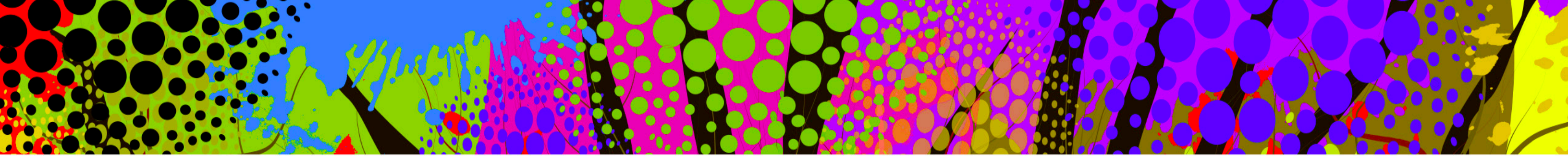
Regional Pediatric Specialty Care Capacity Report



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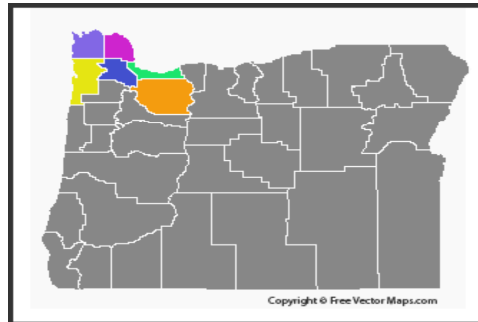
I. Report Introduction

The Pediatric Surge Leadership Group (PSLG) is a chartered Work Group of the NW Oregon Health Preparedness Organization (HPO), the regional Health Care Coalition (HCC) serving emergency planning for health/medical needs in NW Oregon's six counties. These counties are:

Multnomah - Portland Urban Area
Clackamas - Portland Urban Area
Washington - Portland Urban Area
Columbia - Portland Urban Area
Tillamook - Coastal County
Clatsop- Coastal County



For pediatric specialty care, hospitals in this region and across Oregon transfer children to three institutions for tertiary and quaternary care. These institutions are:

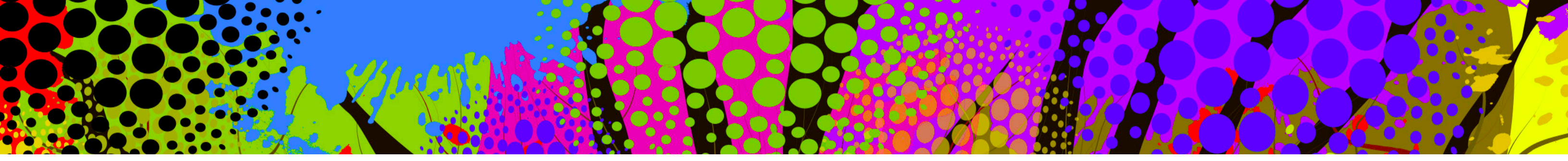
- Doernbecher Children's Hospital at OHSU (Trauma & Medical)
- Randall Children's Hospital at Legacy Emanuel (Trauma & Medical)
- Providence St. Vincent Medical Center (Medical)

In a disaster/emergency affecting children, ensuring correct alignment between patient acuity and specialty beds is critical. (E.g., ensuring the sickest/most critical children receive specialty care services). Hence, the purpose of this data report is to:

1) inform the three pediatric specialty care institutions about the volume of available pediatric specialty care beds and support services available between them;
2) provide insight for non-pediatric specialty hospitals on the finite assets available at this care level.

In the event the three pediatric specialty care institutions are overwhelmed and unable to receive patients, hospitals that normally transfer pediatric patients need to develop plans to care for pediatric patients until pediatric specialty care beds become available. Planning for a pediatric transfer hold time of 72-96 hours in a surge event is the recommendation of the PSLG.

The PSLG has created planning tools to assist hospital administrators, emergency managers, nursing managers, and medical officers to manage space, staffing, and supplies to care for a surge and/or extended care of patients.



I. Report Process & Methods

The PSLG's first step was to assess capacities in pediatric specialty care centers to help the three institutions understand the regional capacities and clinical "bandwidth."

Next, a review of assessment tools, toolkits, and planning guidance identified best practices in pediatric surge planning. The PSLG selected a survey instrument used by the Los Angeles EMS Agency, in partnership with Children's Hospital Los Angeles (CHLA) to do surge capacity assessments. We adapted it for the Portland Metro Area's pediatric specialty care centers.

