Case Example: Decisions Related to Phased Reopening of Ambulatory Pediatric OT Services

Background

A rehabilitation department in a large health system was following their state's recommendation for phased reopening of pediatric ambulatory services. The health system's rehabilitation department included acute, sub-acute, and outpatient adult rehabilitation services; wheelchair, splint, and feeding clinics; as well as aquatic and group therapy programs. Patients in the acute and sub-acute settings continued to receive services during the COVID-19 disruption, and therefore the aim was to create a plan for outpatient and clinic services, and other programs. The rehabilitation management team used AOTA's Decision Guide for Phased Reopening when creating a plan for these areas.

The rehabilitation management team knew that many practitioners had ethical concerns related to PPE, and used AOTA's Ethical Response to the COVID-19 Pandemic: An AOTA Ethics Advisory Opinion, and the CDC's guide to optimizing PPE to respond to those concerns. They also checked their state's website for specific reopening guidance and procedures. The team also watched some of AOTA's COVID-19 webinars and learned about risk/benefit assessment of reopening. As a starting point, the team modified the risk assessment found in John's Hopkins Public Health Principles for a Phased Reopening During COVID-19 to fit occupational therapy practice. They also referenced CMS' Recommendations to Re-Open Health Care Systems in Areas with Low incidence of COVID-19.

Risk Assessment

After considering ethical concerns and exploring related resources, the team conducted a risk assessment of each service area. The team hoped the assessment would inform their decisions associated with areas to open first.

Table 1. Occupational Therapy Service Area Risk Assessment

Occupational Therapy Service Areas	Contact Intensity	Number of Contacts	Modification Potential	Mitigation Resources / Hierarchy of Controls
Outpatient	Low/Medium/High	Low	Medium/High	Elimination of Hazard and Substitution Engineering Controls Administrative Controls PPE
Splint Clinic	High	Medium	Medium	Administrative Controls PPE
Wheelchair Clinic	High	Medium	Medium	Administrative Controls PPE
Feeding Clinic	High	High	Medium	Administrative Controls PPE
Aquatic Therapy Program	High	Low	Low	Administrative Controls
Group Therapy Programs	High	High	Low	Administrative Controls PPE

When completing the **outpatient service area risk assessment** the management team decided that the contact intensity and modification potential would vary according to diagnosis and intervention strategy. Therefore, the team completed an additional risk assessment based on those factors (**Table 2**). Through using this process the team

Note: CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; OSHA = Occupational Safety and Health Administration; PPE = personal protective equipment (e.g., gloves, gowns, face shields)

was able to determine that with proper administrative controls, such as increasing hours of operation and staggering appointment times to allow for transitions, they could reduce staff and client contacts in the outpatient pediatric setting.

After completing the **splint and wheelchair clinic risk assessments,** these areas seemed less variable to the team. They decided that the contact intensity was likely high in all of these service areas. They also determined that because practitioners, vendors, and rehabilitation aides were present during splint fabrication and wheelchair modifications the number of contacts remained medium despite administrative controls. The modification potential was medium because they could put administrative controls and PPE in place, but they could not implement the principles of elimination of hazard and substitution or engineering controls.

According to the **feeding clinic risk assessment,** the contact intensity was high secondary to the need to provide intra and extra oral intervention strategies for most cases. The number of contacts was also high because practitioners, caregivers, behavioral therapists, nutritionists, and physicians were often involved in the sessions. The modification potential was deemed medium and the team also noted their inability to modify interventions that could result in coughing or spitting, generating aerosol droplets. The team had concerns surrounding the need for additional PPE for these sessions.The team was also concerned regarding handling food and its availability.

The **group therapy program risk assessment** demonstrated that the contact intensity was high because the children in groups often interacted with each other, not only verbally but by touch. The team also knew it would be very difficult to ensure children remained 6 feet apart during group therapy. The number of contacts was also high due to the number of practitioners, children, and rehabilitation aides present during the group sessions. The team deemed the modification level as low because it would be impossible to make the administrative adjustments to scheduling needed to limit interactions before and after the sessions.

