Pediatric Director's Forum Discussion Call Summary

Tuesday, March 31, 2020

12-1 pm EDT

DISCUSSION TOPIC: Staffing During Covid-19

*This information is current at time of the call.

I. Participating Organizations- 10 organizations identified themselves as present on the call. Call was facilitated by IPRC Director, Cindi Hobbes.

II. Initial Remarks

a. A physician leader shared initial thoughts on the relative scarcity of pediatric rehabilitation specialists and the need to preserve clinicians through this pandemic. Rehabilitation professionals are at high risk for disease transmission as we are an "in your business" profession.
b. ORG A shared their experience. As an early community to experience COVID-19, they have implemented the following plans:
    i. Focus on information flow within the hospital – ORG A has created one source for all "TRUTH" for the whole organization. All units/employees should check there for current information. This eliminates confusion.
    ii. Limit number of people on site at any given time
        1. Use Telemedicine whenever possible; Outpatient providers utilizing telehealth/telephone visits
        2. Limit non-essential staff in building– Staff offices are tight, so limited space is for essential staff only. All others work from home.
        3. Medical Staff – only 2 attendings and 1-2 fellows/residents onsite at a time (for rehab)
    iii. Rounding done virtually or with limited teams
        1. Clinical Nutritionist, Social Workers on phone
        2. Limit # of people going into rooms – when possible, rounding done outside of patient room
        3. Phone calls for huddles and rounds instead of in person
    iv. Screen Staff who are on site – temperature checks each day
    v. All patients allowed one caregiver at a time. Exceptions made for:
        1. Car transfers (done outdoors)
        2. Practice of outdoor skills
    vi. Medical Team Changes
        1. Rehab Unit now admitting patients 28+ years old to allow area adult rehabs to accommodate post COVID-19 patients

2. Physician labor pool plans – plans identified for which types of patients each provider can care for if needed
3. Baclofen refills – clustering/batching pump refills, identified other community providers that can provide this

vii. Nursing Team Changes
1. Conserve PPE, Group nursing care whenever possible
2. Change Care Routines/responsibilities - One person do as much as possible in each visit to prevent need for more staff to enter room
3. Switched to multi-use PPE

viii. Therapy Team Changes
1. Limit/Eliminate Students and Observers
2. Block Scheduling
    a. ORG A has seen a 30% decrease in caseload due to cancellation of elective surgeries and decreased acute care services provided
    b. Providers are scheduled for consecutive days in hospital and then consecutive days WFH or PTO
    c. Each clinician is in building for 6 days per 3 weeks, days are concentrated
    d. Increases continuity of care for patients
    e. Decreases exposure for clinicians, preserves staff and decreases risk of transmission
3. Decrease therapy frequency in Acute Care Services – evaluate need based on urgency, need for services, PPE considerations
4. Defined # of people allowed in therapy gym/office
5. Alter Therapy Schedules
    a. Combining sessions to be longer sessions (ex: 1- 60 min session vs. 2- 30 minute sessions)
    b. Alternate PT/OT to conserve PPE (Each treat every other day)

ix. Accept that some necessary decisions go against what “feels right” or is “best practice” clinically/therapeutically

III. Group Discussion

a. What staffing models for Clinical Leadership Preservation (physicians, nurse leaders, therapy leads) has your organization developed and implemented due to COVID-19?

i. ORG B
1. Leaders rotate days in the office over all 7 days in the week; No 2 leaders are present on the same day.
2. All psychology services are provided via telehealth.
3. Nursing: using float pool nurses on unit to stagger scheduling of highly trained rehab nurses
4. Higher census right now (IP), but expecting it to drop due to no elective surgeries and lower trauma census

ii. ORG C
1. Rotating Leaders on site
2. Inpatient Rehab census remains high – cross training Outpatient staff to cover in rehab, day program, and acute care
3. Focus on resiliency and support to combat high anxiety levels in front line staff

iii. ORG D
    1. Each therapist allotted WFH (work from home) days and documentation is consolidated to those days
    2. If staff are treating in both IP and OP settings, must treat inpatient clients first and then schedule outpatients
iv. ORG E
    1. Physicians are on a 2 week rotation: Week 1 – On Rehab Unit, Week 2 – Consult
v. ORG A
    1. Therapy census decreased due to no elective surgeries
    2. Frequency of provided services intentionally decreased
        a. Only doing what is absolutely necessary
        b. Many missed visits