This survey assessed 11 areas of hospital operations:

Emergency Department	Post Anesthesia Care Unit	Provider Pool
Inpatient Pediatric Acute Units	Respiratory Therapy	Outpatient Services
Neonatal ICU	Surgical Services	Pediatric Expansion Plan
Pediatric ICU		Telemedicine Services

Institutional leadership reviewed the survey; hospital managers collected the data in 2017. The three specialty institutions reported data in varied ways that made developing a composite picture for pediatric services challenging. Thus, the data tables are constructed to maintain the integrity of each institution's data submission on the survey.

Note: To give other hospitals a general window of the capacities at the pediatric hospitals, the data in this report are for planning purposes only. The numbers are average volumes over the course of a year and do not reflect seasonal variations in patient volumes. Also, Crisis Level Bed estimates are not included in this Report, as it is nearly impossible to accurately capture this data. The PSLG recommends hospitals approximate crisis care levels at about four times of routine capacities across the entire hospital.

III. Inpatient Units

A. Emergency Department (ED)

Children's Emergency Department Capacity

Facility	Number of Rooms	Number of Beds
Randall	22	26
Doernbecher	11	11
Providence St. V	13	13

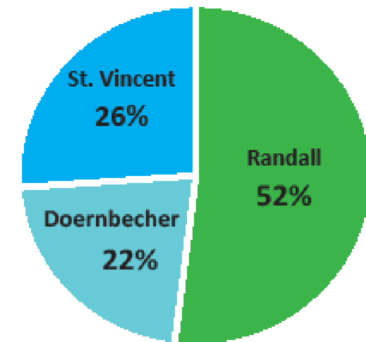
Adult Emergency Department Capacity

Facility	Number of Rooms	Number of Beds
Legacy Emanuel	29	29
OHSU	31	31
Providence St. V	45	45

Combined Emergency Department Capacity (Adult + Peds)

Facility	Number of Rooms	Number of Beds
Randall	22 + 29 = 51	26 + 29 = 55
Doernbecher	11 + 31 = 42	11 + 31 = 42
Providence St. V	13 + 45 = 58	13 + 45 = 58

Children's Emergency Department Beds
Total of 50 Beds Regionally



Nursing Staffing Levels for Children's ED

Facility	Nurses	Ratio Range
Randall	9-12 nurses for 26 beds	~2-3 patients per nurse
Doernbecher	2-6 nurses for 11 beds	~2-5 patients per nurse
Providence St. V	*	*

Provider Staffing Levels for Children's ED

Facility	Providers	Ratio Range
Randall	1-3 Providers for 26 beds *Attending & Resident Likely*	~3-15 patients per provider
Doernbecher	1-3 Providers for 11 beds *Attending & 1-2 Residents Likely*	~3-11 patients per provider
Providence St. V	1-2	*

