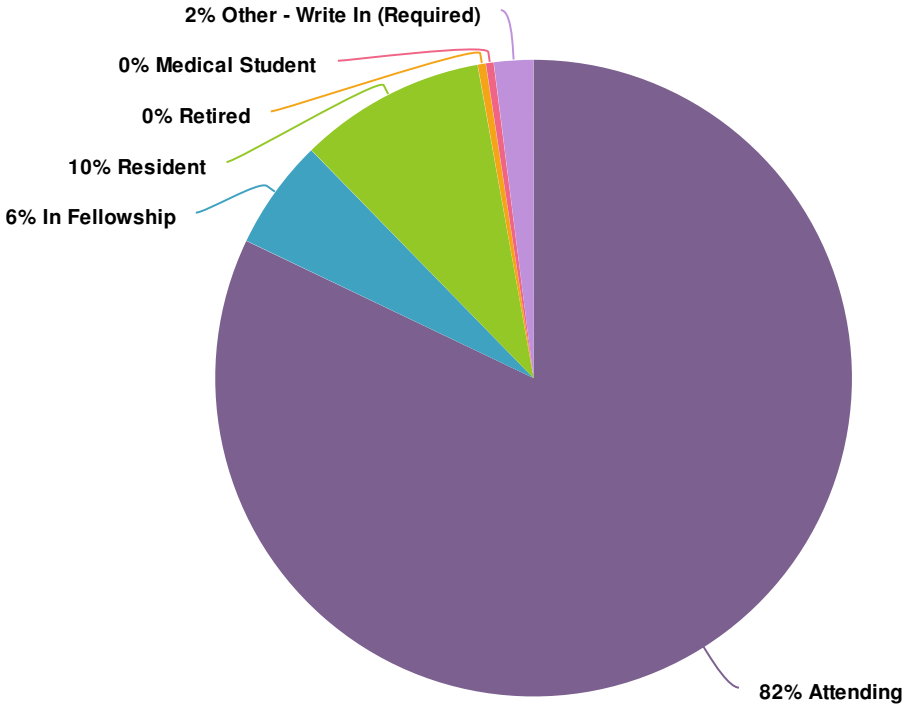
Report for 2020 - COVID-19 Impact on Physiatrists

Response Counts

Completion Rate:	**88.3%**		
	Complete		226
	Partial		30

Totals: 256

1. Which of the following best describes your professional status?

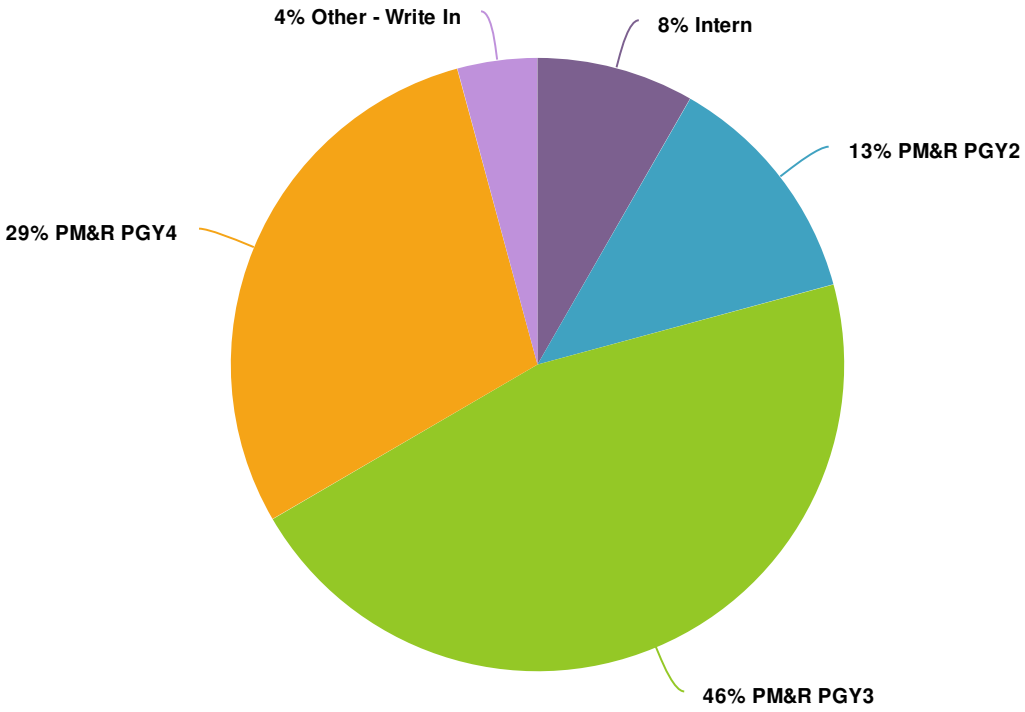


Value	Percent	Responses
Attending	82.1%	207
In Fellowship	5.6%	14
Resident	9.5%	24
Retired	0.4%	1
Medical Student	0.4%	1
Other - Write In (Required)	2.0%	5

Totals: 252

Other - Write In (Required)	Count
International medical graduate	1
Locums	1
Private Outpatient Practice	1
Private practice	1
free standing rehab medical director	1
Totals	5

2. Which best describes your current level of education?



Value	Percent	Responses
Intern	8.3%	2
PM&R PGY2	12.5%	3
PM&R PGY3	45.8%	11
PM&R PGY4	29.2%	7
Other - Write In	4.2%	1

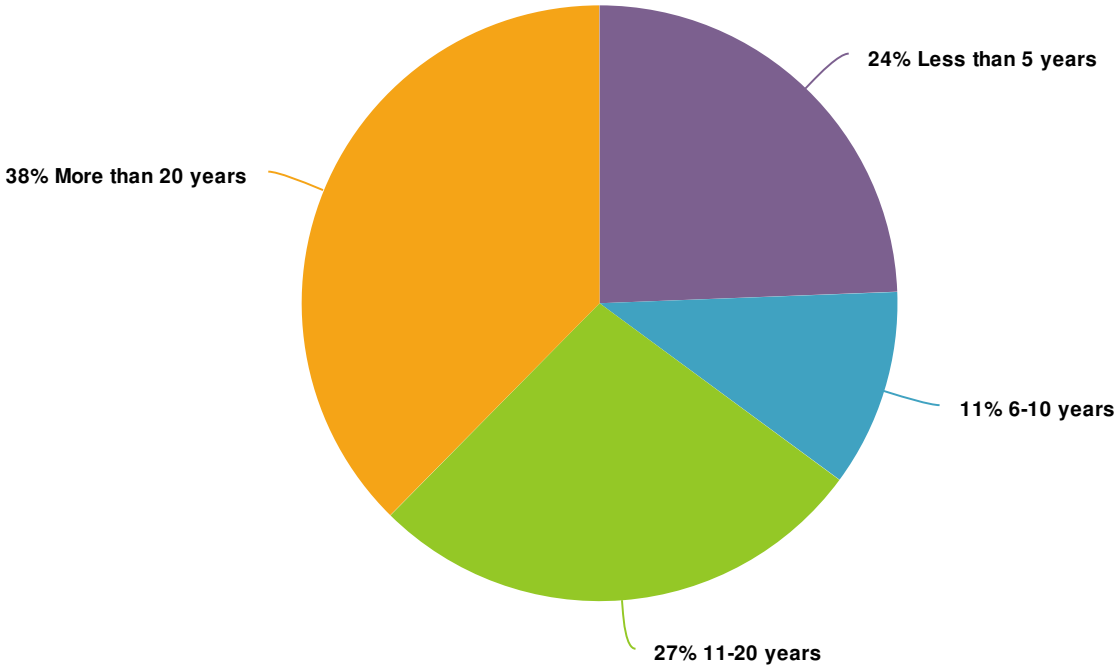
Totals: 24

Other - Write In	Count
PMR PGY5	1
Totals	1

3. What sub specialty are you pursuing in your fellowship?

ResponseID	Response
80	Spine and sports
85	Sports Medicine
87	sports medicine
90	Sports Medicine
118	Sports
161	Interventional Spine
169	Cancer Rehabitation
177	Sports Medicine
210	Pediatric Rehabilitation
215	Sports Medicine
231	Pediatric Rehabilitation Medicine
253	Interventional spine, EMG, sports
255	Pediatric

4. How many years have you been in practice?

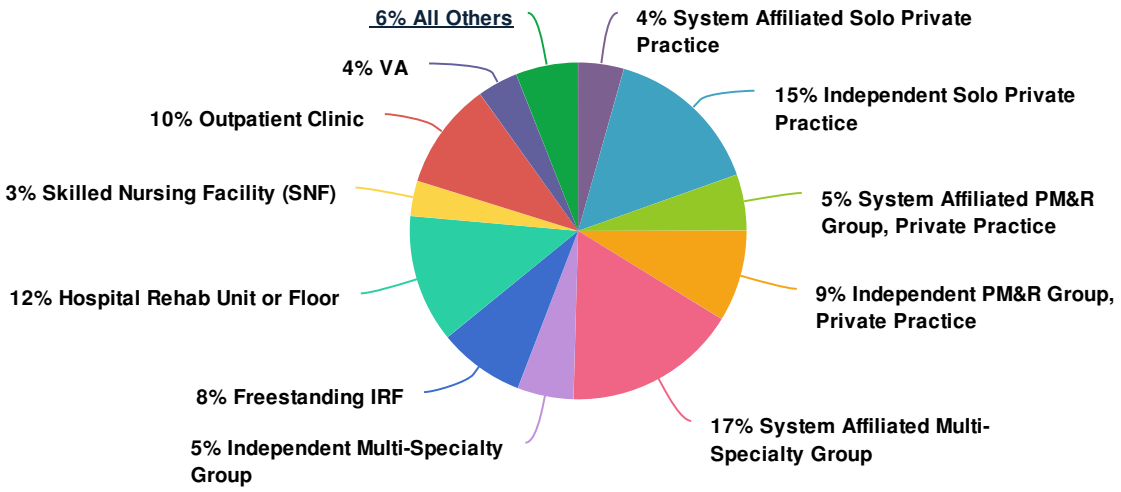


Value	Percent	Responses
Less than 5 years	24.4%	50
6-10 years	10.7%	22
11-20 years	27.3%	56
More than 20 years	37.6%	77

Totals: 205

Other - Write In	Count
Totals	0

5. Which of the following best describes the setting in which you spend the majority of your clinical practice?

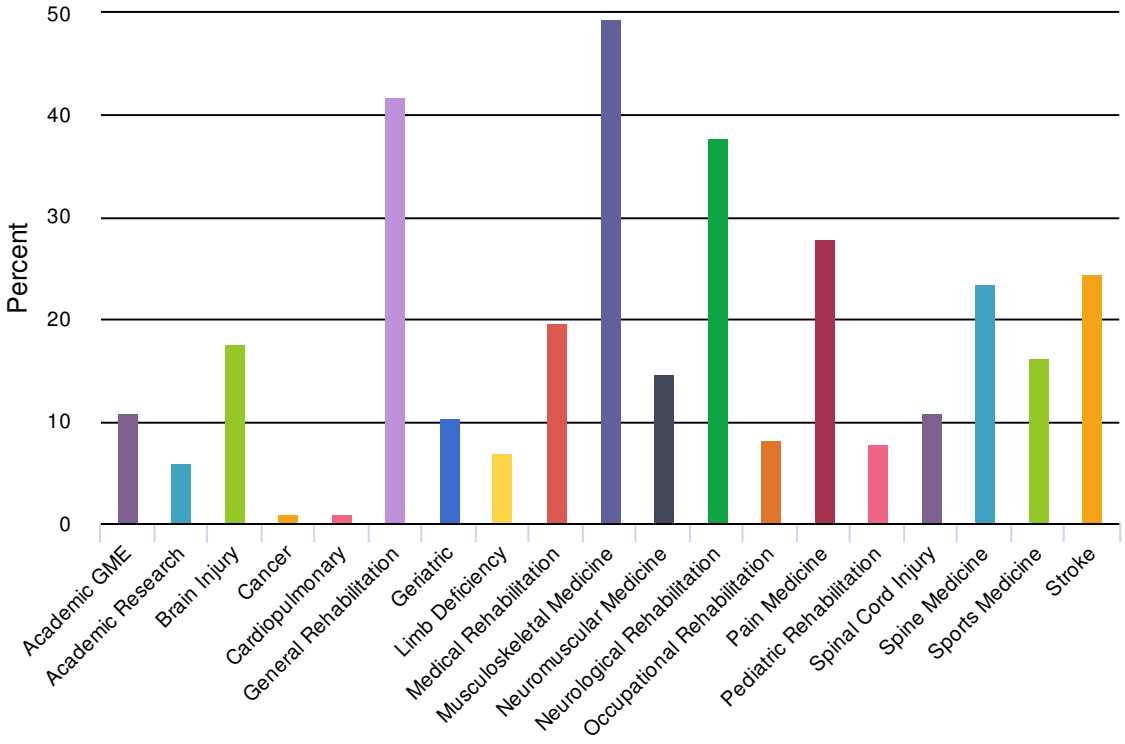


Value	Percent	Responses
System Affiliated Solo Private Practice	4.4%	9
Independent Solo Private Practice	15.2%	31
System Affiliated PM&R Group, Private Practice	5.4%	11
Independent PM&R Group, Private Practice	8.8%	18
System Affiliated Multi-Specialty Group	16.7%	34
Independent Multi-Specialty Group	5.4%	11
Freestanding IRF	8.3%	17
Hospital Rehab Unit or Floor	12.3%	25
Skilled Nursing Facility (SNF)	3.4%	7
Long-term Acute Care (LTach)	1.0%	2
Sub-Acute Care Facility	1.0%	2
Outpatient Clinic	10.3%	21
Home Health	0.5%	1
Non-Clinical	1.0%	2
VA	3.9%	8
Other - Write In	2.5%	5

Totals: 204

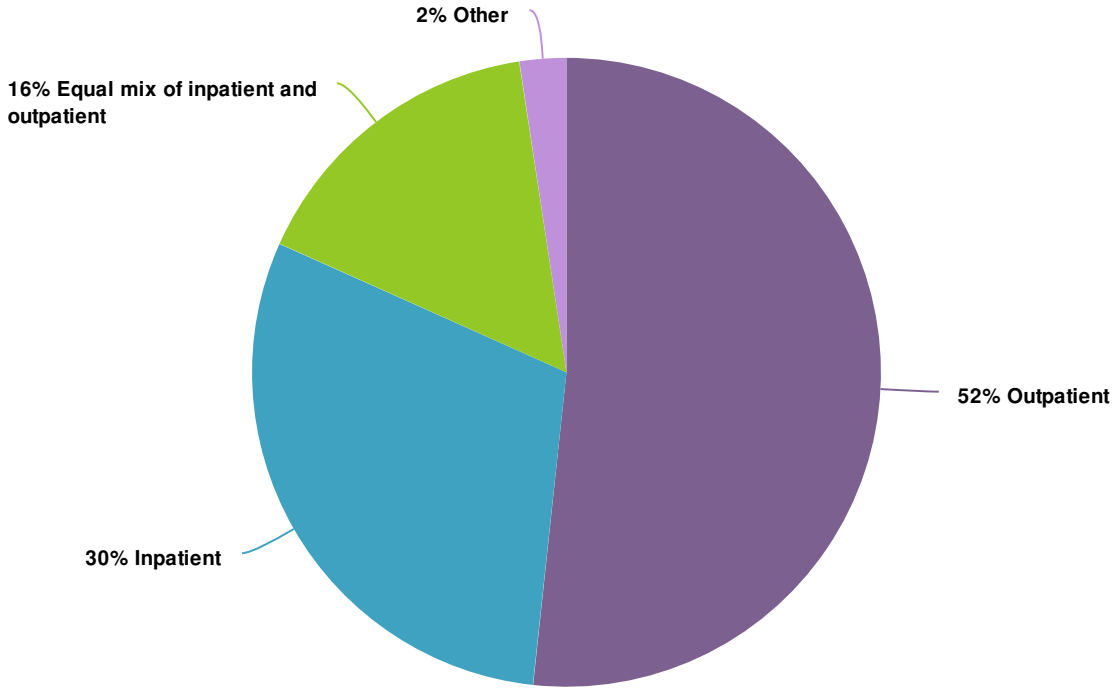
Other - Write In	Count
Academic Children's Hospital	1
Academic pmr practice and irf	1
HMO	1
Independent ortho group	1
Locum tenens	1
Totals	5

