ORIGINAL QUESTIONS:

Do you have staff that spend all, or almost all, of the their time seeing one type of patient (just NICU, just inpatient rehab, just burns)? If so, in what ways has it been beneficial and what have been the challenges?

If you provide both IP and OP care, do you have staff that just see inpatients? Just outpatients?

Do you provide weekend coverage? If so, how does staffing work for that? (for example, schedules Tuesday-Saturday, everyone required to complete a certain amount, just certain staff work weekends, PRN Staff?)

RESPONSES:

ORG A

Do you have staff that spend all, or almost all, of the their time seeing one type of patient (just NICU, just inpatient rehab, just burns)? If so, in what ways has it been beneficial and what have been the challenges? We have one PT who sees all or most of our non-rehab inpatients. This PT works 10 hour days, full days Saturdays and business closure days, half days Sundays (it's more than one person, staffed by 1.25 FTE and on call staff) Relations with trauma and ortho docs as well as acute care nursing have improved significantly. Because this person is dedicated to inpatient acute, she is able to be very flexible - if a patient is being casted, for example, she can easily move her schedule around.

If you provide both IP and OP care, do you have staff that just see inpatients? Just outpatients?

All of our staff at the hospital site can, and do, see inpatients. That being said, we do have an inpatient rehab team. Those therapists serve as primaries for rehab inpatients, and the PT mentioned above sees most of our other inpatients. When acute inpatients need OT or SLP, our first go to is the inpatient team, but there are times when an outpatient therapist will be scheduled to see an inpatient. Our IP team also sees outpatients when IP is slower and OP is busy. Let me know if that doesn't make sense!

Do you provide weekend coverage? If so, how does staffing work for that? (for example, schedules Tuesday-Saturday, everyone required to complete a certain amount, just certain staff work weekends, PRN Staff?) Weekends and business closure days, we have a number of on call staff who help with the coverage. Therapists at any of our sites can also volunteer to be a part of the weekend business closure day team. If there are still slots that need to be filled after all the volunteers have been scheduled, the therapists who work at the hospital site are scheduled in. This past year, we did not need to use any SLPs who didn't volunteer. There were about 8 slots for OT left over, and about 20 or so for PT. Therapists who did not volunteer ended up having a maximum of three days for the whole year, and it is in one of the last slots, so they may not even be needed...

ORG B

Our staff are more generalists doing inpatient post-op/wounds, clinic, outpatient (intensive and recurring), rehab. However, we have a couple part-time therapists who mostly do clinic and equipment clinic.

No, but a change may be coming from our headquarters with this directive in 2019. We have such a small staff that it doesn't seem to make sense since we really need to be able to cover anyone and everyone.

We are only on call on the weekends for post-ops or if a patient has missed minutes or days for rehab. We have a call schedule for OT/PT and just have to flex time usually if they come in. Otherwise, we also have some PRNs who cover who then just get paid when they work

ORG C

We have three teams of therapists for each discipline (PT and OT) – acute, inpatient rehab, and outpatient. We do have some therapists who are on the acute or rehab teams and see patients in multidisciplinary clinics on the outpatient side, but for the most part people are either all inpatient or all outpatient. In addition to the rehab team (who exclusively see inpatient rehab patients), we do have some staff that are dedicated almost entirely to one area of acute (NICU, in particular).

Our weekends are covered by a combination of per diem staff and staff that voluntarily work weekends for extra money (it's paid at a per diem rate), and staff that are mandated to work weekends (or be on call for weekends) to round out any uncovered days.

ORG D

We have a mix of specialty and general therapists. We have a critical care, NICU and a cardiac competency so you must complete those before working in a specialty area. Also the NICU doesn't do well with a large number of therapists coming and going so we definitely have specific therapists there.

If you provide both IP and OP care, do you have staff that just see inpatients? Yes for PT and OT. Speech do swallow studies, voice outpatients and all the inpatients

WE have just weekend staff, staff that flex the days of the week, regular staff that pick up weekend days and then PRN who cover. (for example, schedules Tuesday-Saturday, everyone required to complete a certain amount, just certain staff work weekends, PRN Staff?)

ORG D

We have also had these growing pains. When our primary outpt clinic moved off site we began to split into outpt and inpt teams. However, we still had a lot of staff who split (by day) between both (ex: mwf outpt, t/tht acute care)

Over the years we have found having full time dedicated staff to acute care has made us more efficient, more visible and easier on the staff. So currently we only have a handful of people who are splitting their time.