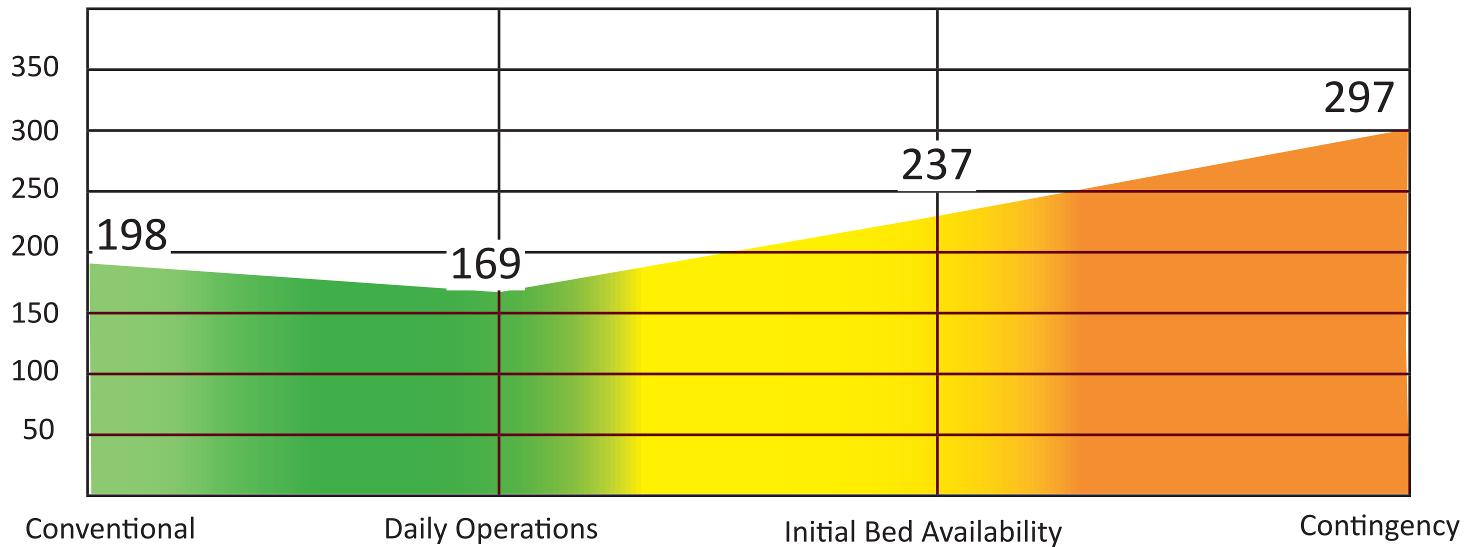
Average Daily Patient Volumes

Randall: 75
Doernbecher: 40
Providence St. V: *

III. Inpatient Units

B. Inpatient Pediatric Acute Units

Facility	Conventional Beds (# of Licensed Beds)	Daily Operations (Average Daily Staffed Beds)	Immediate Bed Availability (+ 20% of Conventional Beds in 4 hrs)	Contingency Beds (+50% of Conventional Beds)
Randall	96	91	19	48
Doernbecher	82	77	16	21
Providence St. V	20	19	4	4



Nursing Staffing Levels in Pediatric Acute Units

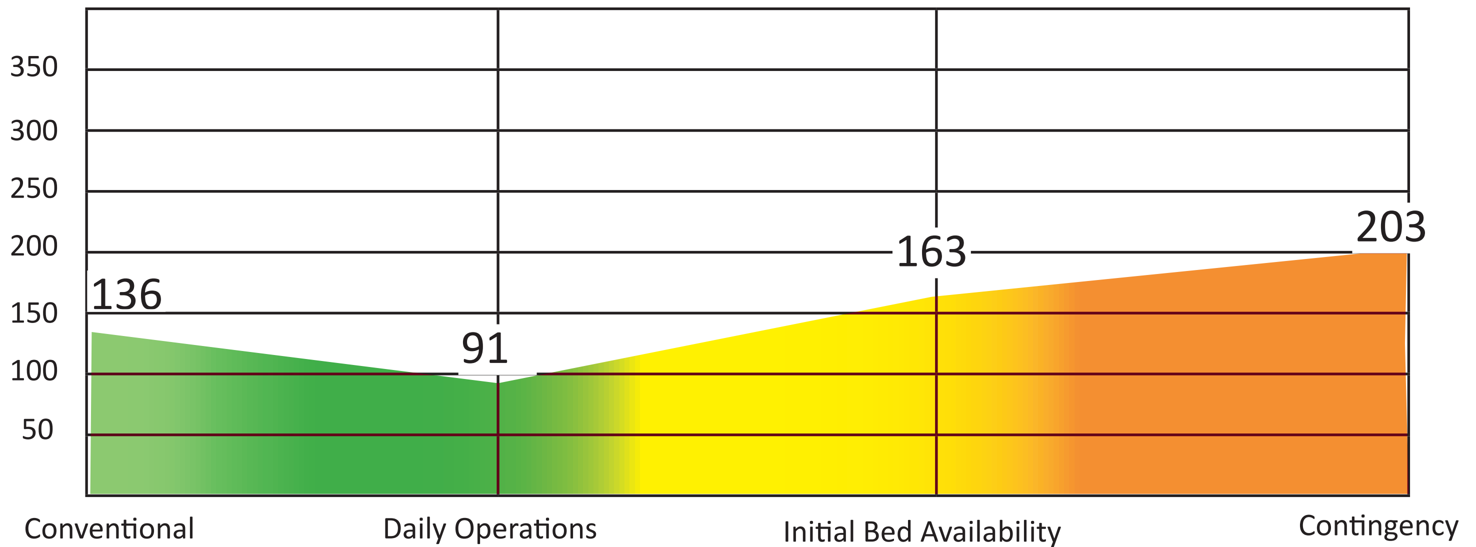
Facility	Number of Nurses	Ratio Range
Randall	24 nurses for 96 beds	~4 patients per nurse
Doernbecher	27 nurses for 61 beds	~2-3 patients per nurse
Providence St. V	4 nurses for 12 beds	~3-4 patients per nurse

Provider Staffing Levels in Pediatric Acute Units

Facility	Number of Providers	Ratio Range
Randall	6 on average for 96 beds	~16 patients per provider
Doernbecher	4 on average for 61 beds	~15 patients per provider
Providence St. V	1-2 on average for 12 beds	~ 6 to 12 patients per provider

