone discussion with the referring providers. This model involving direct, verbal communication allows us to strengthen our liaison relationships and provide peer support to our colleagues. As a trial, we started attending Palliative Care sitdown rounds in the ICU yesterday. Although only 1 consultation was generated from this brief 45 minute encounter, the clinical nurse manager said that seeing us brought a smile to her face. The group shared their experience of witnessing 3 deaths before noon and the emotional pain of placing an 18 year-old on vvECMO. Our TELE CL RNs are now performing the dual role of facilitating the MD TELE consultations as well as providing on-the-ground peer support to the bedside nurses. We are realizing that the liaison part of our job may be more important now than ever before.

Unfortunately, during the development of this TELE CL roll out, two of our ED Psychiatrists (representing half of the ED workforce) became COVID-19 positive. One provider returned to work after a week-long absence and the second provider has yet to resume her usual clinical duties. Although these initial few weeks have been stressful and surreal, we have experienced several positive outcomes. The crisis has broken down barriers between the various clinical services (ED, Inpatient Psychiatry and CL) in a way that we had not previously experienced. Clinicians are stepping up to cover each other, share resources, and support one another. New collaborations are occuring between the ED, CL, Outpatient Faculty Group Practices, Inpatient Psychiatry and even Child and Adolescent Psychiatry. As the situation evolves, we will be required to adapt and will do our best to keep pace. This has been a humbling experience & we appreciate the opportunity to share it with the ACLP community.