Challenges arising in the transition to carrying for adults in free-standing pediatric hospitals with possible solutions

**Topics:**
**Rounding/Clinical**
1. What to do for complex cases?
2. Curriculum planning

**Operational:**
1. Questions regarding ACGME credentialing for Residents
2. Questions regarding credentialing for Attendings
3. Criteria for to accept adult patients
4. Patient Flow into the Hospital

**Multi-disciplinary coordination:**
1. Drug procurement for adult-specific medications/dosing

**Potential solutions outlined:**
**Rounding/Clinical**
1. **What to do for complex cases which may require additional medical services?**
   a. Solutions tried in various institutions:
      - Created adult consult services, however if short on staff this may not be possible
      - Have one medicine attending credentialed (or med-peds who is already credentialed) and have them run the list with multiple pediatric led teams (essentially having the medicine MD function as the attending and pediatric MDs function as senior residents)
      - We are working on virtual curbside options with adult providers, updates to come
   b. For procedure heavy or acute medicine challenges i.e. MI or CVA check with your ICU faculty. many institutions have found that their ICU staff are comfortable in handling these acute situations. If they are not, this is something which you should discuss with the nearest adult institution to discuss facilitating transfers

2. **Curriculum planning:** The education team has put together one-pagers for major diseases and high yield basic rounding tips. [https://www.popcornetwork.org/main-menu](https://www.popcornetwork.org/main-menu)

**Operational:**
1. **ACGME credentialing for Residents**
   a. In a declared pandemic (defined as a level III pandemic under the ACGME guidelines), the ACGME allows residents to practice beyond their scope of practice. However, each institution should ensure that this is what their local ACGME/hospital administration is abiding by.

2. **Questions regarding credentialing for Attendings**
a. This remains unclear, however appears to be institution dependent. However hospitals in surge areas have been able get expedited credentialing (NY, Seattle)

3. **Criteria for to accept adult patients**
   a. **Age**: Many institutions already have age cut-offs for adults they accept to services with congenital disease (ie. Cardiology, oncology). Start by instituting those age cutoffs across all services. As needs change, slowly increase the age as necessary. Several institutions with Covid-surge levels have increased their age limits to 40-45.
   
b. **Disease process**:
      i. **Covid Vs. Non-covid patients**: Many free-standing pediatric hospitals have started the transition to adult patient by only accepting non-covid patients, however given the surge in certain cities, they have had to transition to accepting covid patients as well. Therefore planning for Covid adult patients should start early. Planning should include:
         - Procurement of additional PPE
         - “Clean” vs “Dirty” floors. The flow of patients with confirmed or suspected Covid should be separate from those without.
         - Adult size intubation materials and vents. Collaboration with respiratory teams, pharmacy, nursing and ICU staff in the event of a code or respiratory event (this should also include ethics considerations in line with hospital policies of when to resuscitate).
   
c. **Felony convictions**: Important to devise a system which considers the legal status and the ability for hospitals to manage potential sex offenders or patients with potential for violence. Some institutions have used this as exclusion criteria for acceptance.

4. **Patient Flow into the Hospital**: ER vs direct admission from other institutions vs a dedicated “partner hospital”
   
   - The ER option has been utilized by institutions who feel they have the space and proper equipment to manage adults. Several institutions have expressed discomfort with adults coming into their ER for initial treatment as the ER rooms are not properly equipped or set up for adult care.
     i. Again, it should be noted that while some institutions dealing with surge initially did not accept patients through the ER, depending on the needs of your community, this may become a necessity. Therefore, planning for this and procurement of adult medications and equipment should be considered early on
   
   - In the case of both accepting adults through direct admission as well as from a “partner hospital” who may only see adults, some institutions have found a benefit in dedicating one physician at the pediatrics hospital to accept patients, making that the role of that individual for the entire shift. This helps to minimize surprises as well as the flow of patients during the transition.

**Multi-disciplinary coordination:**
1. **Drug procurement for adult-specific medications/dosing:** Many pharmacies in freestanding pediatric hospitals have formed relationships/agreements with local adult hospitals to share medications. Check with your institution.

2. **Engagement of other groups:**
   a. Nursing, CNAs, Nurse Practitioners, Chief Residents, Respiratory Therapists.