b. How have closures impacted rehabilitation services and continuity of care? QUESTION from Group: What are you experiencing regarding Length of Stay on Inpatient Rehabilitation Units?
    i. ORG E
        1. Increased LOS due to Outpatient services closed/limited, telemedicine increased, increased LOS on Inpatient Rehabilitation Unit due to no good outpatient plan for some patients
    ii. ORG C
        1. Increased LOS due to decreased OP services
        2. Local Ronald McDonald house closed to new patients (many day hospital patient families stay here) so less discharges to day hospital
    iii. ORG B
        1. Census decreased because families want to go home
        2. Families are deciding to go home even with limited OP services available
c. QUESTION from Group: How are you handling staffing with Childcare/School Closures?
    i. ORG E
        1. Therapists offered to take a personal leave due to having to care for children at home
        2. Local YMCA now providing daycare for children of medical providers (were not previously providing this service)
        3. Alternating schedules with spouse/partner to flex childcare hours
    ii. ORG C
        1. Local YMCA expanded care for children of healthcare workers
        2. Hospital has contracted with local private daycare to expand childcare for healthcare workers
        3. Hospital program for employees – will help cover costs for in-home childcare for healthcare workers
        4. Hospital program for back up care – ORG C offers 80 hrs/year of backup childcare to help offset costs for private childcare so employees to go to work if their regular childcare is not available. This has expanded.
d. How are you minimizing or staggering possible exposures for therapists, nurses, and physicians? How have you changed your policies and practices?
    i. ORG F
        1. Developed “A-B” Schedule Plan

a. Therapists split into 2 groups
b. One group comes on-site for one week and provides care while other group WFH
c. Groups alternate each week
d. Telehealth offerings for appropriate patients (Inpatient)
e. Telehealth offerings for Outpatients

e. QUESTION from Group: How are you able to make therapists whole financially? Are your therapists salaried or hourly?
    i. ORG E
        1. Therapists are hourly.
        2. Struggling to provide full pay/hours.
    ii. ORG C
        1. Therapists are hourly.
        2. Not having trouble with hours for inpatient rehab and acute care therapists, but are having difficulty with outpatient therapist hours.
        3. OP therapists cross training to IP sites
        4. Therapist creativity
            a. Robotics/Aquatics closed to Outpatients (due to being on IP site) – moved Robotics equipment to alternate site to be able to see Outpatients there.
            b. Robotics staff seeing patients 7 d/wk to minimize # of patients and clinicians in same place
        5. Increased Projects and TeleMed
            a. Each therapist must call entire caseload at least 1 x each week to check in (not billable, but good for continuity of care)
            b. Working on developing telemedicine program (expected to roll out in next 2-3 weeks)
        6. Hospital Labor Pool
            a. Huge effort to redeploy displaced staff
            b. Therapists are cleaning, painting, staffing visitor desk, etc. to make up hours
    iii. ORG A
        1. Salaried (PT/OT/ST), Hourly (PTA, COTA, Aides)
        2. Hospital Labor Pool to make up hours

f. How are you preparing if staff members on your team become infected or need to care for an ill family member?
    i. ORG F
        1. Constantly updating contingency plan
        2. Communicate expectations (what to expect) to other departments as the plan changes
        3. Change/clarify guidance on who is essential/non-essential services
        4. Rehab department soliciting input from physicians, nursing, therapists, and others to determine the best balance between risk and care provision
    ii. ORG A
        1. Physician pool created
        2. Physicians identify which types of patients they have expertise to care for / cover

g. Have there been instances when you have had to advocate for an alternate plan for the Rehabilitation Department from the rest of the hospital?
    i. ORG C
        1. Exceptions to Hospital's 1 visitor policy
            a. Family training near discharge – have made exceptions to 1 visitor policy to ensure a safe discharge
            b. Families with complex dynamics (Parents with separate households, custody arrangements)
            c. Non-English Speaking Families
        2. Closed outdoor spaces
            a. Exemptions made for Rehab staff to take patients into outdoor spaces/gardens to work on dynamic surfaces
            b. Therapeutic benefit of being outdoors

Summary compiled by: Cindi Hobbes