

Report from Mount Sinai Beth Israel, New York, NY

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Mount Sinai Beth Israel in New York began to receive COVID+ patients one month ago. The past four weeks have felt like a year. Early weeks for our service were highlighted by scrambling to get tele-psych in place, writing and rewriting workflow guidelines, trying to keep track of the ever-changing PPE recommendations and constant bombardment of information. I've attached our latest guidelines here.

Tele-psych: In anticipation of tele-health, we downloaded the platforms to our phones and practiced on one another to prepare. Once the tele-health machines arrived, they were first placed in the ED and ICU and later on the med/surg floors. Trying to use them was like a comedy of errors, and as many here have mentioned, the rate-limiting step being the patient facing machine. Depending on the unit, either staff were unaware of the machines, too frazzled to help, brought the wrong machine to the unit, turned on the machine facing the floor instead of the patient, or sometimes the battery had run out. Hours would pass between the start of the consult and attempts to re-contact medical staff to turn on, re-position, or take the machine into the patient's room. With time, the ED has become the most familiar with this technology. There are still many glitches and we have a long way to go.

Last week, C-L received two iPads on stands with wheels that we use as a backup to the existing machines on the units. The main question has been who will bring it into and retrieve it from the patient's room? While the default system is still the med/surg staff, we have one person on each of three C-L teams assigned to be the designee - as a last resort. The schedule rotates between attendings, fellows, and residents.

Staffing: On week two, we began alternating our two fellows, one onsite and the other work from home. Our junior residents are being redeployed to medicine and we now have seniors rotating on C-L. We are anticipating the real possibility that C-L attendings may be redeployed at some point. We are trying our best to keep staff morale up, ordering food for the team, holding guided meditation sessions, while trying to find joy in simple and silly things.

Consults: Like other places, consult volume initially increased due to agitation/delirium, but has since declined. With regard to 1:1 observation, thus far, suicidal patients are placed in a room with a window where the PCA can observe from outside. The PCA will enter in full PPE if needed or when the patient requires toileting. There are tragic stories of family members being admitted together just down the hall from one another, yet unable to be together when one was coded and died.

Future Directions: As we look towards the future, we know the worst is yet to come and that all we can do is be prepared. We are trying to remain optimistic about tele-psych and hope that the process will become more streamlined with practice. We will continue to support one another as well as our medical colleagues on the front lines. The next few weeks will bring the most challenging trials of our lives. As the keepers of the delicate liaison between psychiatry and medicine, without ever knowing it - our field has been preparing us for this all along.

