HOMERuN Hospital Medicine ReEngineering Network

HOMERuN COVID-19 Collaborative Surge Workforce Planning Focus Groups

December 22, 2020 Newletter

The Hospital Medicine Reengineering Network (HOMERuN) is a national network of Hospital Medicine investigators at 12 academic medical centers (AMCs) and 50 affiliated sites. During the COVID-19 pandemic, HOMERuN leadership formed the "COVID-19 Collaborative" as a mechanism to share information and practices regarding pandemic responses across participating institutions.

The HOMERuN COVID-19 Collaborative held focus group discussions on surge workforce planning on December 4, 2020. Below are key themes identified in the discussions.

Organizers and Facilitators: Luci Leykum, Andrew Auerbach, Gopi Astik, Marisha Burden, Clark Davis, Shaker Eid, Angela Keniston, Shradha Kulkarni, Anne Linker, Matthew Sakumoto, Devin Worster

Successful Strategies

- *Expanded "helper" workforce from APPs, other specialties, residents/fellows*
  - Expand the size of teams with more non-hospitalists overseen by hospitalists rather than creating new teams with people unfamiliar with inpatient care.
  - Recognize the importance of maintaining hospitalist supervision ("helpers" can assist with follow-ups and cross-cover, but overnight and admitting shifts remain the role of hospitalists).
  - Clearly communicate new team structures which can cause downstream issues for nurses or families regarding which provider is the main point of

contact.
    - Continuity is key. Onboarding, training, and scheduling a rotating stream of volunteers is difficult. Blocks of dedicated time on service is preferred.
        - At one site, each specialty was assigned a week of inpatient work and was responsible for recruiting, scheduling, and logistics.
- *Load-balancing and redistribution of patients (COVID-19 and non-COVID-19)*
    - Distribute patients to other hospitals throughout the network.
    - Send low-complexity patients to direct care by specialty services as "primary team" with Medicine consulting.
        - Examples: non-surgical cholecystitis to Surgery, simple GI bleed to GI, stable NSTEMI to Cardiology
    - At one institution, non-Hospital Medicine specialists care for COVID+ patients, as that care is now felt to be more protocolized and straightforward.
    - Take advantage of existing team structures for teams that may be able to care for COVID-19. Build buddy systems to help those teams. Hospitalists can help consult/oversee care on more patients with this model.
- *Virtualizing workforce*
    - Utilize inpatient telehealth and video visits to reduce exposure risk and PPE usage.
    - Allow cross-cover calls from home for both workforce expansion and increased provider satisfaction.
- *Decrease in dedicated COVID-19 units*
    - Geographic cohorting of COVID-19 patients was initially required in the first surge to consolidate knowledge and conserve PPE. Greater availability of PPE and more experience with the care of COVID-19 patients appear to have further catalyzed transition away from respiratory isolation units for COVID-19 patients.

> *"A common [theme] was really robust communication with the groups...check-ins with the [hospitalist] group, check-ins with the ICU. Everyone talked about how communicating kept everyone engaged, and despite how busy everyone was, they were still seeing a robust volunteering from their own group."*

Challenges Faced

- *Burnout and morale*
    - Many discussions around how to maintain goodwill and volunteerism of hospitalists and non-Hospital Medicine providers.
    - Avoiding gathering spaces (particularly shared workspaces and dining areas) is producing a sense of loneliness and disconnectedness among inpatient providers.
- *Maintaining staffing flexibility while maintaining non-COVID-19 patient volumes*
    - Elective surgeries, procedures, and non-COVID-19 admissions are back to pre-pandemic levels, resulting in additional capacity constraints for personnel and space.

    - There is difficulty defining levels of surge and optimizing staffing levels with actual demand. Some sites use inpatient census, others use county case counts.
    - Appropriate timing of staffing is important so people are not pulled in too late or too early (both of which negatively impact morale and burnout).
- *Preserving clinical education*
    - In the first surge, residents were pulled from electives to cover wards and ICU.
    - Now, many sites report a tiered approach; first maximizing hospitalists, then other Medicine specialties (including Primary Care), then Medicine fellows and residents, and finally non-Medicine specialties.
- *COVID-19 vaccination*
    - Many discussions around how to prioritize staff and workflows for a phased rollout (accounting for vaccine side effects and vaccine availability).
    - This is an area of active discussion within the collaborative and will likely be the topic of future updates.

Next Meeting will be January 15, 2021.

Key Takeaways

1. Successful strategies include a mix of adding non-hospitalist team members, redistributing patients, and virtualizing some hospitalist roles.
2. Combating burnout and maintaining morale remains a challenge and a priority.
3. A key new challenge is optimizing staffing flexibility while maintaining non–COVID-19 patient volumes.
4. Minimizing disruption to the clinical experience of trainees received higher attention during later surges.
5. COVID-19 vaccination coordination remains an active topic of discussion.

Links:
https://hospitalinnovate.org/projects/covid-19-response/
https://hbr.org/2020/12/how-to-lead-when-your-team-is-exhausted-and-you-are-too

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