

Report from the Medical University of South Carolina, Charleston, SC

Edward M. Kantor, MD, Associate Professor and Vice-Chair for Education and Training (interim), Residency Program Director, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC. Submitted April 23, 2020.

I would have to say that we have not yet fully surged, though the institution invoked our Hospital Emergency Operations Center (HEOC) and started prepping the system around March 8th. That has been incredibly helpful and was done masterfully, in my opinion. Lots of kudos to our “C suite” and health system leadership. Better than I expected, the communication and dialogue has been extraordinary. In my 30 years of crisis and disaster work, I’ve never had the luxury of such a well-organized, responsive and flexible infrastructure in disaster preparation. We went to emergency operations early and are transforming still for sure. The Dean and health system worked surprisingly well together. He ordered all nonessential personnel off campus over a week’s time, very early on, and the health system initiated deflection planning through free “e-visits” for Covid-like symptoms, tented and locked down entrances, and encouraged people not to head to ED. We began drive thru mass screening at a mall parking lot, about three miles away from the main hospital campus around the same time. A giant economic hit, but the right thing to do. It worked pretty well, to be honest. Psychiatry shifted to televideo in about a week, for all outpatient groups (this is a fairly large psychiatry clinical and research department) except for some limited ECT, now some TMS, and our LAI (Long Acting Injectables) clinic. All have new restricted protocols based on urgency and need but are continuing to operate.

We’ve been very lucky compared to many parts of the country, in that our actual surge has been a bit delayed, and we’ve had the benefit of learning from so many other places who surged well before and much more dramatically than we did. I am very appreciative of all the “lessons learned” and recognize the gift of time to better prepare.

For C/L and inpatient services: We started setting up televideo stations in our psychiatric hospital as well as for in-house consults to the other campus buildings and EDs (Trauma/General, Chest Pain Center and Children’s ED). It also allowed for consults from other services to our psychiatry inpatient units. They are essentially computers on wheels (COWS) with cheap video cameras added. The quality has been surprisingly good, and the patients have taken to it well. All have both WebEx and VidyoConnect which provides some flexibility in case of overload or functional loss. So far, we continue to always have in-house personnel, but this gave us the ability to continue to utilize clinicians who were quarantined for exposure, high risk health conditions, etc. as functional members of the team. Early on, we had many more exposures, isolation of staff awaiting testing, and shuffling of care team members to ensure minimum coverage. The televideo stations provide added support and allow us to continue to engage residents in training activities with clinical time, even from home. Chart prep, physician orders, and administrative team functions were easily done, and they are able to participate in rounds effectively. We are rotating team members in and out to decrease exposure on several units, in hope of keeping more people well.

The biggest difficulty has been working on the numerous legacy video platforms which don’t all connect together. Our telehealth office has been pretty flexible at setting up workarounds and adding new licenses. When it was clear that MyChart based video visits were not working well, the whole enterprise changed to Doxy.me within a few days - unheard of flexibility in normal times. The inadvertent win here is that all of my residents and fellows are getting rapid telepsychiatry exposure and truthfully have already achieved basic competence in the equipment. We had just made it a graduation requirement, developed an online training in telehealth last year, and had planned for everyone to have the experience starting with the 2019

intern class. The experience came before the course in most cases but went fairly smoothly regardless. Anecdotally, current residents are quite tech savvy and much better at adapting to multiple technologies than faculty. Everything would have gone much slower and had many more roadblocks during the non-emergency era.

For outpatient services: We quickly cancelled live patient visits through a mass phone call campaign, except for our Geriatric and other high-risk patients. Needing quick support, we converted most existing patient visits first to phone check-ins, then computer e-visits, and ramped up EPIC MyChart video visits. Other clinics were using different videoconferencing platforms, and those were allowed to continue or expand. VidoConnect and Doxy.me were early standouts and gained favor quickly. (Doxy.me has been the clear favorite for most of our outpatient activities, with VidoConnect winning out on the hospital side). Both allow us to easily integrate supervising physicians into visits with residents, which has really helped maintain the training environment and maintain the usual workforce. Once old patients were moving along, we started new intakes on televideo. Initially there were lots of billing questions, particularly for trainee supervision, though it moved pretty quickly as CMS and privates shifted regulations. It took a great deal of department daily leader calls and video conferences to make it work.

Every morning we continue to have an "all leaders" conference call, updating everyone and sharing the "lessons learned" and identifying new priorities. Leaders then pass on the message to their own teams. The enterprise overall has 4 conference calls per day for general leadership in the hospital system, which update everyone on the Covid issues, bed availability, testing changes, positive cases and rule-outs (PUIs). In addition to our enterprise updates, the department and the residency use email and weekly newsletter formats to convey global messaging. For the residents, we have an all-hands "Team Tuesdays" weekly town hall at noon, and the residents have their own meeting with the chiefs on Wednesdays. For the last three weeks, our optional Resident Peer Support Groups are running on Zoom and have now rolled out to the other training programs as well.

Our state lagged in a few areas for billing clarity, but now we have almost universal billing on televideo to match many of the national policies. It took several weeks, but we are currently at >85% of pre-Covid volume in outpatient psychiatry. Ironically, this is probably the first time ever that psychiatry is outpacing every other department in billable services. With routine surgeries and procedures stopped and the overall non-psych inpatient census held at about half capacity, it weirdly changed the fiscal narrative. Some influx of dollars is certainly better than no dollars.

