

COMMENTARY

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Psychiatric Care in a Novel Federal COVID-19 Treatment Center: Development of a Consultation-Liaison Psychiatry Service at the Javits New York Medical Station

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ABSTRACT At the outset of the 2019 coronavirus disease (COVID-19) pandemic, New York City faced the highest burden of COVID-19 cases in the United States. In response, the U.S. Federal Government deployed medical providers from various uniformed services to treat patients with COVID-19 at the Jacob Javits Convention Center in New York City. There quickly arose a need for psychiatric services for patients with COVID-19 and psychological support for medical staff. Psychiatrists were tasked with establishing a consultation-liaison psychiatry service in this unique environment. The authors detail the establishment of a novel consultation-liaison psychiatry service in a large convention center and explore lessons learned from this experience with the aim to empower uniformed psychiatrists to prepare for and deliver patient-focused care in pandemic settings.

BACKGROUND

The 2019 novel coronavirus disease (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2, is a rapidly emerging infectious disease that has, as of December 1, 2020, led to over 268,000 deaths and 13.6 million total cases in the United States.¹ The 2019 novel coronavirus disease first emerged in the United States on January 20, 2020, and by April 7, 2020, there were over 915 cases per 100,000 in New York City (NYC) alone.^{2,3} In response to the significant burden of disease in NYC, the Federal Emergency Management Agency received a request to transition the Jacob K. Javits Convention Center in NYC into a COVID-19 treatment facility. Personnel representing various U.S. government agencies and uniformed services, including

the U.S. Army and the U.S. Public Health Service Commissioned Corps, were deployed to staff the Javits New York Medical Station (JNYMS) at the end of March 2020. This article details the establishment of a novel consultation-liaison (CL) psychiatry service at the JNYMS and explores lessons learned from this experience. We aimed to empower uniformed psychiatrists and other mental health clinicians to prepare for and deliver patient-focused care in pandemic settings.

DEVELOPMENT OF THE CL PSYCHIATRY SERVICE

The JNYMS began accepting patients on March 31, 2020, functioning as an alternative care facility for patients with COVID-19. Owing to the early need for inpatient medicine treatment, multi-disciplinary medical teams were created to allow for safe overlap of medical skill sets. Deployed psychiatrists were therefore initially called to function in the role of a hospitalist, while also serving as consultants for patients presenting with psychiatric and neurological conditions, such as dementia, psychosis, depression, and substance use disorder.

As the JNYMS mission gained momentum and additional uniformed service and nonuniformed service providers supplemented the patient care mission, more primary care providers augmented the established multi-disciplinary inpatient medical treatment teams. On April 10, 2020, approval was provided by Army medical leadership to develop a CL psychiatry team. CL psychiatrists specialize in the diagnosis and treatment of psychiatric disorders arising in the setting of medical conditions and collaborate with primary medical teams to care for patients. Our CL team was developed to

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provide consultation and treatment of psychiatric and neurological disorders as well as liaison services with healthcare workers. The CL service was formally functioning by April 11, 2020, and, at its peak, comprised eight psychiatrists from the U.S. Army, U.S. Army Reserve, U.S. Navy Reserve, and U.S. Public Health Service Commissioned Corps. Each shift was composed of two psychiatrists working from 6:00 AM to 2:00 PM or from 2:00 PM to 10:00 PM, with a dual-trained internal medicine-psychiatry physician functioning as a hospitalist and psychiatry consultant overnight.

CONSULTATION

Many hospitals require the primary treatment team to formally consult the CL psychiatrist. At the JNYMS, as in other medical or disaster settings, there was recognition that all members of the patient treatment team (nurses, medics, physical therapists, dietitians, etc.) identified patient distress at moments that may not be immediately identified by the admitting provider. However, owing to periods of rapid patient admissions and shift change, our model allowed anyone to initiate a consult by radio. Since the service did not require a formal consultation question, a consult simply requesting CL assistance was sufficient.

Consultations were never refused due to the nature of the environment. What might be considered an inadequate consult question in other settings often resulted in recognition of more complex needs. For example, more than one consult for a “tearful patient” led to the discovery of a patient experiencing a recent COVID-19-related death of a significant other. As has been documented in standard inpatient care settings, consults for a “depressed patient” receiving intensive care often led to a diagnosis of hypoactive delirium.⁴ Many minimally clarified consults were disproportionately identified as consult for intervention in bereavement or loss. Psychiatrists often intervened with supportive or other therapeutic interventions, as some patients presented with a combination of their own COVID-19-related distress and death of a loved one.

As the CL service evolved, there was recognition of more direct neuropsychiatric impact of COVID-19.⁵ This was no surprise in retrospect, given that neuropsychiatric sequelae of respiratory viruses, such as delirium, stroke, and psychosis, have been observed since the 1918 influenza pandemic⁶ and have become increasingly recognized in patients with COVID-19.^{5,7,8} Direct and indirect neuropsychiatric manifestations of severe acute respiratory syndrome coronavirus 2, such as delirium, psychosis, and acute stress reaction, were recognized and treated by the psychiatry CL team in collaboration with the primary team.

The psychiatry CL service was able to focus on the neurological and psychiatric needs of patients and enact environmental changes, such as dimming the convention center lights and providing the patients masks at night. Owing to the structural nature of the Javits Convention Center, the JNYMS environment consisted of an open warehouse-like setting with

limited privacy and temperature control, lack of stimulation, and relative social isolation. The CL service enacted policy and individual changes to improve patients’ general quality of life and experience, including therapeutic support by psychiatrist, social workers, and chaplains, as well cognitive stimulation and nutritional support.