Our NICU certified therapists (1 OT, 1 PT) are dedicated to the NICU (with ability to flex to floors during holidays and weekends); we have several other staff who float to help after training
We do not have therapist dedicated to any other floors but as we continue to expand we are considering this. We do have therapist that have more interest and specialization in PICU, PCICU and oncology

They move by days. One day outpatient , the next day inpatient. We found floating within the day was inefficient

We do a rotating scheduling for weekends with ability to flex off the next week or take extra pay. Both disciplines have enough people to only work about 1 weekend day a month; some will offer to do more from time to time. This includes full staff and PRN.

ORG E

We have teams of therapists who mostly see a small sub set of patients, although some cross-cover others. This includes inpatient cancer care, inpatient Rehab, acute care, infants, brachial plexus, DME, AAC, voice, craniofacial, etc. Benefits are that the therapists are very skilled in their areas and have a lot to offer their patients and families. Challenges include more siloing of the therapists; they work in different locations and do not see each other often, lack of cross-discipline communication and learning

Yes, the therapists are mostly divided into inpatient or outpatient. We have a few therapists who work one day in a specific area of outpatient, and the rest of the days inpatient. Our assistants cross both inpatient and outpatient.

We provide weekend coverage for inpatient rehab, inpatient infants (mostly feeding), and acute care patients who could be discharged if seen by PT over the weekend. We are increasing weekend coverage in the acute care area with more speech coverage and OT/PT for patients who would likely make changes if seen. Some staff work Tues-Sat, some work every other Sat or Sunday, some are per diem on the weekend. Outpatient we offer Sports PT on Saturdays and Rehab PT at our regional clinics on Saturdays.

ORG F

At ORG F we have an inpatient rehab hospital and then multiple OP sites. Our therapists are primarily assigned, trained and work in either IP or OP. This is beneficial as staff maintains a more consistent schedule in the respective department. Also, the rapport built within the IP team across disciplines is very beneficial, especially since they treat the same kids 5 days a week. A typical IP schedule is from 8-4. OP schedules have a more sporadic pattern based on hours of operation and patient need (from 8:00 am-7:00 pm)

However, we do cross train all the therapists to be able to treat in both programs. In times of need (high or low census, maternity/vacation/call out vacancies) therapists can cover in the other department when available.

Weekend coverage for OP is scheduled with a consistent therapist- most often this person is a per diem therapist. We have had therapists where Saturdays are part of their regular schedule as well.

For IP, we also cover saturday service. This most often is covered by our full or part-time therapists and paid as a bonus. We also have per diem therapists that will cover IP Saturday services. We create a calendar rotation for weekend coverage throughout the year.

ORG G

Yes – dedicated NICU therapists, other patient populations are not assigned dedicated therapists. We also have staff that float into NICU when needed for patient care. They have completed an additional NICU competency to float in.

Yes we have separate staff that just see inpatient or outpatient. Our outpatient team no longer covers inpatient needs – this is a recent transition.

Weekend inpatient coverage only. We have staff that have a different job title – "Weekend Option". They are paid more to cover a weekend day each week. Other staff coverage needs for weekends (such as a high census weekend) are completed through a volunteer sign up at the time the schedule is completed.

ORG H

Yes, we have dedicated IP staff and within that team, we have staff who primarily cover each of the following: Rehab, NICU, and Cardiac. Our NICU & Cardiac teams cross cover. Some of the Rehab team also can cover NICU but not all are trained. The Rehab team also covers every other floor (MedSurg, etc.)

Our IP team is primarily IP, but do provide some OP evaluations in specific multi-disciplinary clinics.

Our OP team is fully dedicated to OP care at each of our sites. At our main hospital, a few of the OP staff are also trained to cross-cover in IP Rehab

Yes – our Rehab patients are seen 7 days/week. We have some staff whose regularly scheduled work day is Saturday (they have another day off in the week). We also have PRN staff who see patients on Saturday and Sunday.

ORG I

No staff member does solely one patient population. We have 3 staff members with NICU competencies, all staff at the main building have competencies with rehab and inpatients. Staff at

satellites have competencies for rehab and inpatients, but because they cover so infrequently they do not feel comfortable.

All staff assigned as primary inpatient therapists have an outpatient component either later in day for after school coverage or coverage of a specialty clinic.