The risk assessment for the **aquatic program** also generated straightforward results. The team determined that the contact intensity was high because a hands-on approach was always used in the pool. The team also noted that the number of contacts was low because treatment in the pool area only required the practitioner, caregiver, and client. However, the mitigation potential was low (and concerning) due to not being able to use PPE in the water.

Based on the risk assessment it was clear to the management team that it was best to open the outpatient areas first. The team completed an additional risk assessment–related diagnosis, and collaborated with practitioners to make judgements associated with the plan of care, level of physical assistance, and current success with telehealth service delivery.

Table 2. Risk Assessment Example of Pediatric Outpatient Caseload

Diagnosis/Level of Assistance	Treatment Aim	Contact Intensity	Number of Contacts	Modification Potential	Mitigation Resources	Telehealth Availability/Effectiveness
Acute Traumatic Brain Injury/ Minimal Assistance	Improve Functional Transfers	Medium	Low	Medium	Administrative Controls PPE	Yes Low
Cerebral Palsy/ Contact Guard Assistance	Improve ADLs and Functional Transfers	Medium	Low	Medium	Administrative Controls PPE	Yes Medium
Developmental Coordination Disorder/Close Supervision	Improve ADLs and social participation	Low	Low	High	Engineering Controls Administrative Controls PPE	No due to payer NA

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Reopening Plan

The team decided to open outpatient services first, slowly phasing in sessions, capturing approximately 10% of the outpatient caseload in the first 2 weeks of reopening. These clients were those who the team determined a) needed to address goals, such as functional transfers that could not be addressed remotely, and required a low level of contact intensity; and b) were not eligible for telehealth and whose services had low contact intensity and a medium to high modification level. The team decided they would increase the percentage of in-person sessions if no concerns were identified during the first phase of reopening, and if state officials continued to recommend reopening. At that time, the patients who would be contacted were those who required in-person sessions to address their goals and had medium contact intensity and modification potential.

The team also reviewed the considerations in AOTA's Decision Guide for Phased Reopening Occupational Therapy Services, and created the following list of guiding principles for moving forward:

- Eliminating the hazard by continuing telehealth services that were deemed effective
- Developing a web-based reporting form for staff and caregivers to report a COVID-19 exposure
- Developing pre-registration and online payment procedures
- Eliminating waiting rooms by increasing hours of operation and staggering treatment sessions
- Providing clients with clear and concise reopening guidance via web, social media, and other communication platforms
- Developing a COVID-19 partnership pledge indicating concepts such as only one caregiver could attend sessions; face coverings were mandatory for staff, clients, and visitors; and requiring hand hygiene before, during, and after all sessions
- Encouraging staff to work from home for unfinished documentation and scheduling
- Creating physical barriers between the staff and clients when possible, such as adding freestanding, mobile Plexiglas in each area to be used during interventions that did not require direct hands-on assistance by the practitioner
- Scheduling the same number of patients as rooms to eliminate treating multiple clients in the same room during the initial reopening
- Relocating interventions that could safely be done outside, weather permitting
- Redistributing clinical responsibilities to include practitioners conducting pre-screening phone calls, taking part in extra cleaning and disinfecting rotations, and taking daily temperature of staff and clients
- Eliminating the use of equipment that could not be disinfected between clients, such as ball pits and cloth swings
- Facilitating improved hand hygiene practices of staff through education and placement of hand sanitizer

The team also revisited AOTA's Telehealth Decision Guide and found that new guidelines afforded more clients the ability to receive telehealth services. The team decided that those patients who could benefit from telehealth services would continue to receive them during the pandemic. The team also decided that specialty interventions, such as aquatic therapy, with high contact intensity and low modification potential, would not be reintroduced during the pandemic, and other therapeutic options would be evaluated.

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