

Report on Proactive Telephonic Visits to Support Patients Admitted with COVID-19

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Background

The conditions of strict respiratory isolation during hospitalization for diagnosed or suspected COVID-19 place an especially harsh set of psychological demands upon patients. While contending with the extreme fear associated with the illness itself, patients are confined in their hospital rooms with no access to visitors. In addition, physicians and nurses may spend limited time in patient rooms due to fears of contagion, and the necessary use of extensive PPE by staff creates an environment of anonymity and disconnection. In addition, the frequent rotations of physicians and nurses on COVID-19 contingency schedules reduce stability and connection to the clinical staff. These conditions may create severe distress for patients hospitalized with COVID-19 symptoms.

As New York City Hospitals started to fill with COVID-19 patients in early March, the C-L Psychiatry service at Veterans Affairs New York Harbor heard reports from surrounding hospitals of the severe psychological impact of strict respiratory isolation on certain patients. According to these reports, some patients were demonstrating psychological decompensation during COVID-19 hospitalization that was not predicted by their known psychiatric history. This decompensated status included high levels of distress, agitation, and efforts to elope from the hospital. Anticipating a surge in psychological distress in these patients, and potential behavioral sequelae that pose infection risks to staff and other patients, our C-L service designed and implemented a plan to identify all COVID-19 patients in our hospital and provide daily proactive assessment and telephonic support.

Objectives

- 1) Detect early signs of psychological distress and prevent escalation to psychiatric emergencies.
- 2) Identify psychiatric needs that may have been missed by the primary team due to limited time and resources.
- 3) Provide patients an opportunity to process the experience of in-hospital quarantine and facilitate optimal coping and adaptation.

Method

We perform a daily chart review of all patients on the COVID units. We identify patients who can converse (i.e. not intubated, not on NRB or BiPAP, not severely dyspneic) and assess for any psychiatric or significant psychosocial needs. We also make note of any existing language barriers identify need for phone interpreter service. The patients are then assigned to a psychiatrist (i.e. attending, fellow, or resident) from the C-L psychiatry service or a psychologist from the palliative care service. The provider assigned to a patient calls the patient each day throughout their hospitalization, unless the patient declines further calls. We provide a script to all providers making the calls to reference (see attachment). If patients are reached, we briefly document the call in the electronic medical record. We also maintain a separate log of patients.

Observations

We rolled out this plan on March 30th with eleven patients. The service has grown to include over 40 patients on any given day in the month of April. As the number of COVID-19 admissions fluctuates, so does the volume of our service. Thus far we have observed the following:

1. During this period, we have not received consults for patients expressing anxiety or low mood regarding COVID-related illness or isolation, nor have we received consults for assessment of COVID-19 patients' decision-making capacity to leave AMA. We attribute these observations in part to proactively providing psychological support to these patients, helping to maintain patients' negative emotions at a tolerable level. However, we also acknowledge that these consults may not have been requested due to the medical team's shortened bandwidth for assessing psychiatric needs of patients.
2. Patients and family have expressed gratitude for the psychological support received through these phone calls. Specific aspects of the support that the patients appreciate include validation of stress reactions to illness and isolation, as well as having a consistent clinician with whom to speak daily over their hospital course, given the frequent turnover of primary team and nursing staff members. Families have expressed feeling included in patient care through these support calls. They are particularly grateful for follow-up calls after the patients pass away.
3. New policies put in place to protect medicine teams from over-exposure to COVID-19 (i.e. one provider in the room per day, telephonic instead of in-person exams) have significantly reduced the amount of time they spend with their patients at bedside. There is a sense of gratitude among medicine teams that mental health clinicians are attending to their patients' emotional needs, which they have been unable to address under current conditions.
4. We identified several patients who, in spite of their isolation status, expressed the wish to remain hospitalized even after medically cleared for discharge. These were often patients who lived alone without care providers, or those who live in homes where quarantine from other members of household is not possible. These patients described dread associated with the increasing death toll seen in media, and uncertainty about their continued recovery after discharge. Reassurance using objective data only exacerbated patients' anger and frustration due to perceived dismissal of their concerns. These patients responded well to validation of their fear, acknowledgement of uncertainty of long-term prognosis, and a review of concrete discharge plans that include preexisting services for discharged COVID-19 patients (i.e. regular phone follow-ups by primary care clinic staff, visiting nurse service, etc.).

We have no conflicts to disclose.

Attachment: Script for Telephonic Phone Support Screening

Initial prompt:

Hi Mr./Ms. _____,

My name is _____, one of the mental health staff here at the Manhattan VA Hospital.

I am calling because we are offering psychological support to patients who are hospitalized for coronavirus related illness. How are you doing?

Would it be helpful for you to speak with one of our mental health providers over the phone to talk about how you are doing in the hospital?

Patient Answer:

Yes

Is this a good time to talk about how you are doing right now?

At completion of call:

Can we check in with you again tomorrow (or later today?)

For future calls, are there specific times of day you would prefer to be called?

No

I understand. Is there any other way our team could support you during this very difficult time?

Would you like us to call back at a later time to check in with you again?

Things to consider once the patient is contacted for supportive telephone visits:

- Risk assessment (SI)
- Mental health history
- Pt's desire for family to be contacted/supported
- Who's your support? – Family?
- How do you usually cope with difficult times? (i.e. hobbies, religion, spending time with loved ones)