We have per diem staff that cover most weekends. Then all outpatient staff are required to sign up for one to two weekends a year. This is most challenging as the paperwork is different and unless they work in the main building and routinely assist with inpatient coverage, they often do not feel comfortable with patient population.

ORG J

Our staff are divided into outpatient and inpatient teams. Our inpatient team is further divided into a few SLPs that primarily serve the NICU, one SLP assigned to inpatient rehab unit (currently have a 3-month rotation among 3 staff to cover rehab) and the rest of inpatient SLPs are considered "meds coverage" which is all other floors besides NICU and rehab. All outpatient staff are cross-trained to cover inpatient so they can be in the rotation for inpatient weekend and holiday coverage. We do have some cross over between areas- some of our NICU SLPs cover the outpatient NICU follow-up clinic and both inpatient and outpatient SLPs cover outpatient swallow studies.

But during the week, in general, our outpatient staff just see outpatients and our inpatient staff just see inpatients. We have tried a split position with one SLP covering both inpatient and outpatient but did not find that to be effective- time management and productivity was tough.

- Benefits- People are hired into certain positions so they know what they're getting themselves into- low turnover, folks get to do what they like which is great for job satisfaction, morale, and therefore patient satisfaction. Higher quality of care as folks get to hone their skills with certain patient populations

- Challenges- folks get stuck in their silos and communication as well as practice patterns can get delineated between groups, certain pockets of expertise that you only get in certain areas (infant cleft feeding expertise w/NICU SLPs, older peds/adults expertise w/those inpatient folks that cover rehab and burn, etc). Our inpatient and outpatient offices are located in different areas so we really have to make an effort to get the groups together on a consistent basis for staffing, continuing education, team building, etc, so we remain one team.

- We haven't quite figured out creative ways to float SLPs from inpatient to outpatient or vice versa on a daily basis to optimize productivity when cancellations/no shows arise or inpatient census is low. Curious to hear if others have approaches to that!

Yes, there is a rotation schedule sent out well in advance with staffing assignments for weekends. It's evenly divided so everyone generally works the same number of weekends. Our staff have the option to

clock for a weekend rate during their shift or to trade a day off during the pay period. We do have some folks that volunteer for extra weekend shifts for the $$ benefit or to get days off during the week.

ORG K

We naturally made the transition to having a few specialized therapists in a variety of areas. We have therapists that focus within feeding, NICU follow along, concussion, seating & mobility, orthotics/prosthetics, etc. This allows our therapists to focus their continuing education around areas that they have a high interest in. However, we also intermix non-specialty patients onto their caseloads as well so they don't lose general skills. This also helps maintain productivity as the specialty program grows.

The benefits of allowing specialized focus in certain populations is that it's a great way to increase staff engagement by tailoring their workload to areas they're passionate about. It will also improve patient experiences and care around difficult populations. The challenge is that management can't dictate specialization based on department needs. This type of change takes time as you find specialty areas based on therapist interests and cultivate their skill level/program development. Developing each of these specialty programs requires marketing to specific physicians or other upstream sources of referrals.

Our team only sees outpatients.

We are closed on the weekends.

ORG L

We have staff who are primary therapists in certain IP areas. The volumes in the majority of our various patient types(- neuro, ortho, critical care, trauma, etc). vary so that at this point in time we do not have the volumes in each of the areas to support totally dedicated staff. NICU is an area where we could probably support this, but as yet, we haven't gone to this model.

We have OP staff who cost reassign to IP on certain days and for certain clinics. This also occurs if the outpatient volumes are low and the inpatient volumes are high. We also have IP staff who cost reassign to Outpatient on a weekly basis.(this is primarily those individuals who are NDT trained and want to keep up their skills)

We provide weekend and holiday coverage. The expectation is that all staff in the IP cost center and any individual who has an IP day will participate in the weekend/holiday rotation. PT's work typically work a full day on Saturday and 4-6 hours on Sunday. OT's typically work ½ day on Saturday and are on –call Sunday from 8-12. Speech is on call both Saturday and Sunday from 8-12. PT, OT, and SLP are all on call 8-12 on Holidays. If we know about patients needing to be seen in advance, then the on-call therapist comes in and treats these patients. Ideally, we want at least 8 individuals participating in the weekend/holiday rotation. No one wants to work weekends, but working every 8 weeks is very tolerable

to the team. Those individuals who work the weekend, make every attempt to adjust their schedules to minimize overtime, but it is not a given that this can occur.