6. Which of the following clinical area(s) do you consider to be your primary focus? (select up to 5)



Value	Percent	Responses
Academic GME	10.8%	22
Academic Research	5.9%	12
Brain Injury	17.6%	36
Cancer	1.0%	2
Cardiopulmonary	1.0%	2
General Rehabilitation	41.7%	85
Geriatric	10.3%	21
Limb Deficiency	6.9%	14
Medical Rehabilitation	19.6%	40
Musculoskeletal Medicine	49.5%	101
Neuromuscular Medicine	14.7%	30
Neurological Rehabilitation	37.7%	77
Occupational Rehabilitation	8.3%	17
Pain Medicine	27.9%	57
Pediatric Rehabilitation	7.8%	16
Spinal Cord Injury	10.8%	22
Spine Medicine	23.5%	48
Sports Medicine	16.2%	33
Stroke	24.5%	50

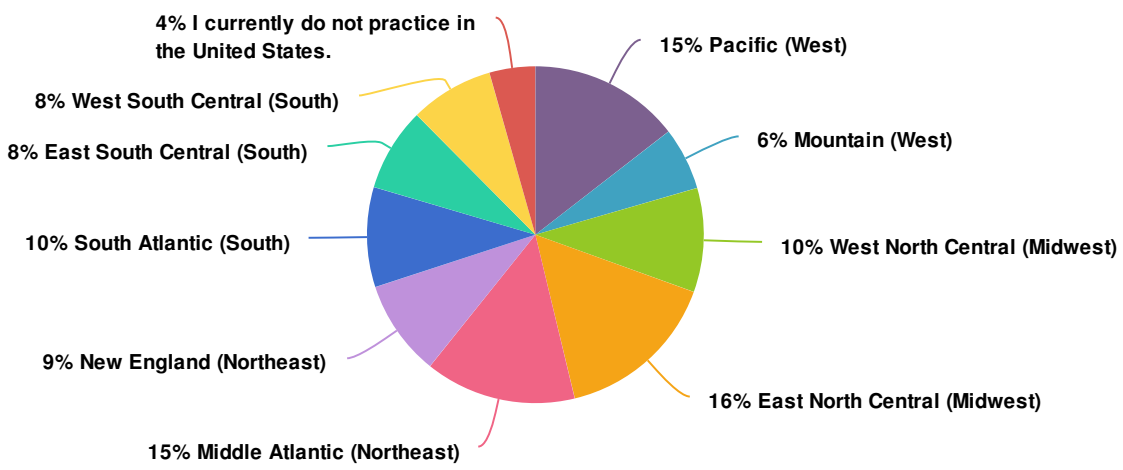
7. What is your primary clinical work?



Value	Percent	Responses
Outpatient	51.7%	107
Inpatient	30.0%	62
Equal mix of inpatient and outpatient	15.9%	33
Other	2.4%	5

Totals: 207

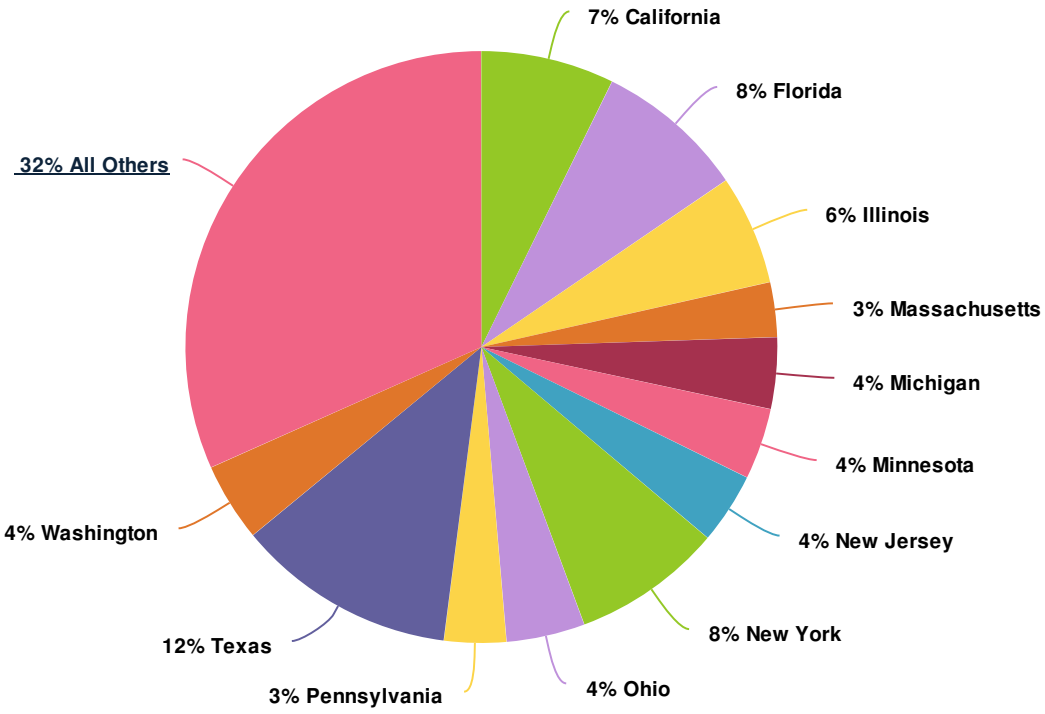
8. In what region of the United States do you practice?



Value	Percent	Responses
Pacific (West)	14.5%	36
Mountain (West)	6.0%	15
West North Central (Midwest)	10.0%	25
East North Central (Midwest)	15.7%	39
Middle Atlantic (Northeast)	14.5%	36
New England (Northeast)	9.2%	23
South Atlantic (South)	9.6%	24
East South Central (South)	8.0%	20
West South Central (South)	8.0%	20
I currently do not practice in the United States.	4.4%	11

Totals: 249

9. In what state or territory are you currently practicing or training?



Value	Percent	Responses
California	7.3%	17
Florida	8.2%	19
Illinois	6.0%	14
Massachusetts	3.0%	7
Michigan	3.9%	9
Minnesota	3.9%	9
New Jersey	3.9%	9
New York	8.2%	19
Ohio	4.3%	10
Pennsylvania	3.4%	8
Texas	12.0%	28
Washington	4.3%	10

Totals: 233

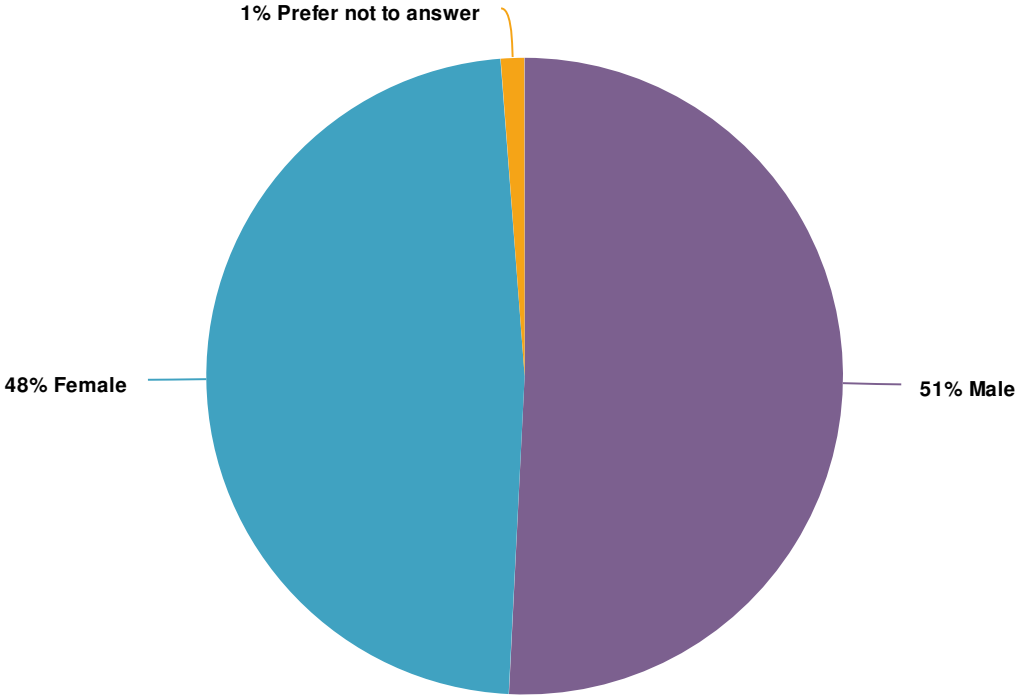
Value	Percent	Responses
Alabama	0.4%	1
Arizona	1.7%	4
Arkansas	0.9%	2
Colorado	2.6%	6
Connecticut	2.6%	6
Georgia	0.4%	1
Hawaii	0.9%	2
Indiana	1.3%	3
Iowa	1.7%	4
Kansas	0.9%	2
Maryland	1.3%	3
Missouri	1.7%	4
Montana	0.4%	1
Nebraska	1.3%	3
Nevada	1.3%	3
New Hampshire	0.4%	1
New Mexico	0.4%	1
North Carolina	2.1%	5
Oklahoma	0.4%	1
Puerto Rico	0.9%	2
Rhode Island	0.4%	1
South Carolina	0.4%	1

Totals: 233

Value	Percent	Responses
Tennessee	0.9%	2
Utah	1.3%	3
Virginia	0.9%	2
Washington, D.C.	1.7%	4
West Virginia	0.4%	1
Wisconsin	2.1%	5

Totals: 233

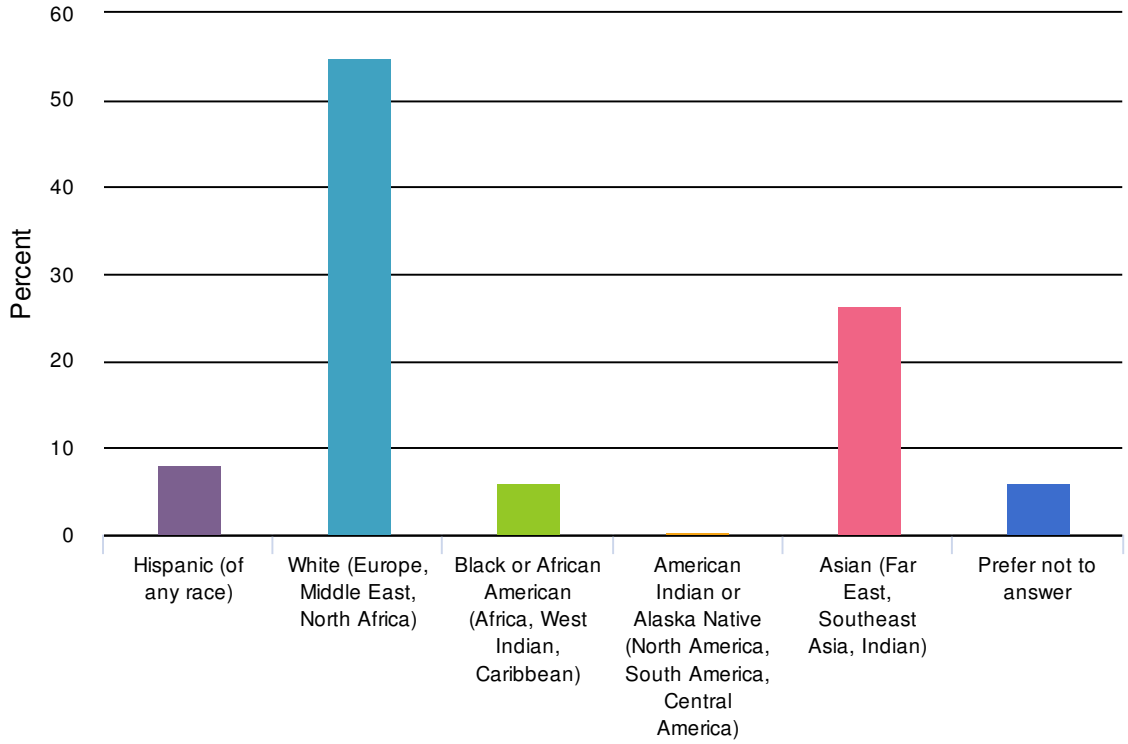
10. What is your gender identity?



Value	Percent	Responses
Male	50.8%	126
Female	48.0%	119
Prefer not to answer	1.2%	3

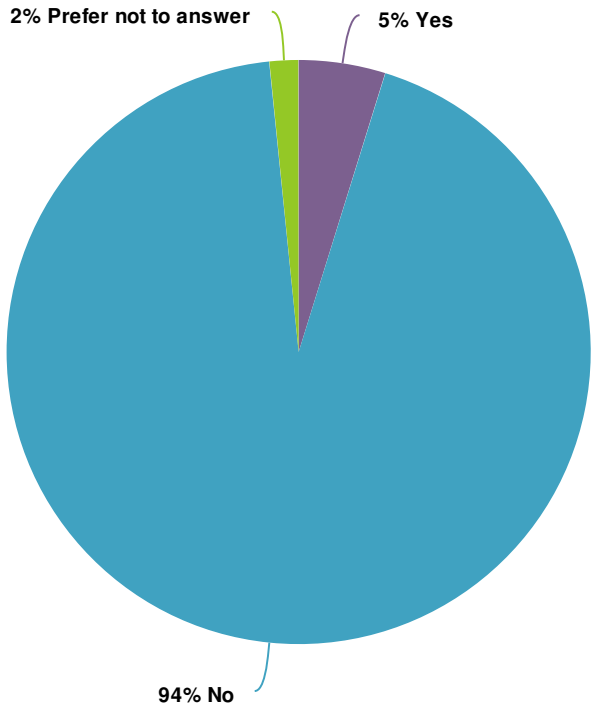
Totals: 248

11. With which race/ethnicity do you identify yourself?



Value	Percent	Responses
Hispanic (of any race)	8.1%	20
White (Europe, Middle East, North Africa)	54.9%	135
Black or African American (Africa, West Indian, Caribbean)	6.1%	15
American Indian or Alaska Native (North America, South America, Central America)	0.4%	1
Asian (Far East, Southeast Asia, Indian)	26.4%	65
Prefer not to answer	6.1%	15

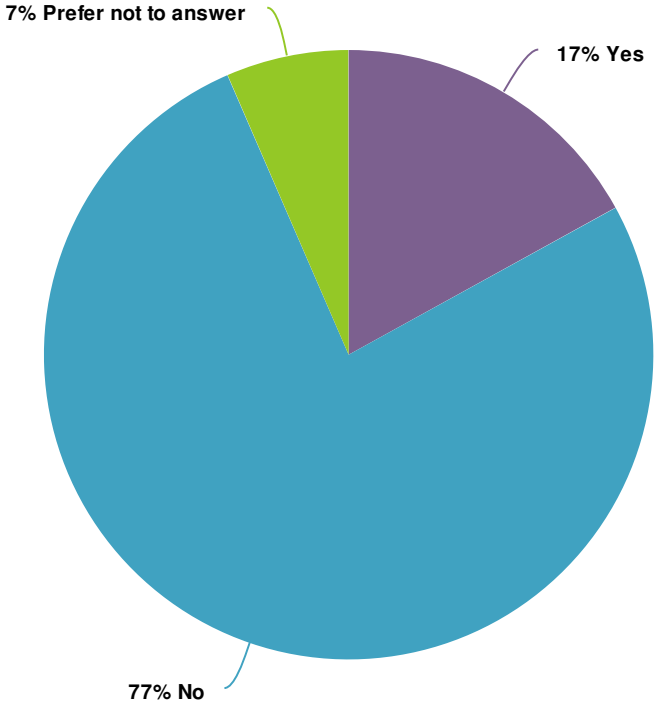
12. Do you consider yourself to have a disability as defined by the Americans with Disabilities Act?The ADA defines an individual with a disability as a person who: Has a physical or mental impairment that substantially limits one or more major life activities; Has a record of such an impairment; or Is regarded as having such an impairment.



