11/16/2022 Pediatric Surge Response Town Hall Notes:

Children's Hospital of Michigan

Biggest Challenges:

- Staffing - have empty beds in ICU and inpatient units and space in ED but no RNs/RTs to staff those beds, so they are closed
- Admitted patients are stuck in ED and new ED patients are stuck waiting
- Compared to other surges, these patients are younger, sicker, and are staying longer

Mitigation Strategies:

- Boarded ED patients are being cared for by inpatient physicians rather than the ED docs so that they can still receive the inpatient care they need, even if they are physically in the ED
- Surgical and other specialty teams round on their patients in the ED every morning so that the ED docs are freed up to take care of new ED patients
- ED docs now have the capacity to work in "pods" without dedicated RN or RT staff and can see and treat lower-acuity asthmatics without RN/RT support
- Higher acuity patients needing things like HHFNC are diverted to space with RN/RT staff
- Incident command center now open, looking to move to a team approach for inpatient nursing care to accommodate more patients. Goal is to have one RN who is familiar with the unit and patient population paired with additional support nurses
- Ambulatory care has opened an after-hours pediatric walk-in clinic

Trinity Health St. Mary Mercy Livonia

Biggest Challenges:

- Larger volume of pediatric patients with no inpatient pediatric unit available to help with the critically ill patients
- Normally, most kids in the area go to one of the bigger pediatric sites but with those sites facing capacity limitations more of those kids are coming to Livonia
- Critically ill patients are also waiting much longer for transfer to tertiary hospitals than previously
- Difficulty finding places to transfer their "borderline" respiratory patients, having to transfer patients as far as Fort Wayne, Indiana

Mitigation Strategies:

- "Team Triage" – physician sits up front with the triage nurse to help identify the sick patients ASAP and expedite testing and care

- Working with their RTs to determine how to better care for the higher-acuity pediatric patients while transfer is pending
- Obtained new pediatric specialty equipment to bridge higher-acuity patients to time of transfer (ex: HHFNC machines)
- Working closely with Trinity Health St. Joe Ann Arbor who is helping them manage some of the "borderline" patients without needing to transfer out
- Partnered with IHA who is now offering next-day follow up for some of the patients who don't necessarily need to be admitted, but would benefit from close observation/outpatient follow-up
- Thinking of other facilities they can transfer to that may not have a PICU but a general care inpatient unit with space
    - Ex: Have had success with Trinity Health St. Joe Ann Arbor
    - Hurley also notes they sometimes have space for lower-acuity patients on their peds general care unit

Emergency Care Specialists (ECS) who staff many of the Corewell Health EDs in West-Michigan including Helen DeVos Children's Hospital

Biggest Challenges:

- Physical space to see patients
- Inability to take transfers from community partners they would normally accept

Mitigation Strategies:

- Cohorting patients with like-respiratory illnesses in previously private rooms to allow for increased capacity in PICU
    - Additional physician staffing overnight to help with increased patient volumes
- Finding flex space to expand inpatient general care capacity
    - Ex: Currently using a nursery in the NICU for pediatric general care patients
    - Ex: Using a sedation space near the ED that can flex to hold 4-8 patients
- Central Command Center that meets multiple times per day to review inpatient capacity and pending transfers
- Created dedicated observation space for their behavioral health patients with access to social work and behavioral health consultants so they receive the care they need without taking up space that could be used for new ED patients/patients needing to be admitted
- Supporting community EDs as much as possible:
    - Sharing pediatric ED observation guidelines and protocols for several common diagnoses
    - Rolling out regional education to RNs and RTs on managing pediatric respiratory patients (ex: nasopharyngeal suctioning for RSV/bronchiolitis patients)

- Updating emergency transfer policies so that patients can now be transported with specialty equipment (ex: HHFNC) borrowed from regional hospitals that would not otherwise be available
- "Triage Officer" who takes calls from outside hospitals to help.
- Hoping to set up "Tele-consults" soon with their hospitalists who can help community hospitals evaluate pediatric patients who may or may not need additional support like HHFNC and/or may or may not require transfer

Chelsea Hospital

Biggest Challenges:

- Didn't have all necessary equipment to take care of critically ill pediatric patients
- Some staff unfamiliar with how to care for critically ill pediatric patients
- Difficulty transferring patients needing higher levels of care, particularly patients weighing <5kg

Mitigation Strategies:

- Working on ED "pediatric readiness"
  - Identified all the respiratory/airway support equipment that they did not have and acquired all the items they were missing
  - Pediatric Readiness information shared by Dr. Lozon from Michigan Medicine: https://emscimprovement.center/domains/pediatric-readiness-project/
- Training RTs on pediatric respiratory guidelines and protocols
- CHM PANDA critical care transport team available for transfers to CHM specifically
  - Outside of this surge, they are available for transport even to other facilities

HFH Wyandotte/Brownstown

Biggest Challenges:

- Difficulty transferring patients needing higher levels of care, having to transfer as far away as Akron, Ohio
- Spending a significant amount of time on the phone trying to find accepting facilities for their patients needing transfers
- Critically ill patients are also waiting much longer for transfer to tertiary hospitals than previously, particularly challenging at their freestanding ED with no RT on staff

Mitigation Strategies:

- Obtained new pediatric specialty equipment to bridge higher-acuity patients to time of transfer (ex: HHFNC machines)

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- Some HFH sites expanding their inpatient capacity for bronchiolitis patients
- Provider visited from CHM who was helpful in reviewing their pediatric equipment and guidelines/policies
- Asking accepting facilities to be more up-front about ability or inability to accept patients to improve efficiency of phone calls, particularly in cases where the outside facility is denying transfer due to capacity issues
    - This sentiment was echoed by many mixed-population sites

Michigan Medicine

Biggest Challenges:

- Seeing record volumes of pediatric patients and running out of physical space
- Large numbers of boarded patients causing congestion in ED
- Upstaffing is challenging with union/bargained-for staff
- Have to provide care to their specialized patients in addition to the surge of pediatric respiratory patients

Mitigation Strategies:

- Opening overflow spaces for ED patients
    - Additional hallway beds
    - Flex space in pathology lab that is utilized in the evenings and on weekends
- Offering incentives for physicians willing to work extra hours
- Working with ambulatory care to see lower-acuity patients
- Transferring lower-acuity patients needing admission to outside hospitals with general care space