C. Neonatal Intensive Care Unit (NICU)

Facility	Conventional Beds (# of Licensed Beds)	Daily Operations (Average Daily Staffed Beds)	Immediate Bed Availability (+ 20% of Conventional Beds in 4 hrs)	Contingency Beds (+50% of Conventional Beds)
Randall	45	34	9	22
Doernbecher	46	34	9	23
Providence St. V	45	23	9	22



Nursing Staffing Levels in NICU

Facility	Number of Nurses	Ratio Range
Randall	16 nurses for 34 beds	~2 patients per nurse
Doernbecher	22 nurses for 34 beds	~2 patients per nurse
Providence St. V	11 nurses for 21 beds	~2 patients per nurse

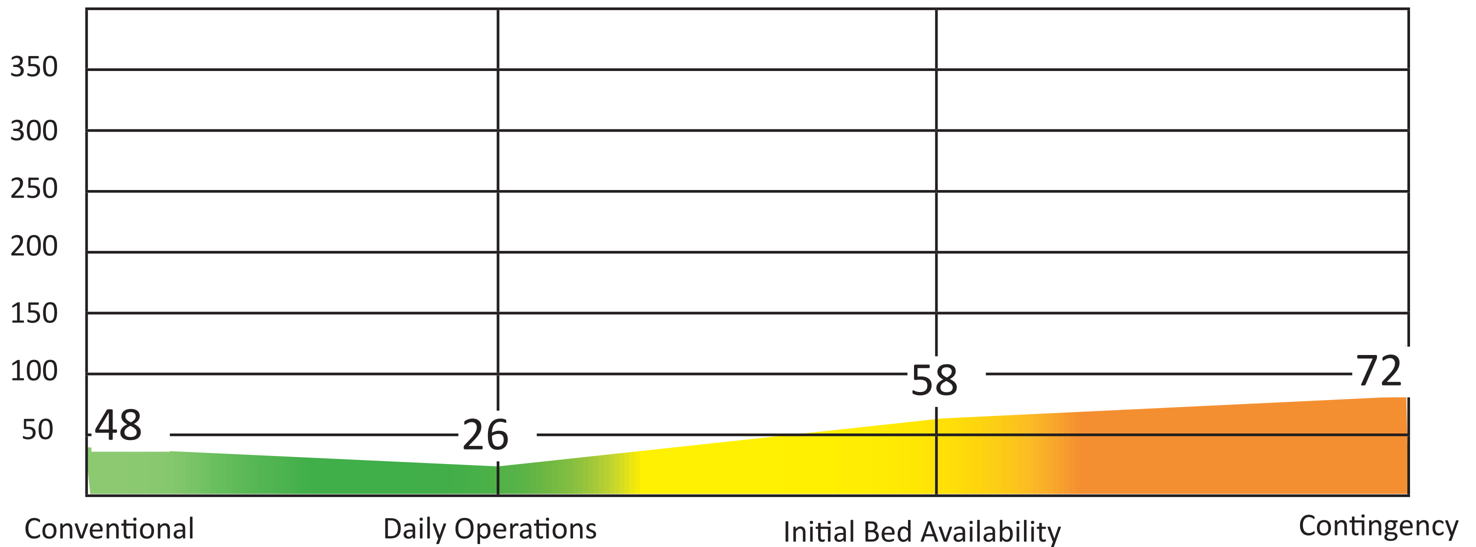
Provider Staffing Levels in NICU

Facility	Number of Providers	Ratio Range
Randall	3 on average for 34 beds	~11 patients per provider
Doernbecher	2-3 on average for 34 beds	~11 patients per provider
Providence St. V	2 on average for 21 beds	~11 patients per provider

III. Inpatient Units

D. Pediatric Intensive Care Unit (PICU)

Facility	Conventional Beds (# of Licensed Beds)	Daily Operations (Average Daily Staffed Beds)	Immediate Bed Availability (+ 20% of Conventional Beds in 4 hrs)	Contingency Beds (+50% of Conventional Beds)
Randall	24	10	5	12
Doernbecher	20	14	4	10
Providence St. V	4	2	1	2



Nursing Staffing Levels in PICU

Facility	Number of Nurses	Ratio Range
Randall	9 nurses for 10 beds	~1 patients per nurse
Doernbecher	6 nurses for 61 beds	~1-2 patients per nurse
Providence St. V	3 nurses for 4 beds	~1-2 patients per nurse