Value	Percent	Responses
Yes	4.8%	12
No	93.6%	233
Prefer not to answer	1.6%	4

Totals: 249

13. Do you consider yourself to be a gender or sexual minority?



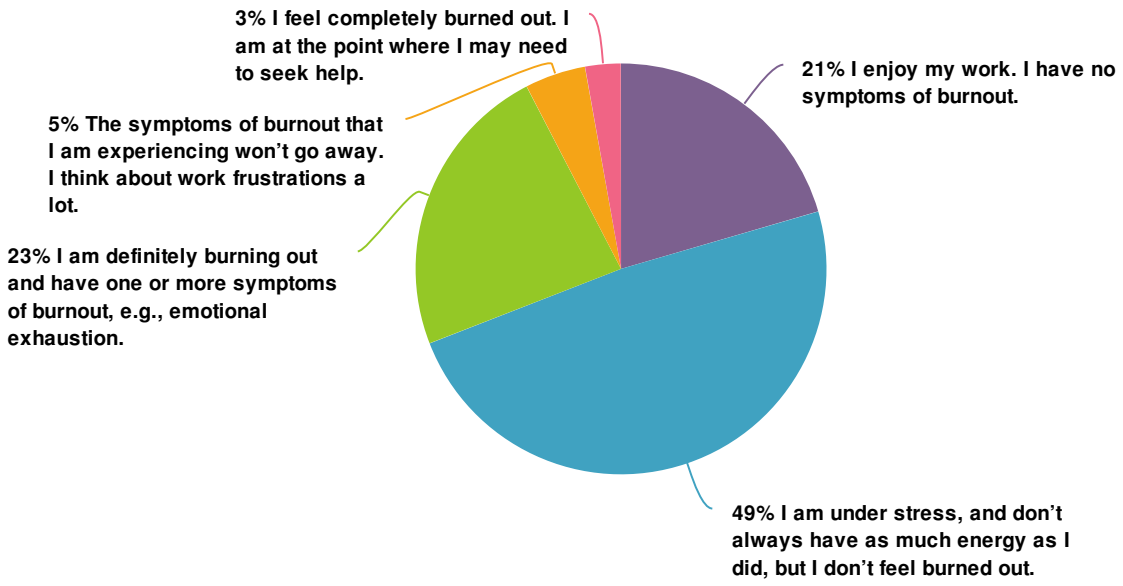
Value	Percent	Responses
Yes	17.0%	42
No	76.5%	189
Prefer not to answer	6.5%	16

Totals: 247

14. What is your familiarity with concepts of:

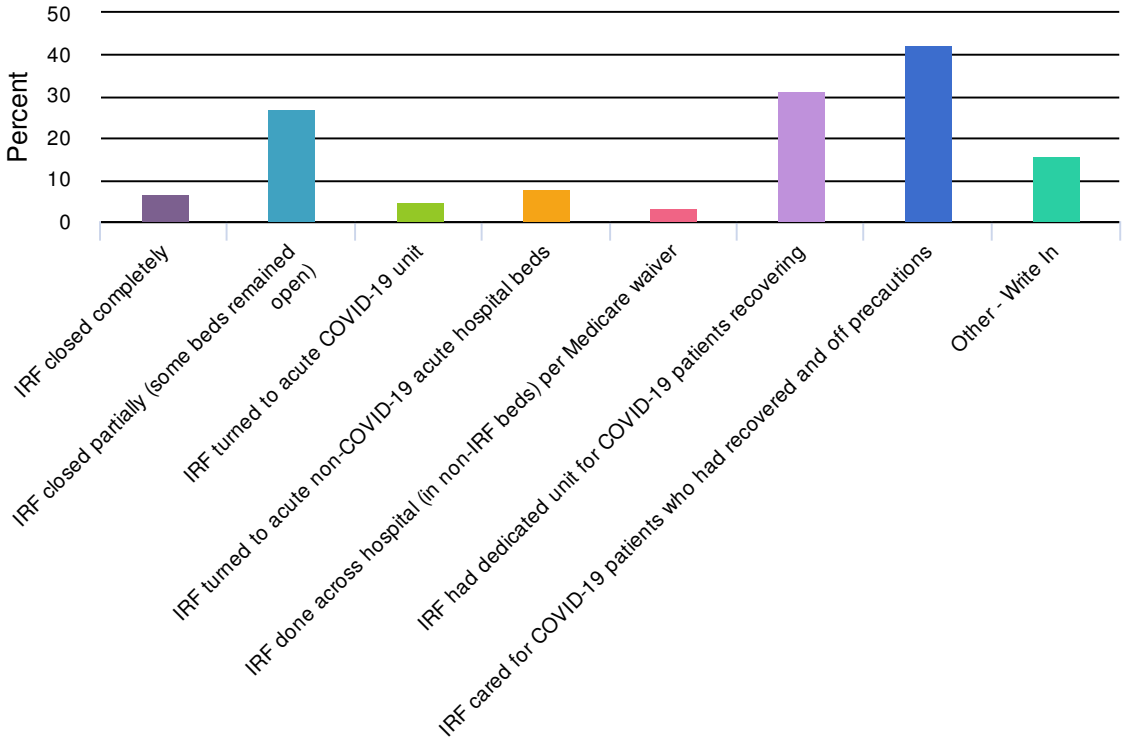
	Not at all familiar	Slightly familiar	Somewhat familiar	Moderately familiar	Extremely familiar	Responses
Disability Rights						
Count	5	20	70	106	47	248
Row %	2.0%	8.1%	28.2%	42.7%	19.0%	
Health Equity						
Count	13	20	68	100	46	247
Row %	5.3%	8.1%	27.5%	40.5%	18.6%	
Intersectionality						
Count	112	33	63	33	7	248
Row %	45.2%	13.3%	25.4%	13.3%	2.8%	
Totals						
Total Responses						248

15. Using your own definition of “burnout,” please answer one of the following:



Value	Percent	Responses
I enjoy my work. I have no symptoms of burnout.	20.5%	51
I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.	48.6%	121
I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.	23.3%	58
The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.	4.8%	12
I feel completely burned out. I am at the point where I may need to seek help.	2.8%	7
	Totals:	249

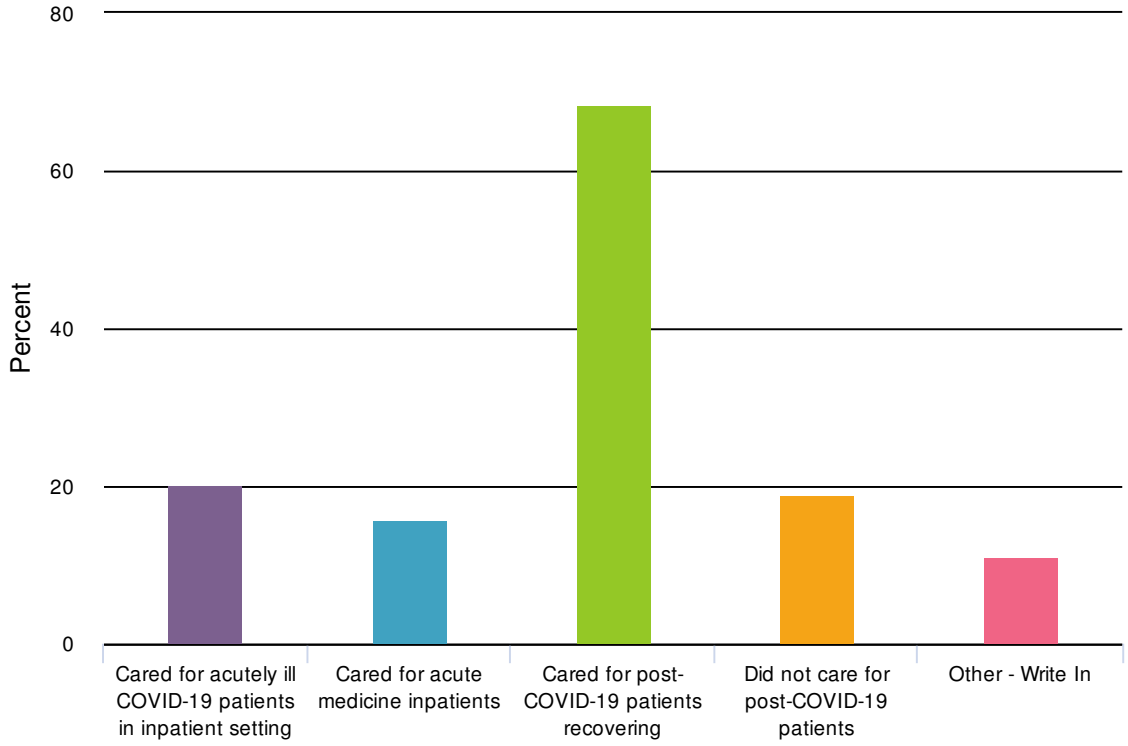
16. What happened to your IRF during COVID-19 pandemic? Select all that apply.



Value	Percent	Responses
IRF closed completely	6.7%	6
IRF closed partially (some beds remained open)	27.0%	24
IRF turned to acute COVID-19 unit	4.5%	4
IRF turned to acute non-COVID-19 acute hospital beds	7.9%	7
IRF done across hospital (in non-IRF beds) per Medicare waiver	3.4%	3
IRF had dedicated unit for COVID-19 patients recovering	31.5%	28
IRF cared for COVID-19 patients who had recovered and off precautions	42.7%	38
Other - Write In	15.7%	14

Other - Write In	Count
No change	2
IRF continued functioning as before, just implementing precautions for COVID-19 patients that were admitted to the IRF	1
No changr	1
None of the above	1
Not affiliated with an IRF	1
Nothing changed	1
Partially reduced in size and now back to full capacity	1
Remained open but reduced census and available community physiatrists reduced the need for locum tenems providers	1
Telemedicine visits for the doctors	1
n/a	1
post acute rehab inpatients remained unchanged	1
stayed open	1
Totals	13

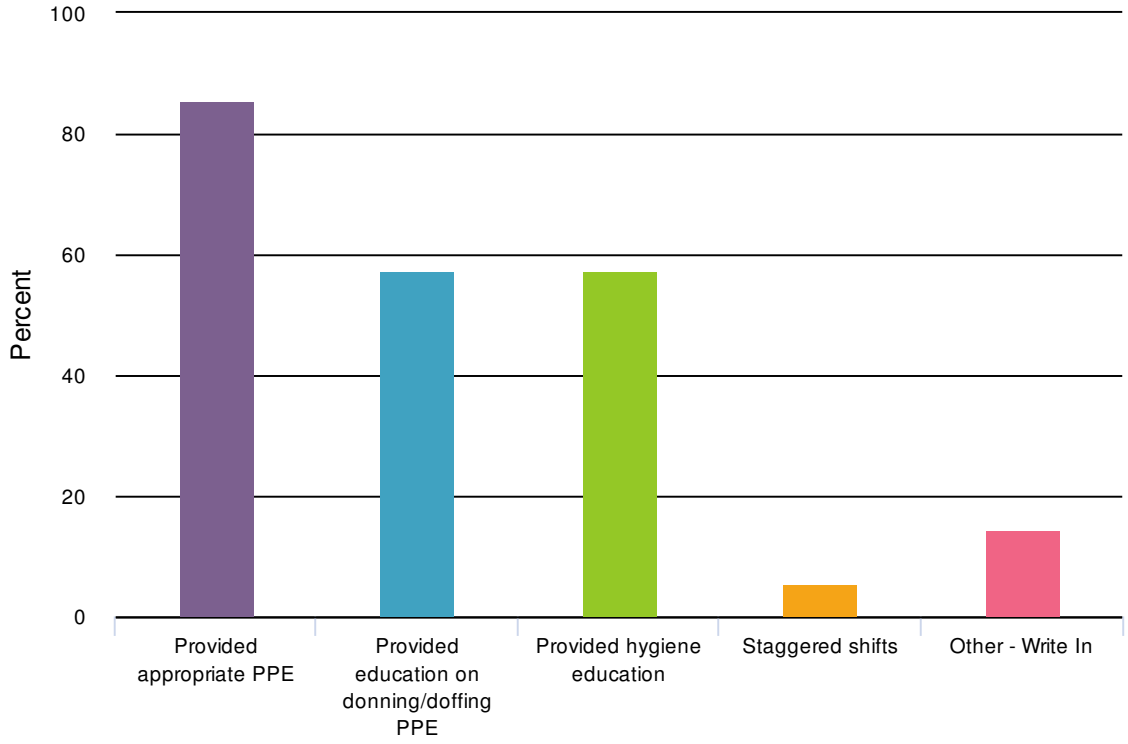
17. What happened to your work during COVID-19 pandemic in the inpatient setting? Select all that apply.



Value	Percent	Responses
Cared for acutely ill COVID-19 patients in inpatient setting	20.2%	18
Cared for acute medicine inpatients	15.7%	14
Cared for post-COVID-19 patients recovering	68.5%	61
Did not care for post-COVID-19 patients	19.1%	17
Other - Write In	11.2%	10

Other - Write In	Count
Cared for acutely covid patients in SNF	1
Cared for typical IRF patients	1
Consults in acute care hospital	1
I would have cared for them but there were only a couple of kids with respiratory COVID and no neurologic COVID found so far	1
Inpatient PM&R consults of covid and non-covid patients	1
No changes	1
Welcomed post-covid patients but need was minimal	1
Work ceased to exist	1
as well as ongoing care of other inpatient rehab patients; outpatient limited primarily to telehealth	1
rehab medicine consults in acute care hospital on COVID patients	1
Totals	10

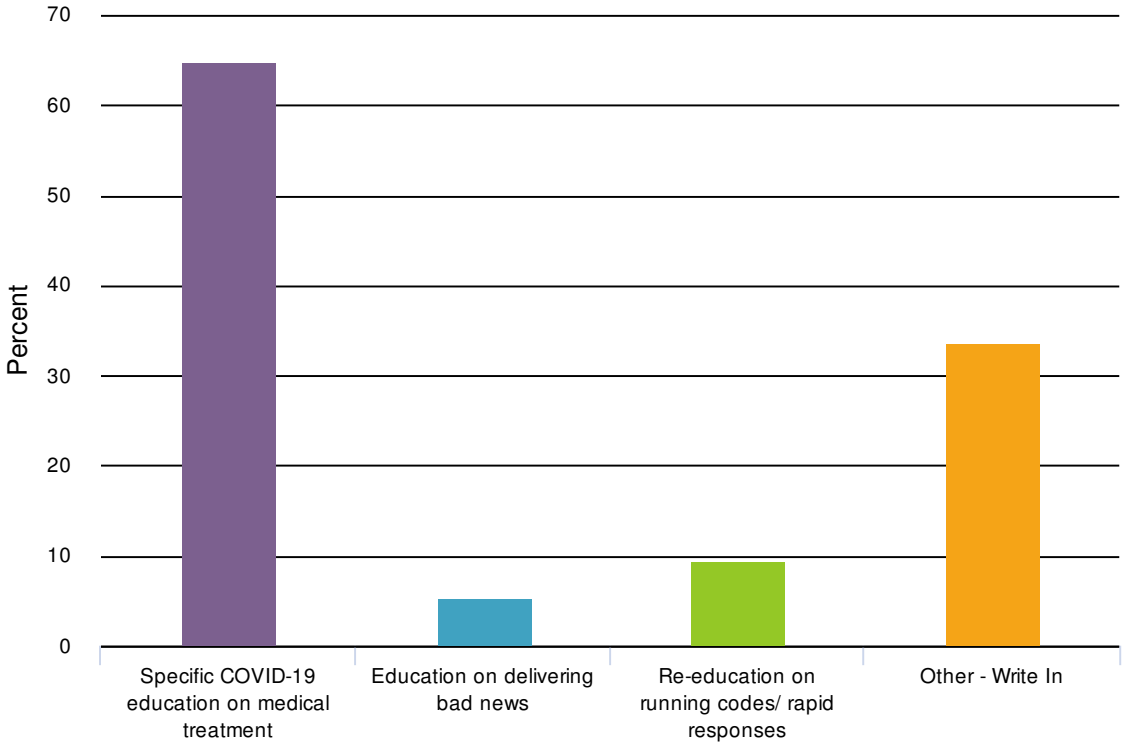
18. What measures did your department place to keep you healthy/safe while working inpatient? Select all that apply.



