COVID- 19 Inpatient CL Workforce Preservation Plan

Justification:

Experts project that the COVID19 pandemic will push the medical system past capacity in many cities. At the same time large portions of the medical workforce are expected to fall sick, compounding the problem. The primary goals of this plan are to preserve the workforce and contribute the public health measure of physical distancing by minimizing exposure and contact by our providers. This is first done by keeping significant portions of the CL team at home when possible thereby diminishing contact that occurs in the process of commuting to and within the hospital. This will also provide psychological respite in preparation for anticipated challenging times ahead.

Research from China has revealed that roughly fifty percent of transmissions occurred through asymptomatic carriers. As a result, providers cannot rely on typical signs and symptoms to determine the need to minimize exposure in clinical care. Rather, for this short window of time when the infection rate is rapidly escalating every medical provider, where possible in their medical practice, should attempt to limit contact with all patients unless absolutely necessary to provide appropriate care. It is difficult to weigh the risk of infection during this time of limited resources. But through the use of innovative systems of staffing and technology, equitable psychiatric care can occur for this brief period to contribute to the collective good.

Team Organization	**In Hospital**	**At Home Call** (within 20min of hospital)
Week 1 and subsequent odd weeks	Attending X Resident X	Resident Y Attending Y Fellow
Week 2 and subsequent even weeks	Attending Y Resident Y	Resident X Attending X Fellow

Call team members in as follows: At home call Resident → At home call Attending → Fellow

Roles and Duties:

1. Fellow
    a. carries the consultation pager
    b. Returns all calls.
    c. Handles all curbside questions
    d. Delegates tasks
    e. Coordinates cares
    f. Conduct medical literature searches and provide summaries for teammates based on clinical cases and need
    g. **Third** to be called in if in hospital team is overloaded
2. In Hospital Attending
    a. Sees all pts that require PPE independently
    b. Calls in at home team members as needed
    c. Provides supervision and education for in hospital resident
3. In Hospital Resident
    a. Sees all asymptomatic/COVID-19 negative pts
    b. Conducts all phone and tele visits
4. At Home Call Resident
    a. Manages all chart review consult questions
    b. Manages all collateral gathering via phone
    c. Conduct medical literature searches and provide summaries for teammates based on clinical cases and need
    d. **First** to be called in if in hospital team is overloaded
5. At Home Call Attending
    a. Provides supervision and education for at home call resident
    b. Conduct medical literature searches and provide summaries for teammates based on clinical cases and need
    c. **Second** to be called in if in hospital team is overloaded

Documentation:

Regardless of the method used to answer the consultation question, the work and recommendations provided should be documented with an explanation that alterations to standard methods of clinical care were made to preserve medical resources, minimize exposure risk, preserve the work force, and/or due to significant vulnerability/risk posed to the pt at this specific time as a result of the COVID pandemic.

COVID guide to CL evaluations **Organized by method of evaluation**

METHOD of EVALUTION	**CONSULT QUESTION**
Curbside	Meds to naive pt Meds Restarting home Drug-drug interaction Primary depression
Chart review	Capacity - AMA if primary team has already assessed capacity Delirium Post surgical agitation = delirium New acute onset psychosis = delirium New acute onset mania = delirium (agitated) Primary psychosis Primary mania TBI
Chart review and collateral (see behavior)	Dementia
Defer until able to communicate	Safety evaluation and pt cannot communicate
Phone	Capacity re consent Safety evaluation and pt can communicate Meds to treatment resistant Adherence to medications
Tele	Post suicide and pt can communicate
In person	Capacity - AMA if primary team has not assessed capacity Behavior NMS/SS/catatonia

COVID guide to CL evaluations Organized by Consult question (alphabetically)

1. Behavior - in person
2. Capacity re AMA if primary team has already assessed capacity - chart review
3. Capacity re consent - phone
4. Capacity re AMA if primary team has not assessed capacity- in person
5. Delirium - chart review
6. Dementia - chart review and collateral (see behavior)
7. Drug-drug interaction - curbside
8. Meds poor adherence - phone
9. Meds to naive pt - curbside
10. Meds to treatment resistant - phone
11. Meds Restarting home - curbside
12. New acute onset mania = delirium (agitated) - chart review
13. New acute onset psychosis = delirium - chart review
14. NMS/SS/catatonia - in person
15. Post surgical agitation = delirium - chart review
16. Post suicide and pt can communicate - tele
17. Primary psychosis - chart review
18. Primary depression - curbside
19. Primary mania - chart review
20. Safety evaluation and pt cannot communicate - defer until able to communicate
21. Safety evaluation and pt can communicate - phone
22. TBI - chart review

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