Provider Staffing Levels in PICU

Facility	Number of Providers	Ratio Range
Randall	1-3 on average for 10 beds	~3-10 patients per provider
Doernbecher	2-7 on average for 14 beds	~2-5 patients per provider
Providence St. V	1 on average for 2 beds	~ 4 patients per provider

IV. Hospital-Based Support Units

A. Post-Anethesia Care Unit (PACU)

Average Daily Volume - Pediatric PACU

Facility	# of beds	Average Daily Volume
Randall	8	18
Doernbecher	12	30
Providence St. V	8	7

Average Daily Volume - Adult PACU

Facility	# of beds	Average Daily Volume
Randall	15	35
Doernbecher	13	55
Providence St. V	*	*

Combined PACU Capacity (Adult & Pediatric)

Facility	# of beds
Randall	8+15 =23
Doernbecher	12+13=25
Providence St. V	*

Pediatric PACU Nursing Staffing Levels

Facility	# of nurses	Ratio Range
Randall	5 nurses for 8 beds	~ 1-2 patients per nurse
Doernbecher	13 nurses for 12 beds	~ 1 patients per nurse
Providence St. V	2 nurses for 8 beds	~ 2 patients per nurse

B. Respiratory Therapy (RT)

Facility	Daily RT pool	Daily RT pool for pediatrics
Randall	14-19	5-9
Doernbecher	14-18	5-8
Providence St. V	18	5-7

** data unavailable*

C. Surgical Services

Surgical Suites in Facility

Facility	# of OR Suites	# of Pediatric OR Suites
Randall	20	All can be used for peds
Doernbecher	36	8
Providence St. V	*	3

Surgical Services Staffing Information

Facility	Staffing per adult/pediatric surgery
Randall	1-2 RN Circulators 1 Scrub (Nurse or Tech) 1 Surgeon 1 Anesthesiologist
Doernbecher	1 RN 1 Surgical Scrub 1 Surgeon 1 Anesthesiologist
Providence St. V	1 RN Circulator 1 Scrub RN or Tech 1 Anesthesiologist 1 Surgeon

Nursing/Surgical Tech Staffing Levels (All patient types)

Facility	Daily Surgical Staffing Level
Randall	36 (Mix RN & Scrub Techs)
Doernbecher	23 (70% RN & 30% Scrub Techs)
Providence St. V	*

** data unavailable*

V. Provider Pool

Specialty Type	Randall			OHSU			St. Vincent		
MDs Only	Pediatric Specialist	Hospital Based	Contract Provider	Pediatric Specialist	Hospital Based	Contract Provider	Pediatric Specialist	Hospital Based	Contract Provider
Anesthesiology	YES	-	10	YES	19	-	YES	*	-
Cardiology	YES	-	5	YES	12	-	YES	*	-
Cardiothoracic	YES	2	-	YES	2	-	YES	*	*
Emergency Medicine	YES	-	9	YES	4	-	YES	*	-
Endocrinology	YES	5	-	YES	7	-	YES	1	x
ENT	YES	-	2	YES	5	-	YES	*	x
Gastroenterology	YES	-	5	YES	5	-	YES	x	*
General Surgery	YES	1	8	YES	9	-	YES	3	x
Genetics	YES	2	-	YES	3	-	NO	*	*
Hematology	YES	5	-	YES	3	-	NO	*	*
Intensivist	YES	-	7	YES	13	-	YES	4	*
Infectious Disease	YES	5	-	YES	6	1	YES	4	*
Neonatology	YES	-	18	YES	14	-	YES	*	x
Nephrology	YES	3	-	YES	4	-	YES	*	*
Neurology	YES	5	-	YES	8	-	YES	*	x
Neurosurgery	YES	3	-	YES	3	-	NO	*	*
Oncology	YES	5	-	YES	17	-	NO	*	*
Opthamology	YES	3	-	YES	4	-	YES	*	*
Orthopedics & Orthopedic Surgery	YES	3	-	YES	4	-	YES	*	*
Pediatrics	YES	7 gen + 18 hospi-talists	-	YES	26	-	YES	x	*
Psych/Behavioral	YES	-	1 +Unity Medical Staff	YES	8	-	YES	x	*
Pulmonolgy	YES	2	1	YES	5	-	NO	*	*
Radiology	YES	-	2	YES	3	-	YES	*	*
Rheumatology	YES	3	-	YES	x	-	NO	*	*
Urology	YES	-	3	YES	4	-	YES	*	x

