

Report from University Medical Center, New Orleans, LA

Erich J. Conrad, MD, FACP, Edward D. Levy, Jr, MD, Professor of Psychiatry; Director, LSU-Ochsner Consultation-Liaison Psychiatry Fellowship, and B. Lochlann McGee, MD, Assistant Professor of Clinical Psychiatry, LSU-Ochsner Consultation-Liaison Psychiatry Fellowship, Louisiana State University School of Medicine, New Orleans. Submitted April 20, 2020.

Clinical Care:

Like other C-L services, we began to platoon coverage around March 18th with the following guidelines and lunar landing analogy:

Pre-Covid, we usually had two teams with 2-3 residents or fellows and two attendings.

New rules: If 6 or less patients are on C-L list – one fellow (or resident) will come in and round with one attending (Neil Armstrong team).

Over 6 patients – one fellow and one resident will come in and round with two attendings (Neil Armstrong and Buzz Aldrin teams). This is the most likely scenario, leaving one resident in orbit.

Over 12 patients – all residents and fellow come in and round with two attendings.

If not in hospital, the resident who is at home (this is the Michael Collins resident) is helping by calling collateral, chart reviewing, looking up drug interactions, etc., and staying in contact via phone.

The designated Michael Collins resident is ready to mobilize to the hospital at a moment's notice depending on volume. These positions rotate weekly.

In addition to measures above, we try to see Covid-suspected or -confirmed cases by calling the hospital phone in their room and looking at them through the window in their door.

We also bought walkie-talkies to communicate with patients who are under a commitment and have had their phone removed. Discretion is used for patients who might use this as a projectile, but it is useful for patients boarding in the ER where there are no phones. The patient walkie-talkies are then wiped down to sterilize and stored in dated biohazard bags to be used again – approved by infection control.

As of last week, we have 15-minute (ER only, admitted patients) and 45-minute (day of procedure patients) tests available to determine Covid-positive patients, which has helped tremendously. We have only had to fully “gear up” with full PPE on rare occasions to get the consult done – only done by attendings.

It has been very impressive how our administration has responded with expanding ICU capabilities, obtaining ventilators and PPE, redeploying staff, and understanding that no Covid-positive patients can be admitted to the inpatient psychiatry units but need to be admitted to Internal Medicine. Pre-existing good relationships with administration and other services has been key to accomplish this.

Our proactive stepped care, screening, and treatment of trauma surgery patients has been able to continue with Psychology doing this function virtually via hospital phone or by Doximity FaceTiming patients. Of interest, there has been a roughly 50% drop in trauma activations for gunshot wounds, motor vehicle accidents, burns, etc.

The ECT service resumed last week (our C-L faculty are also our ECT faculty). It takes longer now, waiting for the 45-minute Covid testing on all patients, and the procedure being performed in a negative pressure room, just in case of a false negative.

All outpatient services are done via telemedicine other than the rare occasion for OB patients that need buprenorphine induction.

Research:

Unfortunately, a lot of research endeavors have ground to a halt with in-person blood draws, buccal swabs, etc., just not being worth the risk. We do what we can over the phone with studies that lend themselves to this and had to get IRB approval of alteration in protocol.

Education:

Medical students are no longer in-house to round with us. Consult, ER, and inpatient teams include students on rounds virtually via laptops or phone.

For the residents and fellows, we have kept up journal club, lectures, and grand rounds via Zoom, albeit its limitations.

We had to cancel our "Second Annual Consultation-Liaison and Emergency Psychiatry Conference during Jazz Fest" due to obvious reasons, and the fact that Jazz Fest is cancelled. Hope to pull it off next year!

Community Outreach:

Our Trauma Survivors Support Group and Burn Survivors Support Group have gone virtual via Zoom.

Our Trauma Recovery Team (Psychiatry, Psychology, SW) has mobilized to offer virtual Psychological First Aid Support Groups to our hospital system personnel via Zoom: groups are

separated for faculty, residents, or hospital staff, with 15 people per group. This has been well received by all.

Other:

We likely became a massive “hot spot” due to the influx of visitors during Mardi Gras, and a tremendous amount suffering has ensued, while regrettably displaying our healthcare disparities. Luckily, it seems as if the “shutdown” is starting to work with a flattening of the curve, and a slight bending down. The streets are eerily quiet at night with only police roaming around in cars – reminiscent of immediately post-Katrina (except it was the National Guard then), but this is an entirely different disaster.

It’s heartening to see the resilience in the medical, surgical, and ICU teams, and our own residents and fellows, with steadfast determination in their eyes, who fearlessly show up for work daily and care for the most ill. This has been truly inspirational.

It’s also nice to have neighbors who are musicians.

Contact us if you need any details on the above.