Value	Percent	Responses
Provided appropriate PPE	85.4%	76
Provided education on donning/doffing PPE	57.3%	51
Provided hygiene education	57.3%	51
Staggered shifts	5.6%	5
Other - Write In	14.6%	13

Other - Write In	Count
Did televisits in one facility. The other facilities did not allow providers into thebuilding.	1
Eventually given appropriate PPE but still had to reuse	1
Had PPE shortages	1
Limited physicians working to 3-4. Others went home	1
N/A	1
No irc	1
Provided robust access for testing	1
Temperature checks	1
limited buildings tto which I go to see residents	1
not admitting covid positive patients, standard well patient precautions were taken	1
spaced out work places and made team meetings via conference phones	1
telehealth for all post acute rehab inpatients	1
telework	1
Totals	13

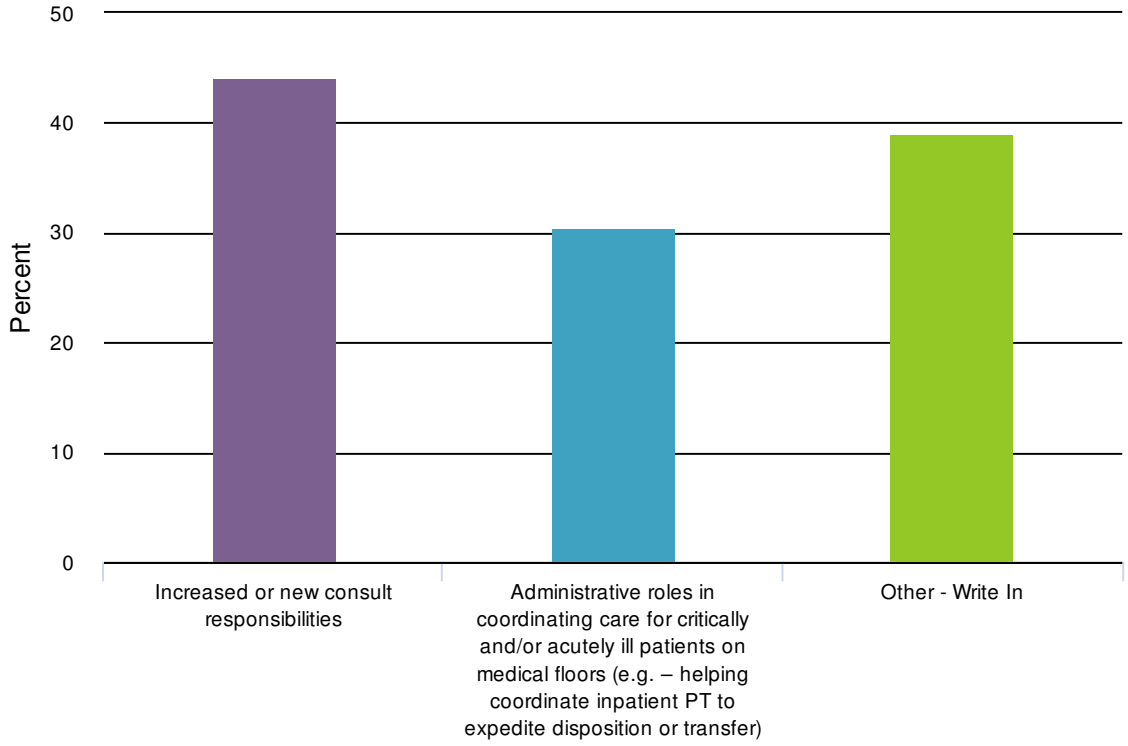
19. What measures did your department take to educate you on treating patients with COVID-19? Select all that apply.



Value	Percent	Responses
Specific COVID-19 education on medical treatment	64.9%	48
Education on delivering bad news	5.4%	4
Re-education on running codes/ rapid responses	9.5%	7
Other - Write In	33.8%	25

Other - Write In	Count
none	6
None	4
I am the only physician in my department. I took it upon myself to review critical care medicine with an online course provided by the Society of Critical Care Medicine.	1
N/A	1
NA	1
No education provided	1
No irf	1
None of the above	1
None of the above, IRF completely over looked by hospital admin	1
None provided	1
None specific	1
None was required	1
having nurse dedicated to ensure proper donning/doffing PPE	1
i did not care for active COVID patients	1
n/a	1
none, did not care for these pts	1
self taught	1
Totals	25

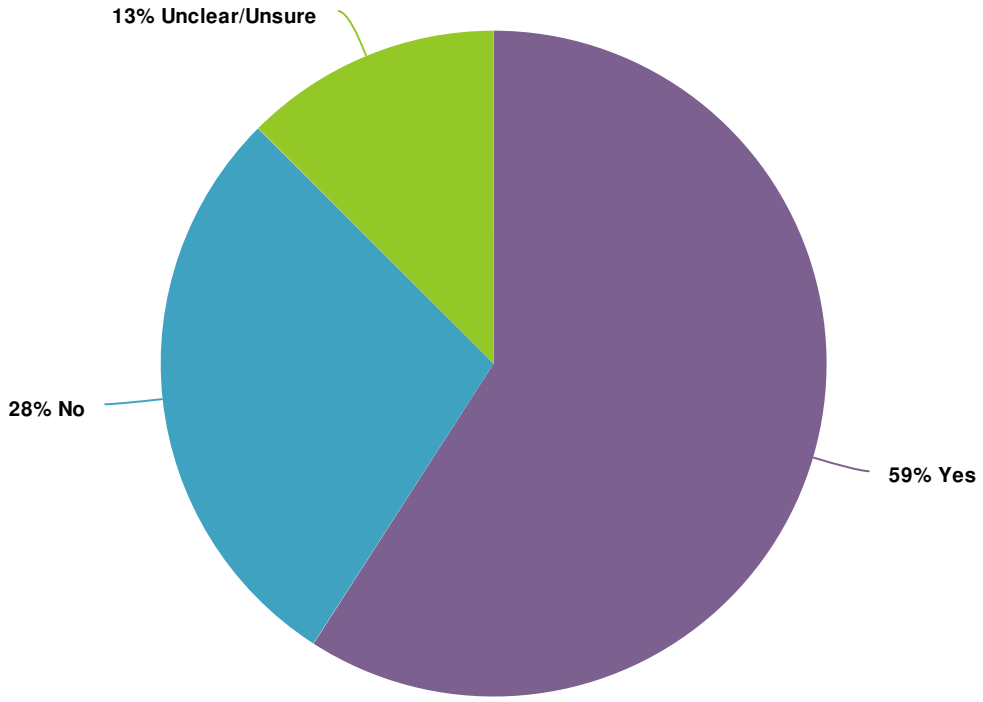
20. In addition to any IRF responsibilities did you have any of the following: Select all that apply.



Value	Percent	Responses
Increased or new consult responsibilities	44.1%	26
Administrative roles in coordinating care for critically and/or acutely ill patients on medical floors (e.g. – helping coordinate inpatient PT to expedite disposition or transfer)	30.5%	18
Other - Write In	39.0%	23

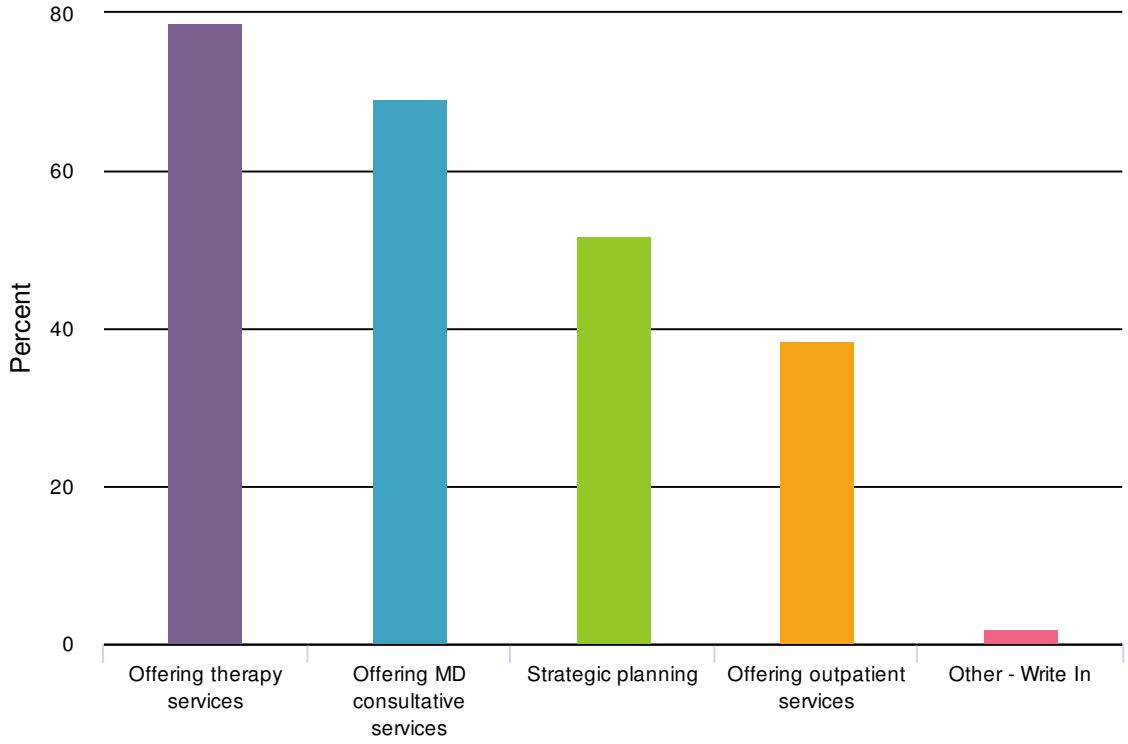
Other - Write In	Count
None	5
n/a	2
none	2
EMG Practice	1
I am doing Locum work and because of my age, there were restrictions applied on getting jobs. Did an 8 week pilot project doing inpatient Telehealth.	1
No irf	1
None of the above	1
None....financial disaster	1
administrative office duties (e.g. answering/sending faxes, answering phone calls, paperwork), covering resident duties (insufficient residents scheduled on inpatient rotations, reason unclear but no coverage for acute care took place)	1
ethics team working on allocation of resources	1
informatics support for COVID 19	1
lots and lots more meetings relating to COVID-19	1
no	1
none needed, volumes did not require	1
not any different	1
not applicable	1
Totals	22

21. Has your department been involved in planning for response/care of post-COVID-19 patients?



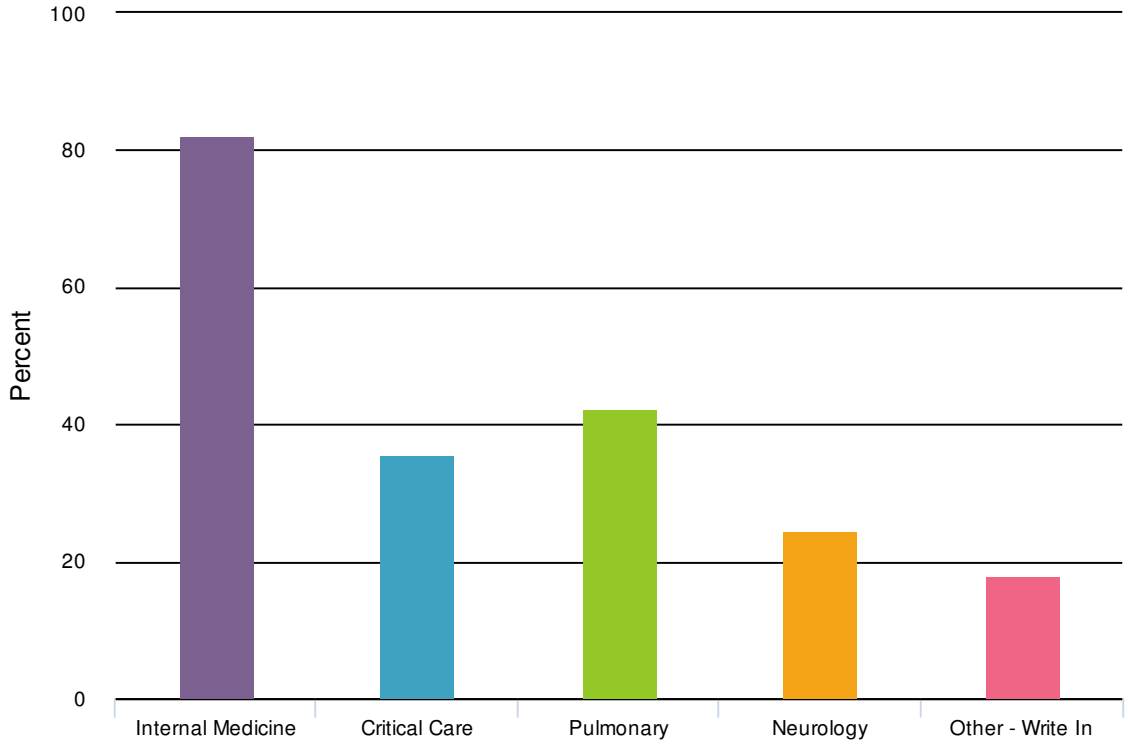
Value	Percent	Responses
Yes	59.1%	52
No	28.4%	25
Unclear/Unsure	12.5%	11
	Totals:	88

22. In what way? Select all that apply.



Value	Percent	Responses
Offering therapy services	78.8%	41
Offering MD consultative services	69.2%	36
Strategic planning	51.9%	27
Offering outpatient services	38.5%	20
Other - Write In	1.9%	1

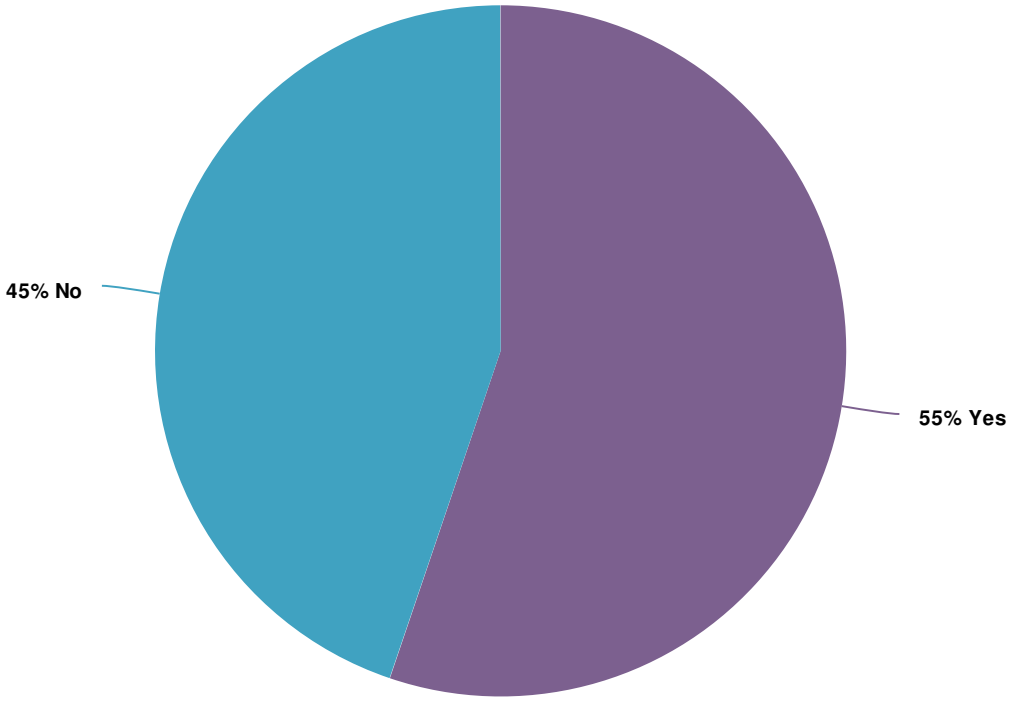
23. What other services is your department working with to achieve this? Select all that apply.



