

Frontline Reports

Frontline Redeployment of Psychiatry Residents During the COVID-19 Pandemic

Early in its transmission in the United States, COVID-19 had a disproportionate impact on New York City, pushing local hospitals nearly to their limits. In the intensive care unit (ICU) at New York–Presbyterian/Columbia University Irving Medical Center (NYP/CUIMC), the capacity of 99 beds was exceeded by nearly 300% in April 2020. This surge required expansion and restructuring of existing inpatient medical services, as well as “redeployment” of attending and trainee physicians from various specialties, including psychiatry. Redeployed residents were essential in directing care for massive numbers of critically ill patients requiring mechanical ventilation and other life-supporting interventions. Here, we describe the process of the redeployment of psychiatry residents at a major urban academic medical center to the front lines of the COVID-19 pandemic.

The psychiatry residency at NYP/CUIMC comprises 10–12 residents in each of the four postgraduate year (PGY) classes. Of 46 residents in the program during the 2019–2020 academic year, 35 participated in redeployment between April 1 and June 3, 2020. The first wave included first-year (PGY1) residents already rotating on medicine services, as well as volunteers from senior classes, before quickly escalating to a maximum of nine residents redeployed by the third week in April, during the city’s peak in hospitalizations. After taking volunteers, program leadership approached individual residents to fill remaining redeployment spots, with sensitivity to residents with complicating circumstances, such as chronic health conditions.

Most residents were redeployed onsite in our primary hospital as medical interns on an expanded ICU team caring for COVID-19 patients, despite some unfamiliarity with managing ventilators. Psychiatry residents were preferentially assigned to ICUs rather than floor or step-down services, where staffing ratios are less favorable and interns have less supervision. Residents were asked to work no more than 3 weeks in the ICUs—a leadership decision to disperse the burden of this work, at the cost of potentially exposing a larger number of residents to the virus. Ultimately, four redeployed residents home-quarantined after developing COVID-19–like symptoms. Given the taxing nature of working in the ICUs, however, we believe that distributing the burden over additional residents was optimal, improving patient care and reducing resident burnout during a crisis of indefinite length.

Less experienced residents, who are closer to training in internal medicine, performed most onsite services. In total, 83% of PGY1 and PGY2 residents were redeployed onsite, versus

67% of PGY3 and 50% of PGY4 residents. Nevertheless, among residents who served onsite in ICUs, the average time commitment (11.4 days) was very similar regardless of PGY class. Additionally, four residents from the PGY3 and PGY4 classes were redeployed remotely as part of a palliative care consultation service assembled to engage in goals of care discussions with families and proxies of critically ill COVID-19 patients.

To support house staff working amid the pandemic, the Department of Psychiatry established a debriefing hotline with volunteer mental health professionals. Within the psychiatry residency, process groups also continued to meet remotely. A new process group facilitated by a trauma-informed psychologist was created for PGY1 residents, given their oftentimes distressing experiences of triaging and treating an unprecedented wave of very ill patients. When the number of new cases subsided, the group transitioned to discussing the distinct challenges involved in caring for patients who were enduring long courses of intubation and infirmity. Despite undeniable challenges, many redeployed residents reported feeling a sense of professional duty to take part, as well as pride in their contributions. However, many also remained uneasy and frustrated about the lack of a clear institutional plan for a second viral wave and what potential future redeployment might mean for their safety, well-being, and specialty training.

Many patients who were intubated for respiratory failure in March still face a long path to recovery. Those who received tracheostomies and were discharged to rehabilitation facilities remain at high risk for medical complications and readmission, and they may have trauma- and stress-related reactions. As psychiatry residents transition back to their primary training, they are uniquely positioned to empathize with the experiences of patients and other health care providers and to speak with authenticity concerning the collective trauma of the pandemic. These shared experiences will undoubtedly shape our work on inpatient, outpatient, and consultation-liaison psychiatry services for years to come.