Our Psychiatry inpatient units are all close to their capacity. ED psych visits were running about the same but have since slowed down. Psychiatry transfer direct admissions continue about as normal as far as volume, including for the child psychiatry unit. We have approximately 100 psychiatric beds in the Institute of Psychiatry, and an additional 12-14 in our Psychiatry ED. This is partly because there are few other inpatient resources for psychiatry around us, including no state hospital in the region that we feed to regularly. We have had to initiate new prescreening protocols and algorithms for transfers, as many outside hospitals have been misrepresenting the symptomatic direct admissions as healthy, sending coughing and febrile ED transfer patients that look very different on arrival than conveyed during the "doc to doc" phone chat. Luckily there was cooperation internally and those pts were quickly shifted to the Medicine Service for rule-out, then returned to us if Covid- or kept on Medicine service if Covid+ or too physically sick otherwise.

We are trying hard to keep all PUIs and Covid+ patients out of the psych hospital, due to the difficulty in keeping people room bound and isolated. So far, we've had really great collaboration on the part of our

HEOC group, the ED, and the Medicine Department. Just this week, we updated our Psychiatry transfer policy so that all direct admits from other hospitals first stop at our psych ED for another in-person screening, done in a negative pressure room - if anyone screens as high risk or symptomatic, they will be rapid Covid tested and held for the results there. Though we aren't yet testing everyone without symptoms, we hope to make it more universal, but the availability of the rapid tests is still limited across the enterprise.

We are still getting a bit of pushback from overall physician leadership on going primarily televideo for inpatient consults, including psychiatry. Hard to clarify the dynamic. Fast Covid testing is still restricted to those with high suspicion or symptoms, but also Pre-Operative and pre-ECT asymptomatic patients. We are trying to utilize a mix of both live and tele as the situation dictates. Interestingly, our new children/women's hospital has televideo presence in every patient room but wasn't being used much except for family phone calls - until now. That quickly solved many consult issues for that building, which unfortunately isn't our busiest cohort for psychiatry consults overall. Covid+ pts and most Covid rule-out patients have access to a limited number of rolling tele-carts for all the consult services.

I am quite thankful that our expected surge is evolving, rather than hitting all at once - the movement is slower and flatter than all initial predictions, both locally in Charleston and across the state. Maybe due to size and spread out population. We could still mess that up, I suppose, depending on our adherence to social distancing. We had an unsettling cluster in a regional nursing home just this week - 57 positive cases. Our initial peak was expected in ~2 weeks, though now it appears that we may already be declining depending which model I view. I'm hopeful we are able to continue with caution, keep global distancing practices, and and continue using as much televideo as is possible - and based on patient need and safety issues, from both patient and provider perspective.

We are still proactively moving our Geri Psych unit over to our old Children's hospital that is contiguous to our main hospital and ED. Fortuitously it was emptied out just 2 months ago, when the new children/women's hospital opened (all on same campus). The Geri unit inherited a really nice atrium that the kids used to have as open space. High ceiling, giant windows - airy and way nicer than we had for them on psychiatry. The unit is an old peds ICU, so each room has a giant hall and outside windows and its painted fairly "Disneyesque." Quite cheerful, less institutional. We may not want to go back. It's a higher medical need group at baseline and it feels way safer to have this group within the main hospital complex. There will be less ambulance movement, and easier imaging, testing, and consultant support. The empty hospital is a significant bonus with overall surge preparation and allowed for a separate Covid+ medical unit/ICU space as well.

We plan to surge any Covid+ psychiatry admissions, that are not significantly ill, into beds opened up by moving the Geri Psych unit. We hope to avoid branding an actual psychiatric Covid unit per se, rather creating an internally available surge capacity for psychiatry Covid+ people. Rule-outs will still start on medicine. Once we hit 3 or more psychiatry admits who are Covid+ on the medicine service, we'll open our surge beds in the vacated space at our psych hospital on campus. The psychiatry Covid area will have in-person, onsite and remote televideo access, designated teams, and separate security. The goal is to avoid staff sharing and cross contamination. We are still working out our on-call plan and exact attending vs resident deployment. It will likely include both. Still, our plans care changing by necessity 2 or 3 times a day.

Hopefully we won't get there as an enterprise, but the National Guard is assisting us in opening a field hospital in our university fitness center. Ideally it will be for less ill patients or those improving with

nowhere to go. If necessary, we should be able to surge our overall capacity by about 25-30%. At baseline we have 700 beds across the medical center.

Unlike many major cities, we are the only academic health center in the coastal third of a fairly large geographic spread - It's known as the "Low Country" of South Carolina, covers the southeastern third of the state, and stretches along the Atlantic coast from North Carolina to Georgia. The closest other academic center is over 100 miles away in Columbia, SC. There are many rural and coastal areas surrounding us with far less resources and less overall hospital resources and capacity. I think we may have a different dynamic locally, that allows for more system standardization, planning, and control, but there is also lack a lot of back-up or alternative specialty care at other centers. As I said before, there is no state psychiatric hospital in our region and only two regional community hospital chains, both private providers, that are playing fairly well with us so far. We will see.

Our "on campus" VA affiliate is running in parallel, has slightly different guidance and plans, but overall is working well with our residents and program staff as the department is fairly interconnected clinically and for research.

This has been long winded and maybe too detailed, but hopefully it's helpful to a few of you out there. I do hope everyone can stay safe and as well as possible through all of this. Would love to keep hearing about what's worked and what hasn't.

Best,

Ed Kantor