Value	Percent	Responses
Internal Medicine	82.2%	37
Critical Care	35.6%	16
Pulmonary	42.2%	19
Neurology	24.4%	11
Other - Write In	17.8%	8

Other - Write In	Count
ID	2
Hospital Administration	1
Infectious disease	1
Shifting care from acute hospital to IRF earlier to free up acutely beds	1
Therapy	1
increasing nursing/therapy staffing	1
none. The hospital just offloaded all the ill patients and we had to carry the load	1
Totals	8

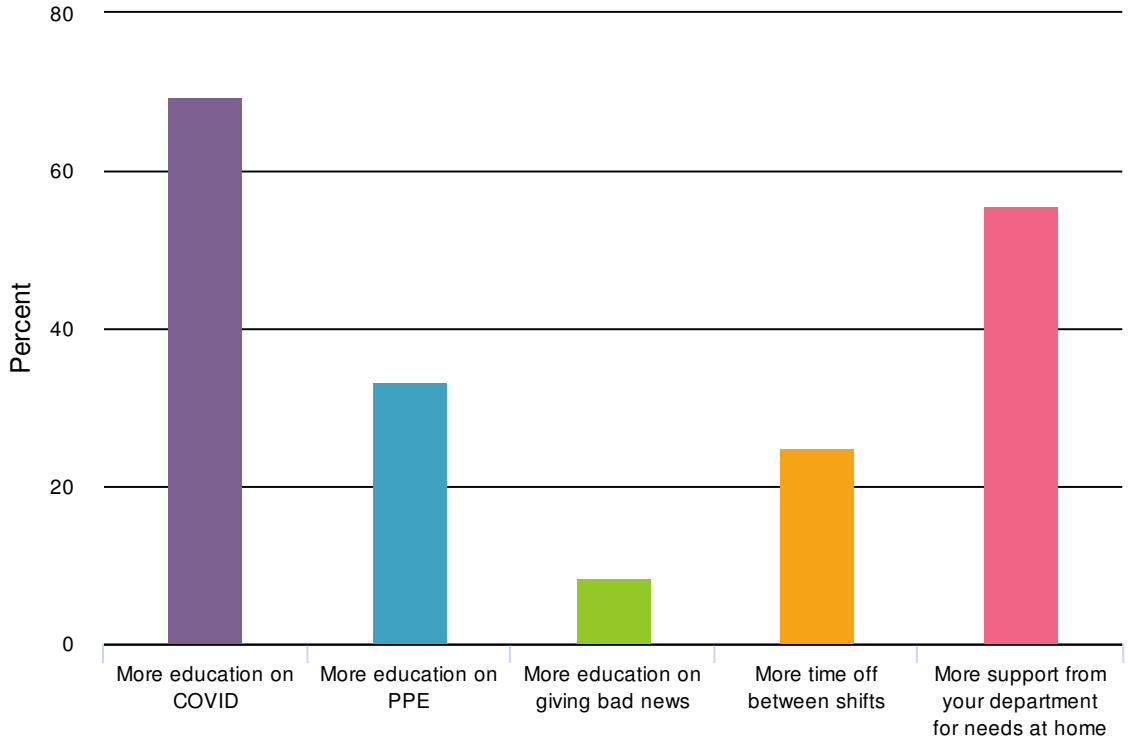
24. Did you feel prepared to deal with pandemic surge?



Value	Percent	Responses
Yes	55.2%	48
No	44.8%	39

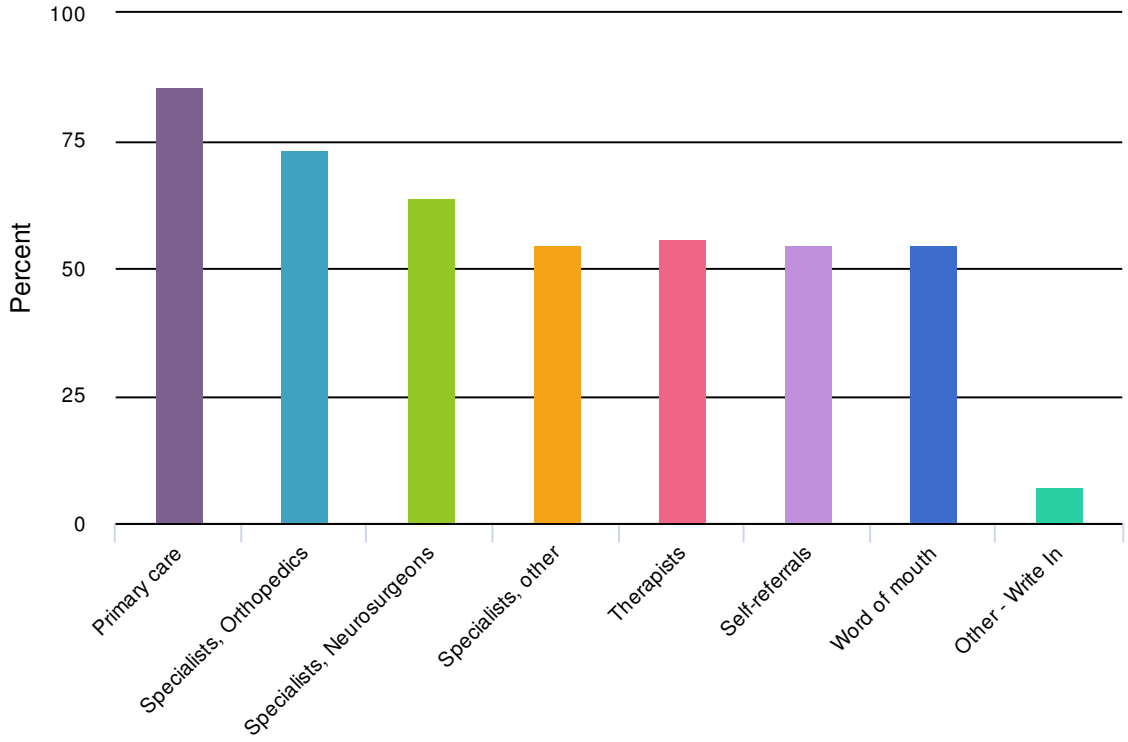
Totals: 87

25. What would have helped you feel more prepared?



Value	Percent	Responses
More education on COVID	69.4%	25
More education on PPE	33.3%	12
More education on giving bad news	8.3%	3
More time off between shifts	25.0%	9
More support from your department for needs at home	55.6%	20

26. Where do you get your referrals? Select all that apply.



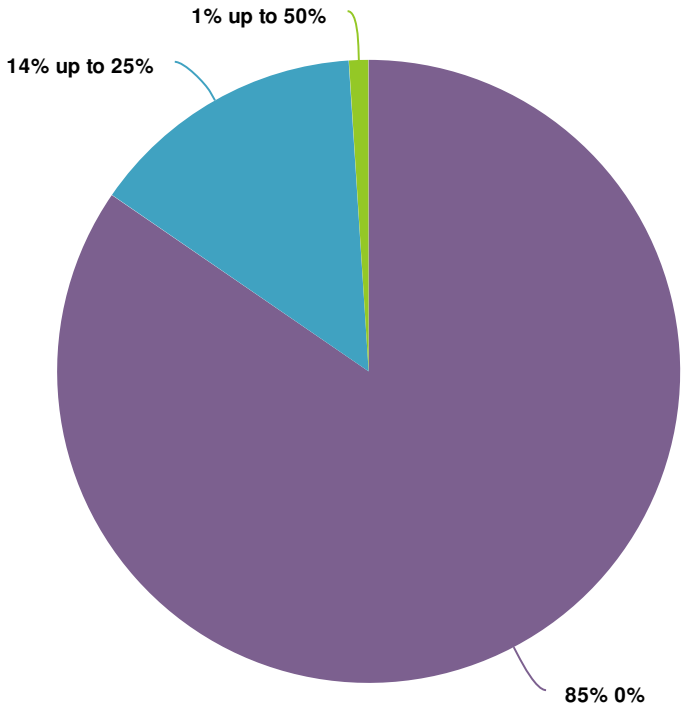
Value	Percent	Responses
Primary care	85.6%	83
Specialists, Orthopedics	73.2%	71
Specialists, Neurosurgeons	63.9%	62
Specialists, other	54.6%	53
Therapists	55.7%	54
Self-referrals	54.6%	53
Word of mouth	54.6%	53
Other - Write In	7.2%	7

Other - Write In	Count
Chiropractors , Occupational Health Clinics	1
Employers	1
Rheumatologists	1
Work Comp insurers/employers	1
Work comp	1
case managers	1
inpatient SCI collegues	1
Totals	7

27. Rank the Following Impacts of COVID-19 on Your Practice (1 being the greatest challenge, 2 second greatest, etc.)

Item	Overall Rank	Rank Distribution	Score	No. of Rankings
Restriction/inability to perform procedures	1		470	88
Telemedicine	2		454	88
Restriction to getting physical therapy	3		427	82
Limited interdisciplinary care with surgeons and others	4		306	78
Increased demand/need for medications as a substitute	5		288	78
Illness in the office	6		263	79
Medication monitoring	7		223	76

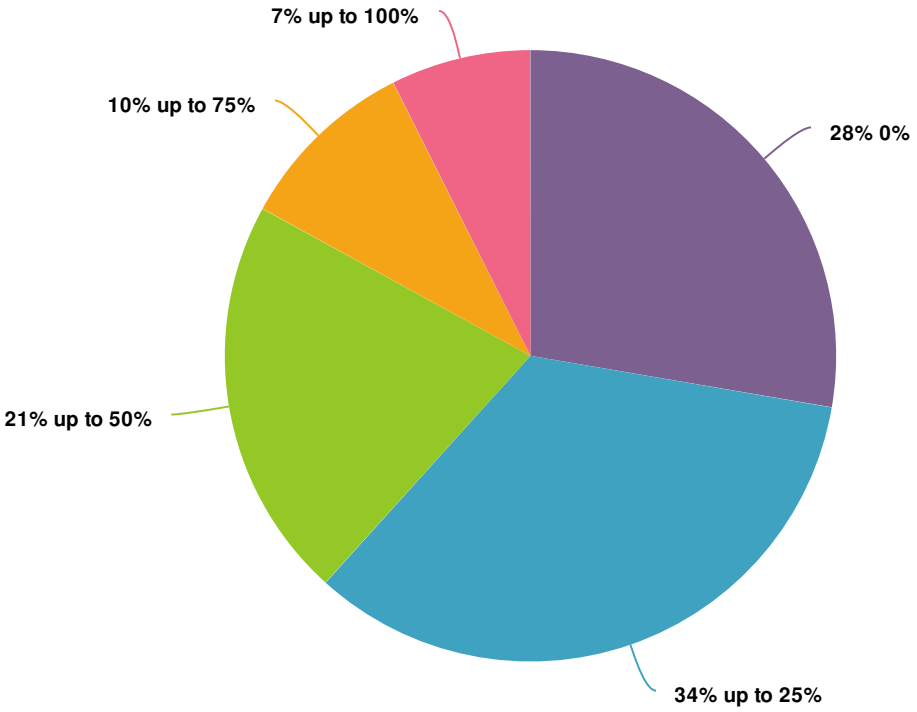
28. Approximately what percentage of your practice was telemedicine prior to the COVID-19 pandemic?



Value	Percent	Responses
0%	84.5%	82
up to 25%	14.4%	14
up to 50%	1.0%	1

Totals: 97

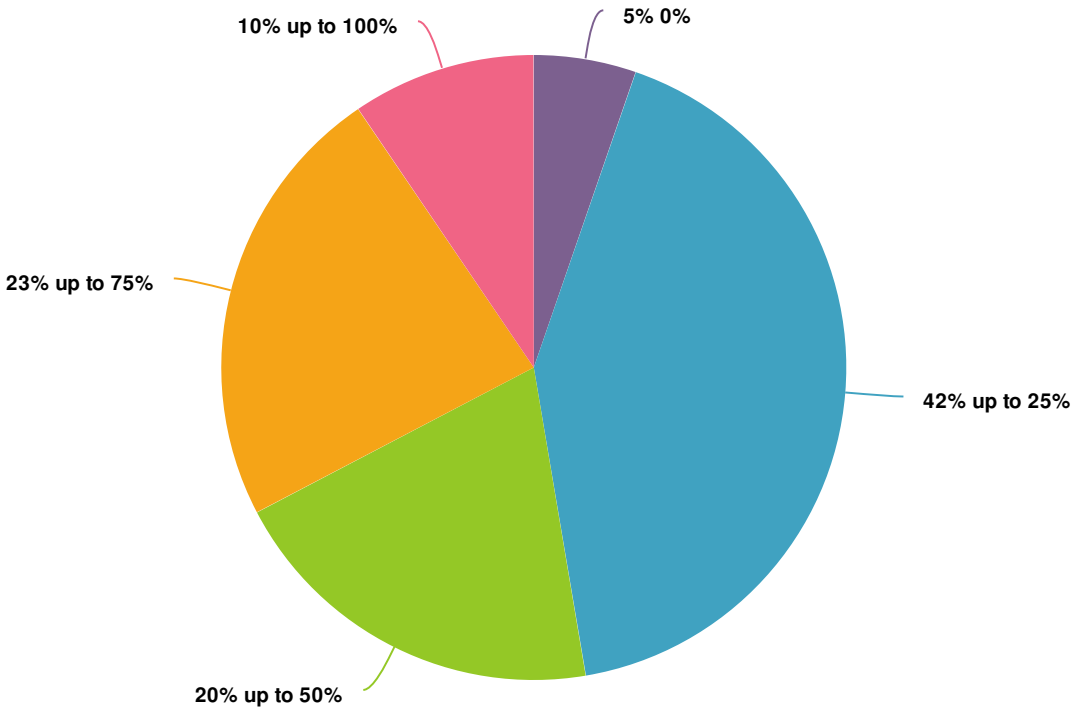
29. During the COVID-19 pandemic, approximately what percentage of your new visits are telemedicine?



Value	Percent	Responses
0%	27.7%	26
up to 25%	34.0%	32
up to 50%	21.3%	20
up to 75%	9.6%	9
up to 100%	7.4%	7

Totals: 94

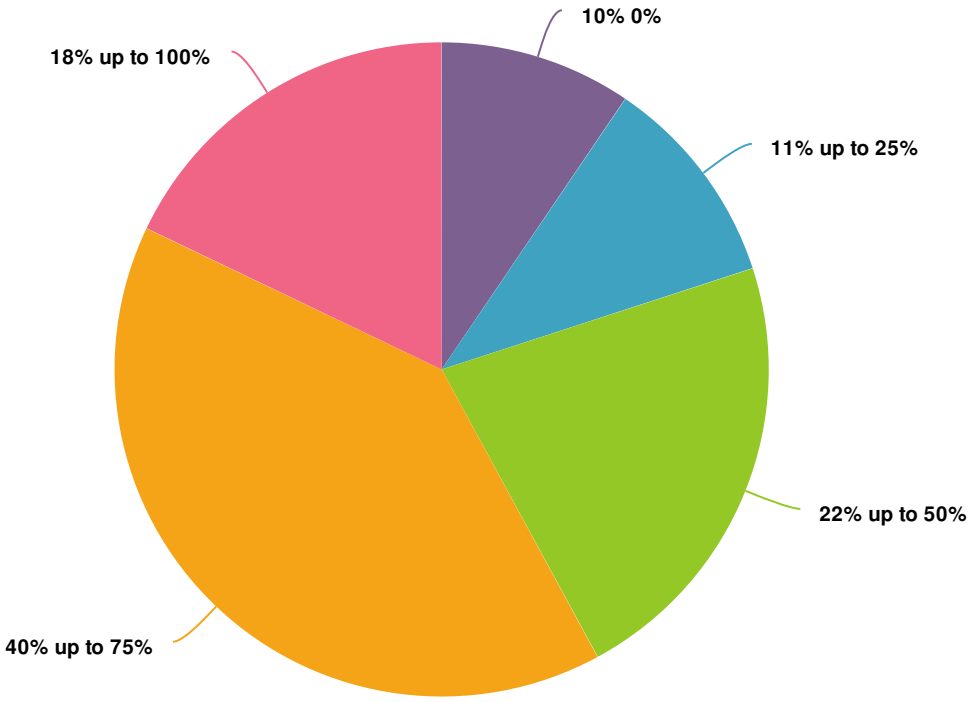
30. During the COVID-19 pandemic, approximately what percentage of your follow up visits are telemedicine?