The service often stepped outside usual CL roles. In the case of high admission rates, the psychiatrists would proactively pivot to assist primary teams with admissions and other patient care. The CL service also played an integral role in working with case management teams to properly disposition patient with psychiatric and neurological disorders to settings that best fit their needs. For example, one team spent time unavailable to the primary team to facilitate transfer of a cognitively impaired patient to an appropriate local geriatric inpatient psychiatric unit.

LIAISON

The liaison aspect of the CL psychiatry service was also unique. The primary medical teams at the JNYMS were composed of a combination of primary care physicians and specialists with varying levels of experience in inpatient medicine. During moments of high patient admission rate or census, the psychiatry CL service benefitted the primary teams in two ways that maximized quality of patient care. First, patients with psychiatric or neurological disorders could take up disproportionate time requirements from primary treatment teams. Therefore, the CL service assisted with diagnosis, treatment, and management. Second, since this patient cohort could take an emotional toll on caregivers, the CL service allowed primary teams to focus care on patients that required higher-level medical care. The CL service would rotate through patient handoffs at shift changes to proactively identify patients in need of psychiatric or neurological assistance. This allowed for improved patient care and granted the primary teams a sense of security and support.

The CL psychiatry service would also informally round on nursing teams. This entailed spending time at each nursing station to inquire about patients who would benefit from psychiatric services, a technique that allowed for rapport building between team members and early identification of patient and healthcare worker needs. In such situations, the team liaised with other behavioral health providers on the team, such as licensed counselors and psychologists, to ensure force health protection. This nonjudgmental and casual approach allowed for early recognition and intervention in healthcare provider populations who otherwise may not have sought care when in increased emotional distress. Provider fatigue and burnout were recognized early by mental health experts in the COVID-19 pandemic.⁹ Through the development of relationships while serving in the hospitalist and CL roles, psychiatrists at the JNYMS aimed to proactively provide an approachable and safe resource for the healthcare workers. This typically took the form of brief, supportive interactions, either during or immediately after work shifts.

Staff training also became integral in the CL service's liaison responsibilities. Many staff members required in-service training in treatment of patients with psychiatric or neurological comorbidities. In particular, many staff were given additional assistance in managing patients with COVID-19 and comorbid dementia or schizophrenia who were disruptive or could not be safely discharged due to homelessness. This hands-on patient training led to decreased emotional distress on behalf of the staff and patients required decreased demand for resources such as medical or psychiatric sitters. This freed up patient sitters to support the mission through other means, including providing direct medical care and other behavioral health interventions.

LESSONS LEARNED

Personal protective equipment (PPE) was appropriately identified as necessary for treatment while protecting provider health. Extensive PPE added a necessary additional physical barrier, as it was identified in protecting the provider, but in many ways affected patient care and relations. Therapeutic modalities such as a handshake were limited. Communication was often a challenge, as the patient typically wore a surgical mask while the provider wore full PPE. The use of facial PPE served not only as a physical manifestation of the separation between patients and providers but limited vocal communication. The CL team quickly learned to emphasize summarization and reflection techniques to assess the psychiatrists' understanding of the patient as well as the patients' perception of the interaction. In response to the muffling effect of the PPE and the relatively loud environment, the CL team members would frequently be required to respectfully increase their volume and speak more slowly. Staff also wrote their names and titles on large pieces of tape affixed to their gowns. The use of language telephone lines was invaluable as English was not the primary language of many patients.

Standard operating procedures were integral to the development of the JNYMS and the CL service in particular. As the JNYMS was growing, psychiatrists contributed to such protocols pertaining to alcohol withdrawal, capacity evaluation, intubation, and delirium.

No electronic medical record (EMR) existed for the field hospital operating at the JNYMS because of the complexity of setting up an EMR in a limited amount of time. Patients presented with a written record, their medications, and verbal report. The psychiatry CL team worked with such information to tease out diagnoses and treatment plans. Even familial collateral information was limited by infectious control procedures, such as speaking with family in person or sharing a phone with the patient. The lack of an EMR also led to a challenge in tracking movement of patients. Various strategies to track and handoff patients were utilized, including de-identified excel spreadsheets and patient boards at nursing stations. This allowed patient tracking during handoffs and increased efficiency in locating patients for intervention. An EMR would be invaluable in future scenarios.

TRANSITION

On April 16, 2020, we initiated a transition of patient care to civilian providers, in order to support turnover of the facility from federal support back to the state. A contract with a local tele-behavioral health company was arranged, and the services began working together from April 18-23, 2020. The civilian tele-behavioral health provider operated independently from April 23 to May 1, 2020, when the last patient had been discharged from the JNYMS. The psychiatry CL service operated for over 1 month, during which time the JNYMS cared for over 1,000 patients with COVID-19.

CONCLUSION

We present this case of establishing a CL psychiatry service in a novel treatment environment as a model for others in the evolving COVID-19 pandemic. To our knowledge, this is the first formal CL service to be developed and operated in a convention center. We feel that this demonstrates the unique potential of psychiatrists (particularly those in uniform) to rapidly adapt and serve varied roles in the treatment of patients in pandemic settings.

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CONFLICT OF INTEREST STATEMENT

None declared.

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