*Key: * Data Unavailable x Present in facility, no number provided, - Zero*

V. Provider Pool

Specialty Type	Randall			OHSU			St. Vincent		
NPs, PAs, and Non-Medical Practicioners	Pediatric Specialist	Hospital Based	Contract Provider	Pediatric Specialist	Hospital Based	Contract Provider	Pediatric Specialist	Hospital Based	Contract Provider
Anesthesiology	NO	-	-	NO	-	-	*	*	*
Cardiology	NO	-	1	YES	4	-	*	*	*
Cardiothoracic	NO	1	-	YES	2	-	*	*	*
Emergency Medicine	NO	-	2	NO	-	-	*	*	*
Endocrinology	NO	-	-	YES	1	-	*	*	*
ENT	NO	-	-	YES	2	-	*	*	*
Gastroenterology	NO	-	-	YES	2	-	*	*	*
General Surgery	NO	1	1	YES	6	-	*	*	*
Genetics	NO	-	-	NO	-	-	*	*	*
Hematology	NO	-	-	NO	-	-	*	*	*
Intensivist	NO	1	-	YES	1	-	*	*	*
Infectious Disease	NO	-	-	YES	0	1	*	*	*
Neonatology	NO	10	-	YES	13	-	*	*	*
Nephrology	NO	-	-	YES	1	-	*	*	*
Neurology	NO	-	-	YES	2	-	*	*	*
Neurosurgery	NO	2	-	YES	2	-	*	*	*
Oncology	NO	2	-	YES	6	-	*	*	*
Opthamology	NO	-	-	YES	1 optome-trist	-	*	*	*
Orthopedics & Orthopedic Surgery	NO	3	-	NO	-	-	*	*	*
Pediatrics	YES	2	2	NO	-	-	*	*	*
Psych/Behavioral	NO	3 PhDs	-	YES	14 PhDs	-	*	*	*
Pulmonolgy	NO	-	-	NO	-	-	*	*	*
Radiology	NO	-	-	NO	-	-	*	*	*
Rheumatology	NO	-	-	NO	-	-	*	*	*
Urology	NO	-	-	NO	-	-	*	*	*

*Key: * Data Unavailable, - Zero*

V. Provider Pool

As an academic medical center, Doernbecher/OHSU, support a large pool of ‘trainees” that in a surge environment can function in a different way to support children’s care needs.

For example, in routine service a fellow will not provide direct care for a patient without the attending. However, in an emergency surge environment, fellows do hold their own medical license and could with some limitations, practice independently, thus increasing the pool of human resources available to treat patients.

OHSU also has 48 pediatric residents (16 in each year of the 3-year training program).

Note: OHSU residents/trainees do float over to Randall Children’s depending on the specialty.

Specialty	# of Trainees Available	Have these trainees completed a residency and in which field?
Pediatric Anesthesiology	3	Yes- Anesthesiology
Pediatric Cardiology	4	Yes- Pediatrics
Pediatric Emergency Medicine	3	Yes- 2 Pediatrics, 1 Emergency Medicine Shared fellowship between Doernbecher & Randall
Pediatric Endocrinology	4	Yes- Pediatrics
Pediatric Hematology/ Oncology	6	Yes- Pediatrics (1 med-pediatrics)
Pediatric Critical Care	2-3	Yes - Pediatrics
Neonatology	6	Yes- Pediatrics
Pediatric Neurology	4 (2 child neurology/ 2 neurodevelopment)	Yes- Pediatrics and Neurology or NDD
Pediatric Opthamology	1	Yes- Opthamology

Specialties w/o Trainees		**Surgical Trainees**	
Metabolism/Genetics	Pediatric Rheumatology	Pediatric Cardiothoracic Surgery	0
Pediatric ENT	Pediatric Urology	Pediatric Neurosurgery	1
Pediatric Gastroenterology		Pediatric Orthopedic Surgery	0
Pediatric Infectious Disease		Pediatric Plastic Surgery	0
Pediatric Nephrology		Pediatric Surgery	2
Pediatric Psych/Behavioral			
Pediatric Pulmonology			
Pediatric Radiology			

VI. Outpatient Services

Randall:

18 outpatient clinics on campus
65 providers staff this area

Doernbecher:

10 on site pediatric clinics; average daily volume is 500 visits
85 patient exam rooms
45 providers staff this area
30 medical assistants on an average day, 3 phlebotomists

St. Vincent:

Providence has an array of outpatient clinics and services for children in the Portland metro area and area and beyond, including express care and virtual care options.