Value	Percent	Responses
0%	5.3%	5
up to 25%	42.1%	40
up to 50%	20.0%	19
up to 75%	23.2%	22
up to 100%	9.5%	9

Totals: 95

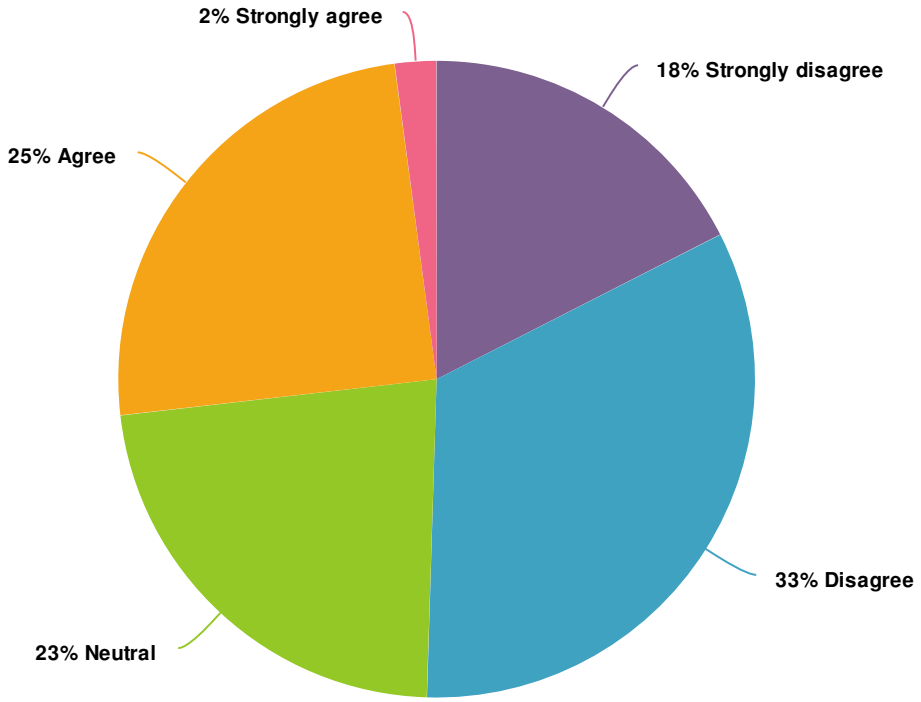
31. Approximately what percent of your telemedicine visits, are you able to give satisfactory care?



Value	Percent	Responses
0%	9.5%	9
up to 25%	10.5%	10
up to 50%	22.1%	21
up to 75%	40.0%	38
up to 100%	17.9%	17

Totals: 95

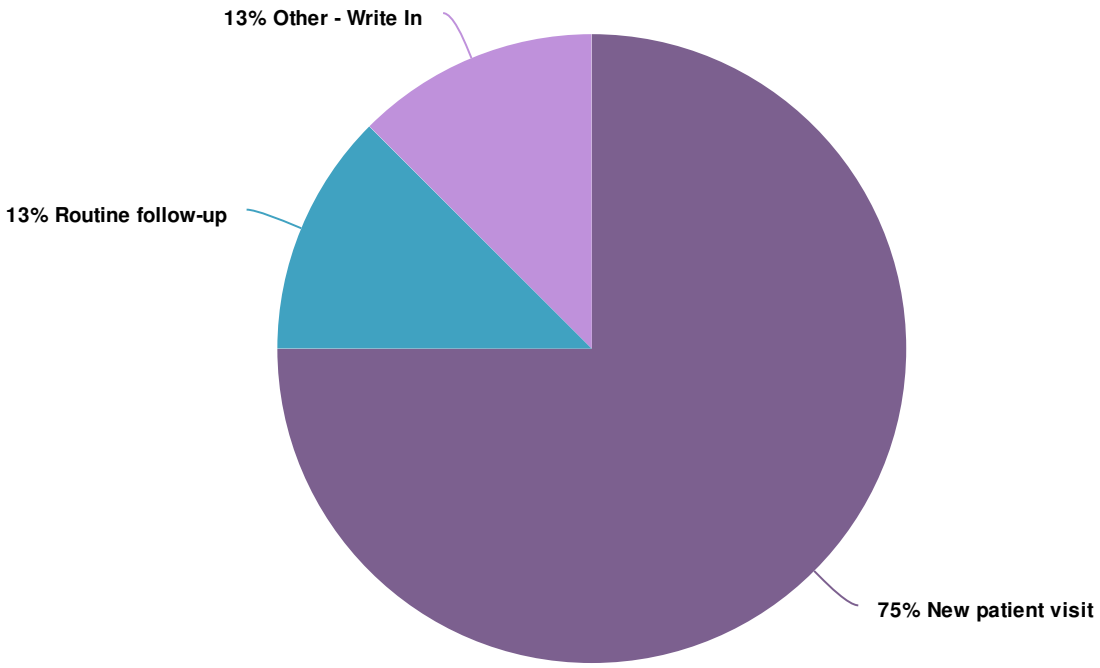
32. To what extent do you believe with this statement: "I believe telemedicine visits are as effective as in-person visits"?



Value	Percent	Responses
Strongly disagree	17.5%	17
Disagree	33.0%	32
Neutral	22.7%	22
Agree	24.7%	24
Strongly agree	2.1%	2

Totals: 97

33. [OLD VERSION] For which purposes do you find telemedicine most difficult? Select all that apply.

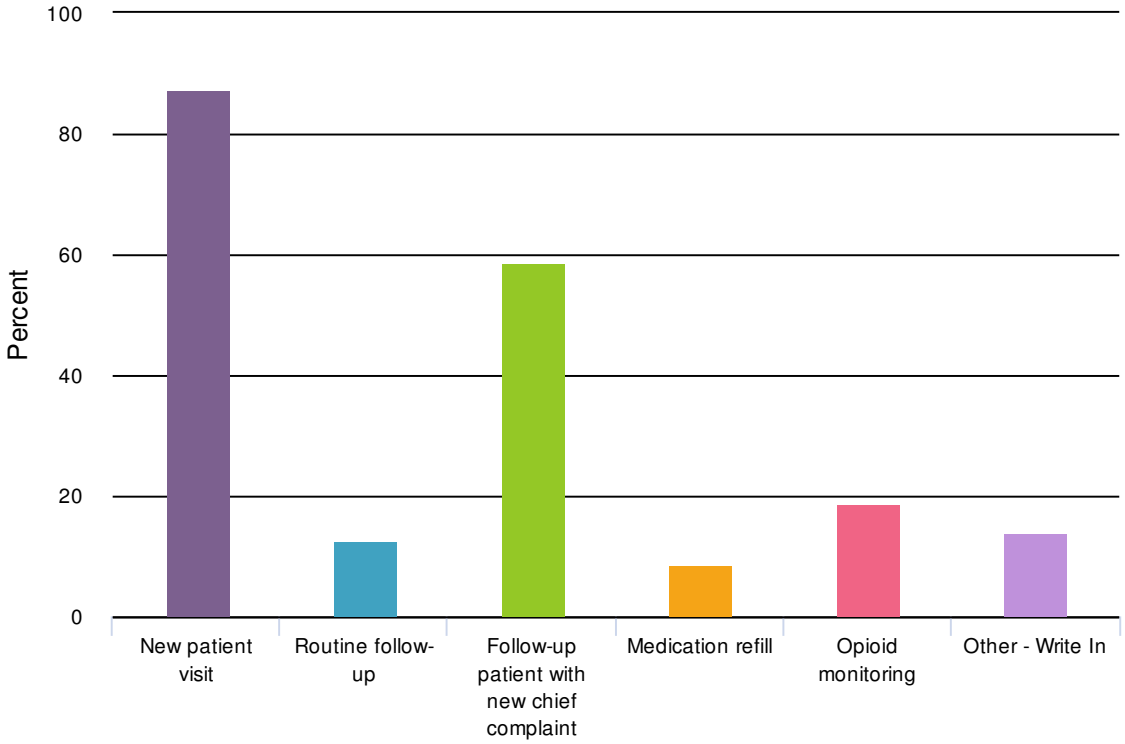


Value	Percent	Responses
New patient visit	75.0%	12
Routine follow-up	12.5%	2
Other - Write In	12.5%	2

Totals: 16

Other - Write In	Count
Need for thorough physical exam	1
Unable to select more than one choice above. New patient visit, follow-up patient with new chief complaint, and opioid monitoring.	1
Totals	2

34. For which purposes do you find telemedicine most difficult? Select all that apply.



Value	Percent	Responses
New patient visit	87.5%	70
Routine follow-up	12.5%	10
Follow-up patient with new chief complaint	58.8%	47
Medication refill	8.8%	7
Opioid monitoring	18.8%	15
Other - Write In	13.8%	11

35. How did your practice setting affect your ability to return to practice?

ResponseID	Response
11	No
13	I did not stop practicing in my private practice. I also go to nursing homes, where several facilities barred consultants during the height of COVID, and others encouraged me to come in and see their COVID patients. Some of my private practice patients were justifiably concerned about coming to my office when they heard that I was going to nursing homes and seeing COVID patients on other days. I also barred some of my higher risk patients from coming to my office for the same reason.
16	People were not coming in.
18	.
19	I did exclusively telemedicine for about 3 weeks with markedly reduced patient volume. Then gradual return over another 3-4 weeks to in-person care. At present I am nearly 100% in person with only a few very high risk individuals who prefer to do telemedicine for followup.
20	I am high risk and I have lengthy visits in people's homes. I had to wait for PAPR to become available.
23	Helped being outpatient with low overhead.
24	We had "mandatory"shut down except for emergency visits. I later learned that not everyone followed that "rule". So although only urgent surgeries and procedures were being performed, other folks were keeping production up by seeing patients in the office. I was doing telemedicine which pays next to nothing

ResponseID	Response
33	Unable to do procedures for two months, limited office hours
34	I was unable to make specific decisions. The organization I work for did setup the telemedicine system, but colleagues in private practice seemed to get setup much quicker
39	Things were closed. Patients didn't want to come in
41	Primarily elective outpatient care, less of a priority often for patients.
45	N/A
46	Minimal- use precautions
58	No
61	Couldn't do elective procedures.
65	distance , fear of the patients
69	.
72	We never closed. We just figured out to do telemedicine for rechecks. Our new patient referrals for EMG's and Consults have been slow to recover as referring physicians are just getting started back up.
75	None. We never stopped, only implemented precautions.
81	Half of our staff was out during for at least a month which made things very difficult
83	large hospital clinic- all telehealth for a month or two
84	Easier because we are a surgical hospital with healthy patients.
86	we are small and nimble so we were able to return quickly
88	It is horrible management. I quit that place joining other group
92	Initially during COVID-19 pandemia, my practice setting was affected due to state/territory government restrictions of non-emergency medical practices operations for 3-4 weeks. After that, it has not been affected.
94	small office. needed to decrease number of doctors in office at one time
97	It did not. We were able to continue practicing and made adjustments as needed.
98	Less patients and longer with each patient

ResponseID	Response
100	We had telemedicine capabilities already. So it was a rapid transition.
103	I primarily perform electrodiagnostic studies so I had to see patients sooner than I wanted to return to practice because of # of referrals and to stay in business.
105	only stopped 2 days and started telehealth the next week full schedule
108	Being independent created financial challenges but it gave me a nimble approach where I could easily change protocols, and also change protocols to suit my level of comfort (ie increased screening, increased time between patients for cleaning, adding air purifier to my office, etc)
109	VA--stricter rules for outpatient/inpatient on SCI units
110	Could not see patients in-person for a period of time.
112	Independent office allowed for social distancing and limited patient to patient contact
116	No problem
119	Initially our building was not accessible due to screening limitations. Now we are minimally affected.
121	excellent practice support
124	Severe pain needing injection same day
137	None now but previously limited due to space to allow for social distancing
143	we did not stop practicing at all during all this time. we continued with telemedicine visits once the national coronavirus shutdown occurred and still saw very urgent patients in clinic if needed. now we are doing a combination practice of both telemedicine and in office appointments with special precautions in place such as -- extra cleaning, pt's are advise to wash hands before and after appointment, all pt;s get temperature checked before entering building and at our office and everyone that enters building is required to wear a mask, etc.
144	Rules from hospital administration
147	Increasing telemedicine
151	We are restricted to seeing 30 % of patients in the office for social distancing and most are for injections or EMGS
153	Inability to perform procedures to test the patients pain.
155	Not as restricted with return to outpatient clinic setting as others who work in hospital, surgery center, etc

ResponseID	Response
156	Having a solo private practice, made it easier to some extent in adapting to changes needed for return to practice.
159	We had to wait until we had PPE to do Emgs. Even now although I work for a university system I have brought in my own PPE There is very poor social distancing amoung ancillary staff
163	Waiting rooms were eliminated
165	reduced patient number due to fear of coming to the doctor
168	We were ok but had difficult with tele visit and examining patients
170	It was very difficult but we found a way that works for us.
171	We kept continuing to work
179	It was not difficult to incorporate telemedicine into day to day. Was able to examine further and next in person follow up visit if need be.
181	Just have to exercise precautions and do more telemedicine
182	Adapted with Telemedicine and Surgery Center
184	University determined policy
188	organizational decisions lead the way over individual practice
189	The medical center where I practiced became the Covid treatment center and I had to relocate to a very small space in a friend's office.
190	Less staff
191	Less clinics
192	Patients reluctant to leave their homes and command
193	pressures to return to practice, not adequate PPE to providers, though consistent with some local standards at other hospitals (though not with others)
195	Had to abide by university wide conditions for reopening
202	It has a minimal impact as Covid rates are currently low in my area
205	Lost 6 weeks of work and income.

ResponseID	Response
207	My practice setting being an academic institution was the primary driver affecting my return to practice.
212	Loss of access to procedures, supplies
213	Unable to purchase disinfectants and PPE at reasonable price. Prices has gone up and it is difficult for a small solo practice to make a profitable business to stay in market.
216	decreased referrals, increase need to distance, sanitize
217	I'm part of a hospital system and so my return to practice wasnt affected drastically
219	Initially 6 weeks of no in-person visits (except for urgent issues), then slowly increased in-person clinic schedule for the next 3 months
227	none
228	No affect
230	Limited accommodation and safety enforcement
232	difficult to complete EDX studies given restrictions in contact
233	I think no
234	Difficulty with having multiple providers in a clinical or work space given need to social distance while at work. Part of my practice is in pediatric sports medicine, and patient volume has also been slow to increase back to normal due to the impact on sports. As I have been transitioning from fellowship to my new position as an attending at a new institution, this has impacted what I originally negotiated in my contract on how much pediatric sports medicine I am able to practice vs my other practice in pediatric rehabilitation.
236	Needed protocols for screening pts coming into office, protocols for keeping staff safe
240	Mandated closure for a few weeks. Then limited patient numbers in office. New patient staying home for the pandemic and limited ability to find safe transportation to clinic.
242	I had to make sure that we quickly implemented an appropriate telemedicine platform to begin seeing patients.
247	didnt affect me
252	Did not have an effect.

