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Letter to the Editor

## COVID-19 psychiatric patients: Impact of variability in testing on length of hospital stay and disposition back to congregate care settings



Dear Editor,

Coronavirus disease 2019 (COVID) is a highly contagious viral illness that can lead to severe acute respiratory syndrome and fatality. This pandemic has changed inpatient hospital treatment at every level of care and significantly impacted our daily lives (Griffin et al., 2020). While frontline healthcare workers have provided heroic treatment to those seriously ill from COVID, clinical care has also been altered for a subset of hospital patients who test positive but are asymptomatic. The authors here explore more specifically the challenges that have emerged with inpatient psychiatric patients who have asymptomatic COVID and its impact on disposition (Bojdani et al., 2020). There has been a growing number of patients who live in community congregate care settings who face a unique barrier to discharge even after reaching psychiatric stability because of their COVID positive status. Due to variability in testing and reluctance of congregate care facilities to accept COVID patients back into the community, the authors experienced many cases in which hospital discharge was delayed anywhere from 7 to 47 days. Thus, on top of social distancing, individuals who are unable to return home face challenges of further isolation, anxiety, and perceived rejection while awaiting COVID results in the hospital.

COVID testing has presented unique challenges to inpatient psychiatric care. Notably, testing timeframes are important. Some COVID tests are processed in 2-, 4-, 6-, 24-hour timelines and for those that are send-out tests the processing time can be longer and lead to increased time that a patient spends as a “person under investigation.” Additionally, testing results can be variable from having cases with a wide combinatorics on positive, negative, and inconclusive results. For example, a patient may initially be negative, and then upon re-testing the patient may be positive. However, the lag time may have been several days, and during this time, other patients and staff could be infected. In addition, a patient may test positive and remain so for well over 4 weeks even though they are no longer infectious. Recently, the CDC has issued guidelines on both testing-based and symptom-based strategies for discontinuing isolation precautions (CDC, 2020). Literature suggests that an individual may carry viral RNA for multiple weeks after the virus is no longer replicating (He et al., 2020). Thus, there have been recent recommendations to use a guideline for 10 days without symptoms to determine when to stop isolation precautions. Due to initial recommendations for negative tests many community agencies are concerned about the risk for infectious spread and request two negative tests with varying intervals of time in between. This can present challenges to disposition for psychiatric patients who may be stable for discharge yet need to wait for two negative tests - prolonging hospital length of stay.

The new challenges of the COVID pandemic has forced hospitals to adapt patient care, especially in congregate psychiatric settings. There remains many lessons and refinement of processes in the way we treat our patients both in and out of the hospital. Stemming from a lack of clear protocols and fears of spreading COVID, individuals with comorbid mental health and asymptomatic COVID illness have not been easily able to return to their community based congregate care facilities. Guidelines and criteria for returning to individual residential and group homes have been inconsistent and typically more stringent than updated CDC recommendations. This is in part due to high rates of spread and mortality in congregate living situations and in part due to miseducation and fear. Stable psychiatric patients are experiencing longer psychiatric inpatient lengths of stay, even when continued hospitalization is no longer the least restrictive environment. In addition, variability in testing results has a significant impact on discharge planning. Although testing variability has been explored in the literature, we report here the direct impact of testing variability on patient care in inpatient psychiatry (Zou et al., 2020). Further studies are needed to assess if viral loading and testing profiles are different for those with psychiatric illness. Subpopulation analyses are needed to assess mechanistically easier testing methods for mental health patients, as some psychiatric patients are experiencing inconclusive or inaccurate results. Early reports on a saliva test for COVID may be helpful as it comes more commercially available.

An important recommendation for clinical care is for community based congregate care facilities to adopt CDC guidelines in a timely manner to minimize delays in care, such as switching from a test-based strategy to a symptom-based strategy (CDC, 2020). This requires close coordination between community and inpatient psychiatric facility leaders, and decision-making to adopt new recommendations. To further facilitate as smooth a transition to a congregate care setting, we found that communication with patient and families and outpatient treatment teams is key. For example, setting up weekly meetings to debrief events and progress and provide psychoeducation to the primary outpatient clinicians and direct care staff of community facilities has been advantageous. Education on updated recommendations from the CDC may also be helpful in alleviating anxiety that facilities have of accepting patients back following a COVID diagnosis. Our team was able to ask infectious disease experts to join such collaborative care discussions to provide further assurance and support recommendations for discharge. Further, our inpatient unit modeled these CDC recommendations by integrating some asymptomatic COVID patients back to non-COVID psychiatric units after completing appropriate quarantine periods. These patients were successfully integrated into regular therapeutic milieu treatment with non-COVID peers and had no

<https://doi.org/10.1016/j.psychres.2020.113324>

Received 15 June 2020; Received in revised form 23 July 2020; Accepted 23 July 2020

Available online 24 July 2020

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symptoms at the time of discharge nor did this lead to further infectious spread. This move helped to illustrate the hospital's confidence in mixing asymptomatic COVID patients back into the community and importantly the individual patient had greater access to more socially normative inpatient psychiatric treatment. Beyond individual provider or unit level patient advocacy, it would be advantageous for hospital administrative leadership to engage with community program leaders to create a space of open dialog about shared goals around best practices of patient care both in the hospital and in community congregate care facilities.

#### Disclosure statement

Nothing to declare.

#### Declaration of Competing Interest

The authors have no declaration of competing interests and no disclosures.

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