VII. Pediatric Services Expansion Plans

Randall:

Expansion planned in:

Dermatoloty - 1 provider
Pediatric Plastics - 1 provider
Pediatric Geneticist - 1 provider
Muscular Dystrophy Program

Doernbecher:

Plans to expand outpatient care and NICU services due to increased population and aging facilities, in the next two years.

St. Vincent:

The Providence St. Vincent Children's ER is equipped and staffed to care for children of all ages, from newborns to teenagers, 24 hours a day. In the coming years, Providence Children's ER intends to continue to meet the needs of our patients in accordance with our mission and values.

VIII. Telemedicine Services

Legacy Health Services/Randall Telehealth:

- Randall providers in the PICU and NICU provide consultation and resuscitation services to hospitals.
- Uses intouch RP-Lites (mobile video cards) located in various parts of the facility.
- Credential providers internally via a traditional process, but have the option to credential by proxy with external partners.
- In a surge event, external hospitals that have an RP-Lite or InTouch device can connect with Randall providers remotely to provide consulation/guidance.
- External Agreements with
  - St. Charles Medical Center - Bend, OR
  - Good Shephard Medical Center - Hermiston, OR
  - Adventist Medical Center - Portland, OR

VIII. Telemedicine Services

See table below for information on the Legacy network.

	Tele-Stroke Consultation	Tele-Baby Recusitation	Tele-Neonatal	Psychatric Consult	Neurology	Pediatric Critical Care	Cardiology Consults
Legacy Emanuel	X						
Legacy Good Samaritan	X	X	X	X			
Legacy Meridian Park	X	X	X				
Legacy Mt. Hood	X	X	X				
Legacy Salmon Creek	X				X		
Legacy Silverton	X	X	X		X	X	
Good Shepard Medical Center	X	X	X			X	X
McKenzie Willamette Medical Center	X						
Unity Center for Behavioaral Health				X			
St. Charles Medical Center						X	

OHSU/Doernbecher Telehealth Network:

- OHSU offers both acute care consults and outpatient specialty appointments via a growing program with an ever-increasing "footprint."
- Acute Care
  - PICU & NICU
  - Newborn Resuscitation
  - Newborn Genetics
  - Technology: InTouch robots and OHSU providers using control stations
- Ambulatory Care
  - Endocrinology for Diabetes
  - Surgical Follow up visits
  - GI
  - Cardiology for lipids
  - Psychology
  - OPAL-K
  - Technology: Cisco meeting on internal OHSU network. Endpoints have medical peripherals (example: electronic stethescope)

OHSU providers are fully credentialed at the recieving facility to deliver telemedicines services.

- In a surge event, providers can use the existing network. Access to other INTOUCH carts in the state would greatly increase access, as those systems do not offer the same level of pediatric coverage.

OHSU/Doernbecher Telehealth Network:

OHSU Inpatient Telemedicine (as of 1/24/2017)					
Affiliate	PICU	NICU	Newborn Medical Genetics	Stroke	Equipment/Other Notes
Adventist Medical Center Portland, OR	Live			Live	InTouch
Asante Rogue Regional Medical Center Medford, OR	Live		Live	Live	2 InTouch Units: ED & Peds/ICU
Asante Three Rivers Medical Center Grants Pass, OR				Live	InTouch
Bay Area Hospital Coos Bay, OR	Live			Live	InTouch
Columbia Memorial Hospital Astoria, OR	Live	Live		Live	InTouch
Grand Ronde Hospital La Grande, OR	Live				3 InTouch Units: ED, ICU, and Ambulatory Clinic
Mercy Medical Center Roseburg, OR	Live			Live	InTouch
Mid-Columbia Medical Center The Dalles, OR	Live	Live		Live	InTouch
PeaceHealth Sacred Heart Eugene, OR	Live		Live		InTouch-> Riverbend Jabber -> University District
PeaceHealth St. John Medical Center Longview, WA		Live			InTouch
Salem Hospital Salem, OR	Live			Live	InTouch
Santiam Hospital Santiam, OR	Live	Live		Live	InTouch
St. Charles Medical Center Bend, OR	Live				InTouch
Tuality Community Hospital Hillsboro, OR	Live	Live		Live	2 InTouch Units: ED & Birth Center
Willamette Vallley Medical Center McMinville, OR	Live	Live		Live	InTouch
In Touch Technical Support: 1-877-484-9119					

VIII. Telemedicine Services

Providence Telehealth Network:

- Telemedicine is used to support the care of children in Oregon's Providence hospitals.
- Acute care instensive care
- Technology - robots and laptop computers
- Credentialing happens at Providence Oregon Medical Staff office for privleges at each hospital
- Would be able to support other Providence hospitals with pediatric expertise in a surge event