36. How have you changed your staffing since the COVID-19 pandemic began?

ResponseID	Response
11	Precautions
13	One staff member stayed home during COVID, and we are working towards having all staff members have online access to computer and phones from home.
16	None
18	no
19	Initially, yes...furlowed 1 of my 2 MA's. However, had to bring her back once in-person volume ramped up and at present my staffing is the same as pre-COVID
20	Almost no auxiliary staff needed.
23	Added. Hired more educated staff. Lots of unemployed nurses and office assistants around.
24	Not at all
26	Lay-off 50% then rehired about 30%
33	We temporarily laid off seven out of ten office staff, and made the other three part time. We were able to rehire everyone after we received a PPP loan.
34	We had to reduce hours. We did not have to furlough anyone. We are at full staff normal hours now
39	No changes

ResponseID	Response
41	Yes, decreased by 30%
45	N/a
46	Unchanged
58	No
61	Staff out more frequently for 2 weeks for quarantine
65	the hours have been cut short , more PPEs
69	The same amount
72	We cut back on staff when we were just doing telemedicine visits.
75	None
81	We are still short staffed but are in the process of hiring. We have had to make sure our staff practices social distancing and has appropriate PPE
83	staff having to leave the clinic/ resign to care for kids who are on cyberschool
84	Hiring more staff as time has gone on.
86	yes laying off due to lack of volume
88	People were on fmla
92	Staff has been relatively unchanged except for those employees with administrative functions not required for patient care that are working remote from home.
94	yes
97	No
98	More time with each patient and telemedicine
100	There have been a lot of transitions.
103	No change but put up barriers, modified work site and assigned cleaning duties to staff. Had to ensure staff was comfortable and felt safe.
105	no changes
108	no

ResponseID	Response
109	unchanged
110	No change now.
112	No
114	We see less patients in the clinic and have fewer docs in clinic to allow less congestion in the waiting area for social distancing.
116	Some employee worked from home. Employee childcare issues. Changing emg/ncs procedures, change in toxicology testing protocols, changes in person to person availability
119	No staffing changes. Many team members telework.
121	staff reassignment occurring to meet team needs
124	None. I work for the VA and have no input on staffing.
137	No impact
138	No change
143	initially there was less need for near 1:1 nurse staffing and less need for front staff workers due to less patients in office and more telemedicine, but this has slowly returned to about 50-75% of where we were about 1 yr ago.
144	more staff hired-especially recently
147	No
151	not changed
153	No changes
155	We have added staff over the past few months
156	Yes. Reduced number of staff.
159	We are really short.
163	n/a
165	Occasional furloughs of staff
168	Slightly

ResponseID	Response
170	We lost a few staff because of the $600/week unemployment. Three girls came back after 7/31 because they wanted to collect the extra unemployment which affected our practice tremendously.
171	Loss of 1 staff member with young children
179	No changes.
181	No
182	Yes. Mostly gone. Doing more outsourcing and myself
184	Reduced staffing
188	none
189	My secretary stated home until we were able to see patients at in office again
191	Downsized and furloughed
192	Multiple furloughs, most have been brought back
193	yes
194	Yes One retired afraid of Covid
195	Yes, limitation for ancillary personnel not physicians
202	I have assistance with virtual rooming for my Telehealth patients.
205	no change
207	Protective measures have been instituted, but staffing has not directly changed since COVID.
212	Reduced by 1/3
213	Decrease hours and hesitant to hear more help, which is needed. Everyone is being stretch thin.
216	decreased hours but paid normal salary
217	Yes. Some of our MAs were sent to labor pools which made put more pressure on us physicians in terms of returning patient phone calls and messages.
219	Some staff were furloughed for a few months during pandemic

ResponseID	Response
227	none
228	No change
230	Yes, reduced
232	none
233	your workload has decreased
234	Some nursing and admin staff are able to work remotely. Still have athletic trainers helping to staff in clinic in-person. Decrease in multidisciplinary clinics being held.
236	Less staffing with so many people sick or under investigation.
240	Decrease number to assist due to decreased patient load.
242	No
247	some of them stop working
252	No

37. What has been the biggest challenge to your outpatient care during the COVID-19 pandemic and why?

ResponseID	Response
9	Ensuring patients and staff follow appropriate mitigation strategies.
11	First time patient telemedicine. Not able to examine them
13	Patients deciding that COVID gives them an excuse to stay home, not move, and to overeat.
16	Having patients not be scared to come in
18	Impact on clinic revenue
19	$$$$$$$$$ No volume, decreased volume = decreased $$$
20	PPE and aerosol filtration.
23	Exposure risk to SARS-CoV-2 coronavirus.
24	Opioid medication monitoring and balancing the need for pain control with other safety factors
26	Lack of information
33	Reassuring patients that our office is safe
34	Early on it was getting approval to do procedures. Now it's making sure we have enough masks and we have a increase percentage of same day cancellations do to possible symptoms of COVID 19

ResponseID	Response
39	In our practice it was that we had to cease doing EMGs since elective procedures were closed.
41	Financial uncertainty and changing regulations.
46	Hard to do complete physical exams
58	No
61	Elective procedure shut down
65	fear of infection, of one of the patients, or staff or ourselfs and the use of PPE and the economic factor
69	.
72	Not being able to get MRI's, CT scans, and other tests. Not being able to have surgeons evaluate patients because their offices were closed except for emergencies. Hospital services were closed except for emergencies.
75	Lack of referrals and wearing masks all day.
81	Staffing has been a real problem for my practice. We are short staffed which puts more stress on everyone else. It is also difficult to effectively communicate with our patients when we don't have the staff to do so
83	getting adequate rehab care for older individuals availability of staff
84	Patients having to wear masks and being uncomfortable.
86	contact tracing. if you are "exposed' to someone do you stay home for 2 weeks? this applies to staff and patients.
88	Not being able to visualize and potential errors
92	Our biggest challenge has been to maintain physical therapy patients to attend face-to-face visits. Also, telemedicine visits with medicare/medicaid patients who are not familiarized with technology or do not have the resources for an optimal videoconference visit.
94	running an office and adjusting staffing requirements due to illness, exposure, need to stay at home due to closed schools, controlling costs to stay afloat!
97	When we were ready to open, convincing patients that we provide appropriate safety measures to allow in-person visits.
98	Physical exam over the computer

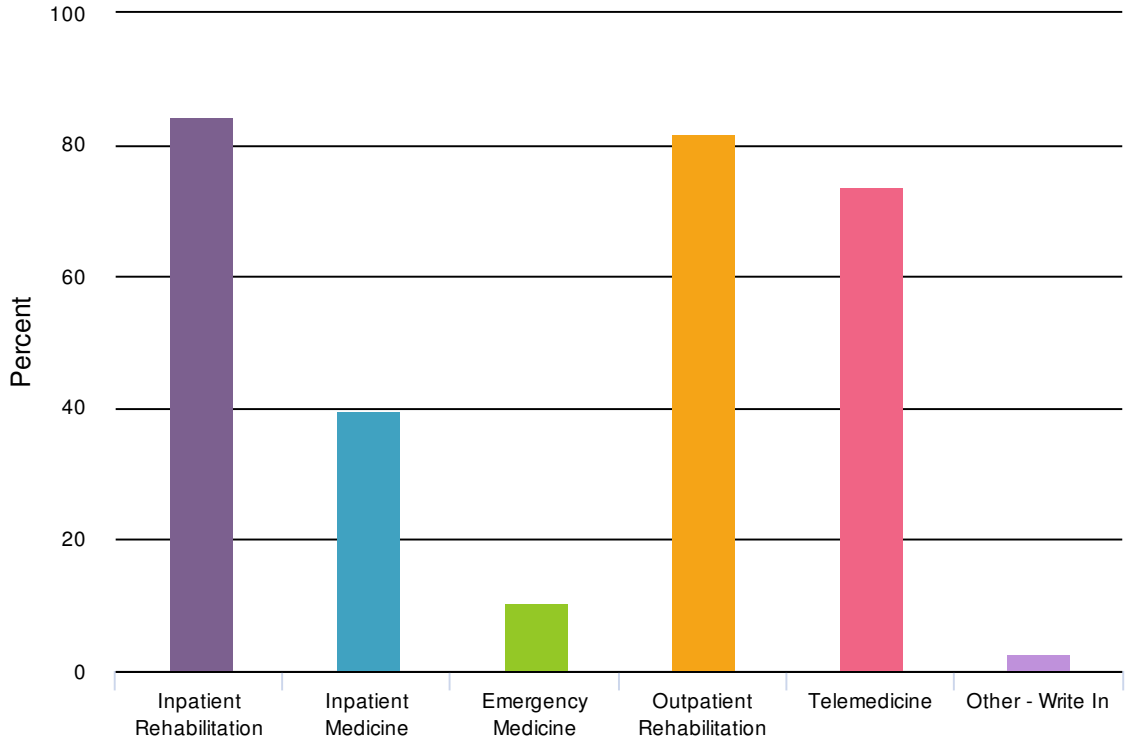
ResponseID	Response
100	Not being able to do procedures
103	Biggest challenge is having enough time between patients to clean equipment and exam rooms. Makes scheduling challenging and I see much less patients as compared to prior to COVID.
105	zoom connections with low tech clinician=me and low tech patients. My staff are Super Users and facilitate everything for me
108	Financially staying viable with decreased appointments but increased costs of PPE, cleaning supplies, etc
109	the constantly changing rules and procedures, pushback from medical center to get even emergency access to patients sometimes
110	None at this time unless some people are not coming for new eval because of fear of infection that i am not aware of.
112	Limited in-office new referrals
114	Updating protocol and making sure the entire staff (front desk, physicians, nurses, MA, admin, patients) are all on the same page
116	EMG nerve conduction studies/urine toxicology testing
119	Patients who don't show up for appointments.
121	patient ability to comply with treatment program due to restricted access to services
124	Diminished productivity from staff working from home, which carried over when they returned to work. This affected patient care as patients were not receiving reassurance calls or telehealth appointment calls in a timely manner. Patients' mental health conditions worsened, which worsened subjective pain level. Providing social support for patients without a social worker on staff.
137	Limited community resources. Not knowing what is open and what is not. Some therapy practices are only doing telehealth
138	Lower volume. Keeping office safe. Hate wearing masks all day

ResponseID	Response
143	the biggest challenge is when patients come to the outpatient clinic ill. in july I had a patient show up to clinic wanting an injection, but just a couple days prior she had come down with headache and diarrhea and was under investigation for COVID (test still pending) and was not following the self isolation protocols. this pt was demanding to be seen and have the injection despite these symptoms. pt was angry when we recommended it was safer to reschedule at a later date, after testing returned and pt's symptoms were improved, though she did eventually agreed to this. it turns out her test came back for COVID and her symptoms got worse in the next 1 week after this. also 2 - 3 weeks prior to the national shutdown and prior to our facility having an improved system in place for temperature checks and univeral face masking, I had 2 challenging patients in my outpatient clinic. the 1st pt, a 23 yo male with URI and much coughing (he did not follow the recommendations for self isolation) and came for an EMG and another pt who had severe pain and temperature of 102 that were seen in our clinic (the latter pt ended up being hospitalized that day). given the lack of access to rapid testing in the beginning of the pandemic and it was difficult to tell initially if my staff or I were exposed to the virus during our interaction with these patients.
144	procedures being cancelled-limits ability to deliver care
147	limited evaluation may lead to insufficient and ineffective care.
151	Having to do video visits because of some technical difficulty at times setting them up
153	Lower patient volume
155	Requirement for some patients to followup in order to do pill count, UDS, etc
156	maintaining cash flow during the time of severely limited in office visits... no patients, no income.
159	Let's face it telemedicine is a crappy substitute for a physical exam and elderly people can't do it anyway. You can't do emg over telemedicine unless you are a true fraudster ! It was tough working when I wasn't feeling well. Admin wants us to be busy - there's a real disconnect from the c suite
163	patients' fear
165	Patients fear of coming to clinic, reduced referrals due to reduced PCP appointments in the community so low census
168	Making patients feel comfortable
170	Staffing has my biggest challenge.
171	The superficial physical exam
173	Support staff have been less reliable as they have been affected stress. Chronically working short handed

ResponseID	Response
179	Getting patients in the region to understand the pandemic is real and eating masks is necessary.
181	Decreased revenue
182	No physical exam
184	Reduced referral volume. Patients refusing telemedicine and preferring to delay for in person visits
188	community dissemination, testing, and PPE
189	Sanitizing the exam room between patients as I now have only one exam room
190	Patients are not wanting to go to physical therapy
191	Maintaining mask wearing requirements
192	Significant number of telemedicine calls initially. Unable to examine patients to assist with treatment plan. Now most are again in person visits
193	not having N95s for EMGs
194	Scheduling procedures
195	Unable to see new patients in the office. Tried some by telemed but this was challenging
202	Having too much time dedicated to Telehealth and not many patients agreeing to have their care managed with a Telehealth visit.
205	telemedicine limits important neuro exam
207	Meeting the needs of referrals has been the biggest challenge.
212	Access to supply and facilities, loss of referrals
213	Cancellation, unsure about billing changes, unable to do procedures since patients prefers not to do injections and come in for doctors visit due to copay or lost their insurance, jobs etc.
216	referrals working less, fear of pts coming in to the office
217	Responding to the increase in patients messages/phone calls/emails because more patients are inactive, at home, and have more time to "live in their pain"
219	Limiting in-person clinic volume, maintaining precautions and social distancing

ResponseID	Response
227	Decrease the number of patients
228	Lost video conferences, poor wifi of patient, dropped calls/visits. Inability to do physical exam virtually for most MSK issues.
230	Patients do not understand safety needs. Administration wants to accommodate patients. Patients first over staff safety.
232	see patients in person
233	I have had to take careful measures for the approach to the consultation and the patients are satisfied and accept the new system with pleasure
234	Burn-out from so much screen time on the computer. We already were facing this burden with documentation prior to the pandemic, and now with so much telehealth, virtual conferences, dept/staff meetings, etc, it has gotten worse. While I liked telehealth prior to the pandemic and still think there is a role for it, there is still much improvement needed to make it more efficient and effective (e.g. physicians shouldn't have to deal with troubleshooting why patients/families cannot access the telehealth visit or why their video isn't working, there needs to be more efficient ways to demonstrate physical exam maneuvers via telehealth such as little avatars that demonstrate the maneuver - I have been either verbally instructing patients/families or demonstrating exam maneuvers on myself to have patients do it but even then, often have to correct their exam maneuver frequently). In addition, there are even more emails than ever to keep up with regarding updates with the pandemic and new guidelines constantly being released or news to keep up with the virus.
236	PPE- shortages, acquisitions, getting staff to mask around each other when supervision not around
240	Connectivity, Variable patient access and load on limited servers on our side to handle video visits by multiple doctors and staff.
242	Safely bringing in patients. I have had to limit the staff exposure to patients to make sure they have a safe work environment and have had to then do a lot more of my own data entry. I believe telemed visits are a good screening tool prior to bringing patients into the office for their physical examinations. I do believe though that nothing replaces a good physical exam.
247	they didnt want to get out of home
252	Making sure patients were compliant in wearing masks.

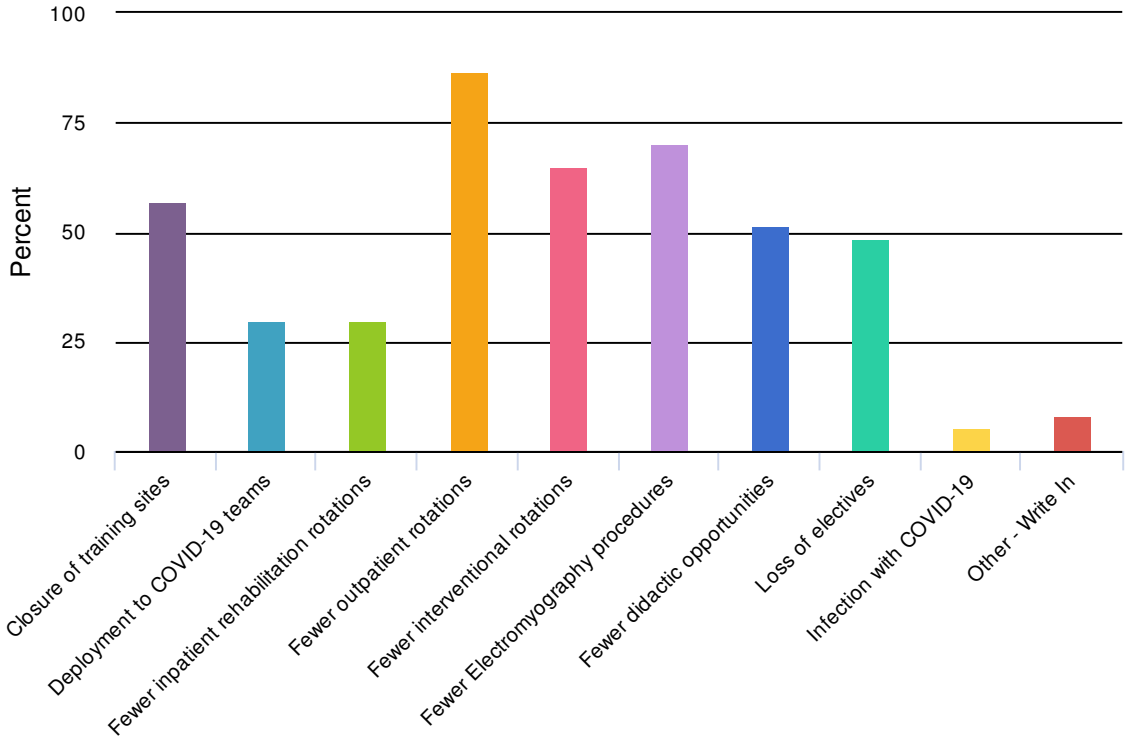
38. Since the COVID-19 outbreak, what type of setting have you worked in? Select all that apply.