As COVID-19 continues to spread at the time of this writing, we hope that sharing the experience of our medical center will provide a useful framework as other psychiatry residency programs seek to balance the exigencies of this crisis against their responsibilities and objectives in educating the next generation of psychiatrists.

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Ensuring Access to Crisis Services During COVID-19

Behavioral health crisis services provide an effective alternative to emergency departments (EDs), hospitals, and jails for patients with mental health and substance use emergencies. This alternative is especially important during a pandemic, when EDs are overwhelmed.

Connections Health Solutions operates crisis centers in Arizona and is recognized as a national model. Many patients arrive via law enforcement. Common presentations include danger to self or other, psychosis, agitation, and intoxication or withdrawal. Patients who might otherwise be arrested or board in EDs are instead stabilized in our 23-hour observation units. With rapid assessment, early intervention, and proactive discharge planning, most patients return to the community without hospitalization.

The crisis setting poses unique challenges not addressed by existing COVID-19 guidelines. The observation units are open spaces that facilitate line-of-sight visualization and social interactions rather than isolation and quarantine. Impaired patients have difficulty adhering to masking and social distancing protocols. There are no guidelines for protecting staff from transmission during a restraint. Testing was hindered by supply shortages and long turnaround times. Furthermore, we were concerned about risks to staff working with agitated or psychotic patients who were unable to tolerate a nasopharyngeal swab.

Despite these challenges, we knew it was important to both our patients and community to maintain 24/7 access to services at full capacity. We focused on two strategies: safely treating psychiatric patients with COVID-19 and keeping our workforce healthy and safe.

We coordinated with local ED leadership on consensus clinical criteria defining which patients we could safely test and treat instead of transferring to an ED. We screen patients for symptoms and exposure and repurposed space to group patients presumed to have contracted the virus. Peers circulate to monitor and encourage masking adherence. We collaborate closely with community stakeholders to ensure placement options for positive patients.

For testing, we partnered with MicroGenDX based on pilot data (since confirmed) showing that sputum samples consisting mostly or entirely of saliva are equivalent to nasopharyngeal swabs for COVID-19 detection. Sputum/saliva testing is easy to perform, minimally invasive, and requires no special swabs. Results are typically available within 24 hours of arrival at the lab.

We also offer testing to staff via our contact-tracing program. Managers track shifts with positive cases and

contact staff who worked those shifts. A daily e-mail lists the units and shifts with confirmed cases so other employees who may have spent time on that unit can request testing and self-monitor. Employees sign consent to use results for tracing; identifying information is not disclosed. Staff can take leave without using personal time off per the Families First Coronavirus Response Act and/or use extended family medical leave. The Human Resources Department contacts affected employees to address their unique situation.

Contact tracing suggests staff-to-staff or community transmission. Staff infection rates have been similar to those in the general population in Arizona. Between April and August, we performed 664 tests with positive rates of 13% for staff (N=561) and 18% for patients (N=103), comparable to the statewide rate of 14.4%. We observed a peak positive rate of 27% for the week ending July 4, comparable to Arizona's 7-day average of 25.9% for the same period. The positive rate from serology testing (5.4%, N=166) was also comparable to the statewide rate of 6.1%.

This approach identifies infected asymptomatic staff who would not otherwise be isolated and provides peace of mind to symptomatic staff or staff exposed to the virus who turned out to be uninfected. Furthermore, quick turnaround enables staff to return to work sooner. In the first month of testing, 11 symptomatic employees had negative tests, allowing them to return on average 4 days earlier than indicated by the Centers for Disease Control and Prevention's time-based strategy, for a total of 45 days saved.

When surveyed, 74% of staff reported feeling supported during the pandemic, compared with 49% of U.S. health care workers who, according to a recent Gallup poll, felt their organization cared about their well-being. Eighty-five percent responded positively to our multimodal communications approach that used Microsoft Teams, town halls, FAQs, and daily e-mails.

At the outset of the pandemic, a member of our leadership team predicted that our employees will remember how our organization handled the crisis. As we continue to adapt to this crisis, we hope to be remembered for taking good care of our patients, workforce, and community.

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