IX. Strengths, Challenges, & Planning Opportunities

Strengths (derived from data submissions):

- **Capacity and turnover volumes of EDs**
  - *Randall turns over their ED beds on average three times per day.*
  - *Doernbecher turns over their ED beds on average four times per day.*
- **Capacity and turnover volumes of PACUs**
  - *Randall turns over their Pediatric PACU bed capacity on average two times per day.*
  - *Doernbecher turns over Pediatric PACU bed capacity on average two and half times per day.*
  - *St. Vincent's turns over their Pediatric PACU bed capacity on average once per day.*
- **Flexing adult resources for pediatric use: (see challenges)**
  - *These institutions are able to move resources to best manage the emerging situation across multiple areas of the hospital.*

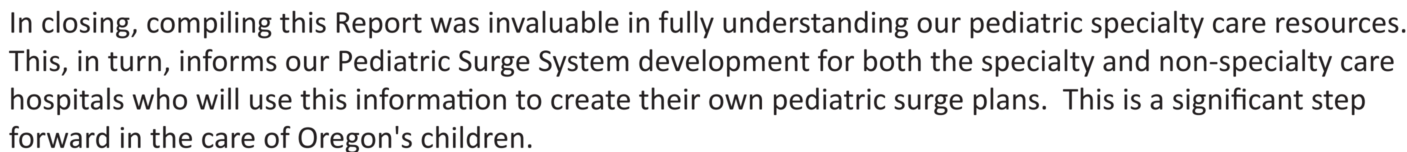
- **Flu/RSV season allows for a smaller surge scenario annually that can apply pressure to the pediatric inpatient system**
- **PACU and Pre-operative beds are interchangeable and can flex to meet response needs.**
- **Staff and providers are eager to support children in a disaster and have an inherent "duty to respond" that will servie their institutions well in an emergency.**

Challenges (derived from data submissions):

- **Flexing adult resources for pediatric use:**
  - *Larger and longer duration incidents impact the amount of flexibility in services*
- **The presence of behavioral health patients in the emergency department and in the inpatient setting can make rapid surge efforts challenging.**
- **Specialty providers and surgeon sharing across institution:**
  - *Capacities for performing pediatric surgery are limited by the number of pediatric surgeons available in any certain specialty. One pediatric surgeon covers both Doernbecher & Randall at night and on weekends, with an additional pediatric surgeon on back-up call.*
- **Balancing adult emergent surgical needs with pediatric surge needs:**
  - *The capacity for pediatric surgical procedures is limited by the number of concurrent adult emergent surgical procedures needing to be performed.*
- **Expansion of inpatient beds outside of hospital footprint:**
  - *Extensive work is required to obtain waivers to expand bed levels outside of the traditional hospital building.*

Planning Opportunities:
A compilation of strategies, potential resources, and best practices

- Understand the role of urgent care centers and their ability to care for pediatrics to support surge response in an infectious disease event.
- Build a robust network of pediatric specialty facilities/Children's hospitals to transfer patients to outside of Oregon.
- Develop an understanding of how non-pediatric hospitals can provide care to decompress pediatric specialty care patient load.
- Support a flexible plan for use of outpatient space and staff across institutions for most flexible operations across different potential hazards.
- Understand how changing patient care ratios and use of crisis standards of care can expand care capacities at the unit and support service area level.
- Understand how routine collaborative processes for bed management and transfers between the three institutions should be strengthened with an eye toward disaster/ emergency operations.
- Understand how Providence's Center for Medically Fragile Children could expand bed options.
- Develop partnerships for rapid discharge of behavioral health patients to assist surge operations.
- Develop a concept of operations for the use of telehealth services across the state and across health systems to support patient management/wait periods at acute care hospitals (up to 72-96 hours).
- Expand flexibility of Respiratory Therapy pool by increasing adult and pediatric credentialed Respiratory Therapists and allow for more floating to pediatric settings to reinforce skills.
- Resources at already at capacity for Labor and Delivery/Mother Baby affecting opportunities to surge. Focus for this population should be on evacuation of mother/ baby couplets.
- Understand the interplay between adult and pediatric services when shaping a disaster system of care. Plan for unintended consequences of redistributing healthcare resources during an emergency.



In closing, compiling this Report was invaluable in fully understanding our pediatric specialty care resources. This, in turn, informs our Pediatric Surge System development for both the specialty and non-specialty care hospitals who will use this information to create their own pediatric surge plans. This is a significant step forward in the care of Oregon's children.

X. Acknowledgements

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