Value	Percent	Responses
Inpatient Rehabilitation	84.2%	32
Inpatient Medicine	39.5%	15
Emergency Medicine	10.5%	4
Outpatient Rehabilitation	81.6%	31
Telemedicine	73.7%	28
Other - Write In	2.6%	1

Other - Write In	Count
Rehabilitation Consults	1
Totals	1

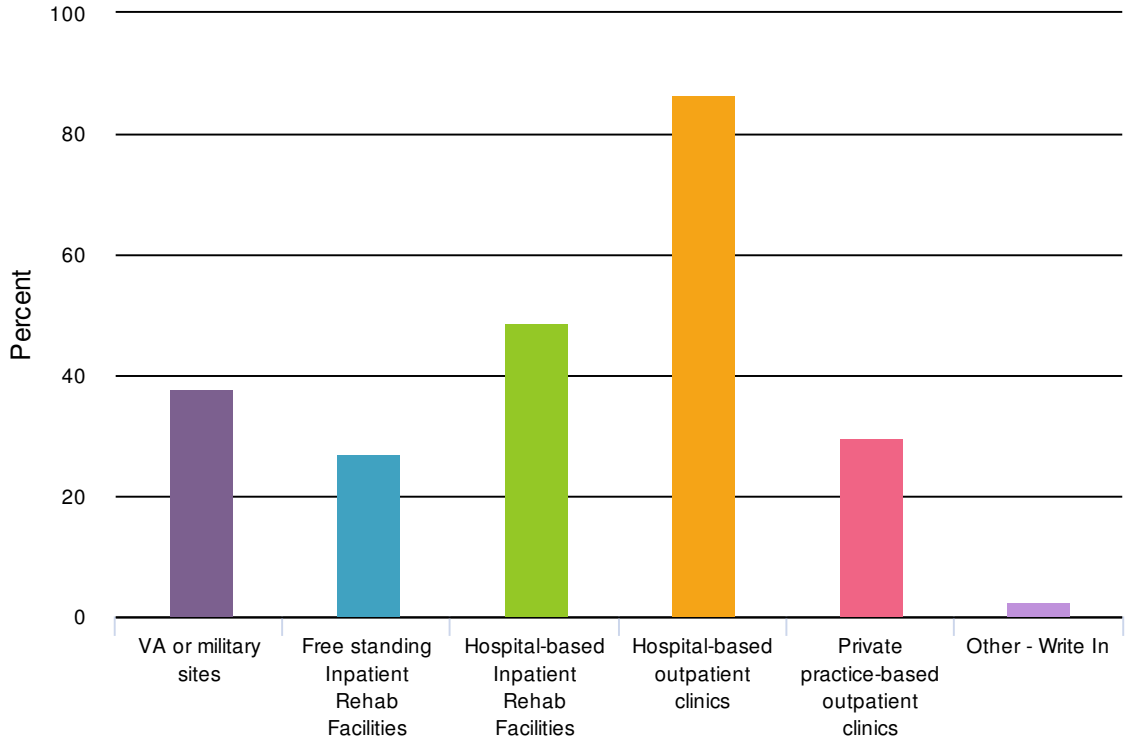
39. How was your training interrupted by the COVID-19 pandemic? Select all that apply.



Value	Percent	Responses
Closure of training sites	56.8%	21
Deployment to COVID-19 teams	29.7%	11
Fewer inpatient rehabilitation rotations	29.7%	11
Fewer outpatient rotations	86.5%	32
Fewer interventional rotations	64.9%	24
Fewer Electromyography procedures	70.3%	26
Fewer didactic opportunities	51.4%	19
Loss of electives	48.6%	18
Infection with COVID-19	5.4%	2
Other - Write In	8.1%	3

Other - Write In	Count
Fewer patients	1
Increased personal stress / family worry	1
Longer work hours with sicker rehab patients on inpatient rotations	1
Totals	3

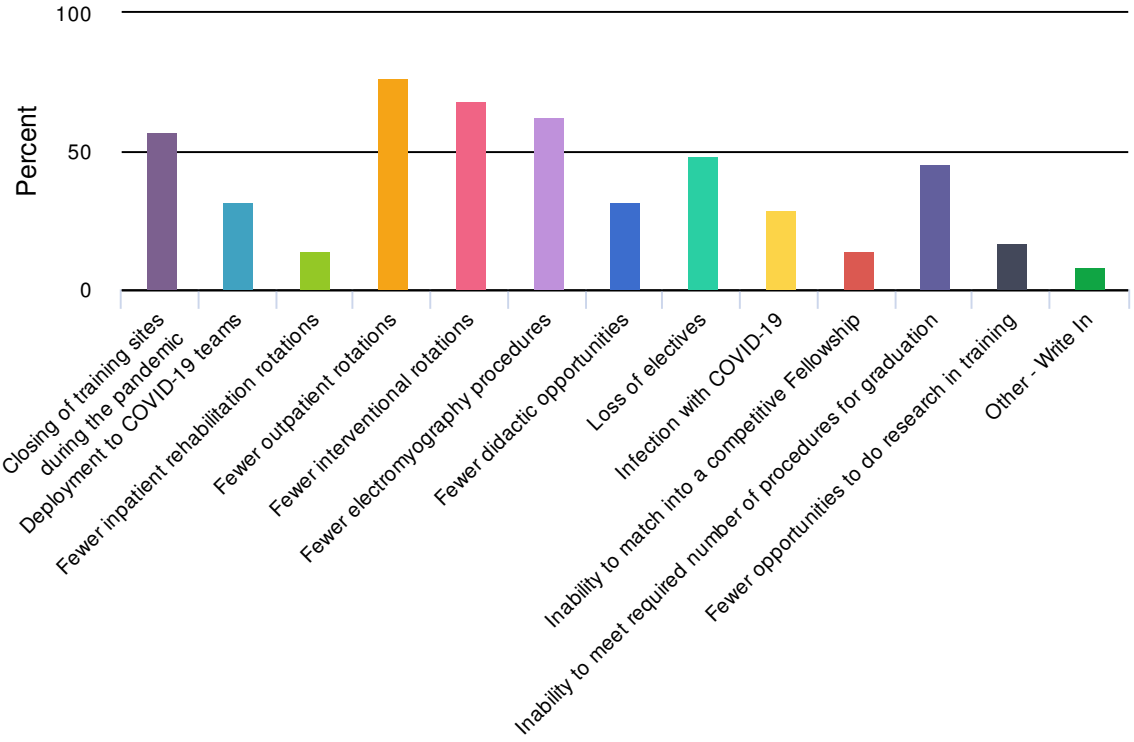
40. Which training sites were most affected by the COVID-19 pandemic? Select all that apply.



Value	Percent	Responses
VA or military sites	37.8%	14
Free standing Inpatient Rehab Facilities	27.0%	10
Hospital-based Inpatient Rehab Facilities	48.6%	18
Hospital-based outpatient clinics	86.5%	32
Private practice-based outpatient clinics	29.7%	11
Other - Write In	2.7%	1

Other - Write In	Count
university-based clinics	1
Totals	1

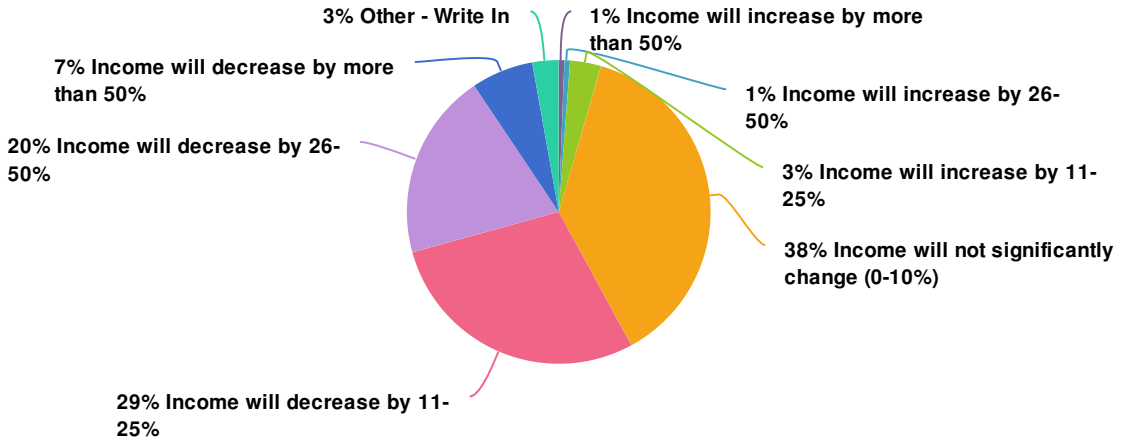
41. What concerns you regarding the consequences of COVID-19 pandemic on your training? Select all that apply.



Value	Percent	Responses
Closing of training sites during the pandemic	57.1%	20
Deployment to COVID-19 teams	31.4%	11
Fewer inpatient rehabilitation rotations	14.3%	5
Fewer outpatient rotations	77.1%	27
Fewer interventional rotations	68.6%	24
Fewer electromyography procedures	62.9%	22
Fewer didactic opportunities	31.4%	11
Loss of electives	48.6%	17
Infection with COVID-19	28.6%	10
Inability to match into a competitive Fellowship	14.3%	5
Inability to meet required number of procedures for graduation	45.7%	16
Fewer opportunities to do research in training	17.1%	6
Other - Write In	8.6%	3

Other - Write In	Count
Fewer opportunities for court side sports training, loss of US training	1
Loss of training opportunities at the end of residency	1
Trouble finding a job	1
Totals	3

42. To what extent do you anticipate that your annual income will be impacted this year by the COVID- 19 pandemic?



Value	Percent	Responses
Income will increase by more than 50%	0.6%	1
Income will increase by 26-50%	0.6%	1
Income will increase by 11-25%	3.3%	6
Income will not significantly change (0-10%)	37.6%	68
Income will decrease by 11-25%	28.7%	52
Income will decrease by 26-50%	19.9%	36
Income will decrease by more than 50%	6.6%	12
Other - Write In	2.8%	5

Totals: 181

Other - Write In	Count
100% decrease	1
I worked very hard and was under compensated to pay for those who did not work.	1
Just started new role as an attending physician so do not anticipate my salary will be impacted since my contract was negotiated and signed during the pandemic	1
No change	1
employee-don't know	1
Totals	5

43. Is there anything you feel Physiatry added in your hospital or practice setting during the surge that was essential or unique (i.e. recharge rooms, meditation services, etc.)

ResponseID	Response
8	n/a
11	No
13	Encourages self treatment for those who did not want to go to physical therapy or to in person visits with me. Focus especially included thoracic and respiratory techniques in the face of COVID.
15	Took more patients and sicker patients. I did a whole second job for 5 months
16	Nope
18	yes
19	No
20	No
21	Physiatrist was key to coordinating a dedicated COVID-19 unit as well as logistics relating to patient care. Increased psychology services for patients/families/staffs.
23	No.
24	No
27	N/a

ResponseID	Response
28	No
31	Chest therapy and proning
33	Nothing, in fact the hospital took one half of the beds from the rehab unit for one month and placed acute care (non covid) patients there
34	No
39	Ability to do Post-COVID clinics. This interdisciplinary practice model was much appreciated by our hospital system.
40	Not really
41	Physiatry remains an under-positioned speciality.
42	no
46	Medical cannabis
49	Daily huddle meetings
52	They made us all feel safe by adding PPE's for everyone even the non clinical staff. That showed inclusion and respect.
57	we carried the terrible load of an acute hospital that emptied out very sick and medical complex patients with insufficient staff and a skeleton crew of physicians that suffered dearly.
58	No
59	I thinl we provided extra help where needed on the acute side which relieved stress as well as a sounding board for discussions on how to handle the COVID-19 situation
61	No
63	No
65	no
66	a six week zoom meeting/class with physicians and psychiatry on different coping and self care topics
67	No
69	.

ResponseID	Response
70	Our rehab program moved into a new hospital earlier than planned to offload the acute hospital, freeing beds for COVID units. We also accepted all the rehab inpatients from another hospital (Jackson North) to enable that hospital to convert their rehab unit to a COVID unit during the surge here in Miami.
72	Telehealth follow up visits for spinal cord patients were very beneficial for the patients and need to continue. Patients need to be able to continue to do Telehealth from their homes and we need to be able to get reimbursement equivalent to in person visits.
74	No.
75	No. Also, WTF is a recharge room? Our hospital is going broke and no services that fail to make money are going to float.
79	No
81	We are planning to add a relaxation room but have not yet implemented this
82	nothing new. Physiatry turned into an IM service to care for medically compromised patients who could not or would not go to SNF
83	people still got hurt and sick
84	Physiatry lobbied for direct patient care and fought to not delay care for patients in urgent need.
85	No
87	Our residency program gave us $25 gift cards to order take-out food since we were not getting breakfast at our didactic sessions in person.
88	I did not want to be in
90	We were an asset on the consult service due many patients suffering from disorders of consciousness or impairments due to prolonged hospitalization and/or intubation.
92	I am not aware of resources available.
94	continued care of pain patients via telemedicine was key
96	We had very little COVID19 in our state this spring. We are beginning to experience a surge now.
97	No
98	More PPE
100	Physiatry helped COVID patients recover sooner.

ResponseID	Response
101	We added designated Covid floors where we had an attending-resident team that met regularly with other members of the unit to assist with determining appropriate rehab needs and dispo. We also created a video exercise program with various levels of intensity that runs 24/7 on a hospital TV channel for patients who can self direct their rehab.
102	Nothing
103	Ability to find alternative and flexible solutions for patients. Physiatry is used to working with team members from other disciplines and be creative in providing care. We also spend more time looking at patient's function and factor in all aspects that may affect that: socioemotional, economic, family/friend support, etc.
105	daily zoom meetings from the incident command center systemwide with updates initially. than QOD, now weekly and changing to monthly next month
107	NA freestanding
108	Rehab to post-COVID patients. The deconditioning element, on top of cardiovascular effects, has been a big issue for survivors
110	No
111	We had beds that we could have given to acute COVID patients but they weren't needed.
112	N/A
113	Reduced in house call hours, increased ability to complete work off site
115	free snacks
116	None
118	Proning ICU patients
119	no
121	care coordination, discharge planning
122	no
124	None
126	Not really in children's hospitals, or at least in my children's hospital

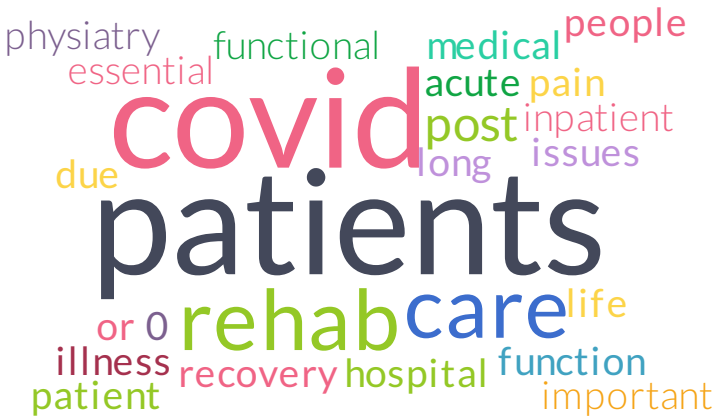
ResponseID	Response
127	Listing of resources for wellness related to COVID-19 was distributed to faculty and residents/fellows within my department
130	Practice closing
131	Meditation services
133	Rehab for critical patients
136	Our recreation therapists provided activities that were helpful to pts across the hospital. Our assistive technology therapists helped set up the approval WiFi and iPads so it's could talk to families. Colleagues in other departments were amazed at the resources our therapists (pt/ot: all too) added. We also helped bring in an interdisciplinary approach, which seemed new to our colleagues
137	Better understanding of how critical care patients can have disability
139	I worked in different hospital IRFs. Hospitals that provided PPE (N95) were the most helpful. I didn't see any extra services.
141	Wound debridement
143	No
144	no
145	took over a dinner room and placed extra hospital beds in preparation for a surge
147	limited access to procedures
150	Covid recover clinic/program
151	We did COVID screening calls and helped staff the hospital during the surge
152	no
153	No
155	Screening questions and cleaning procedures
156	-maintaining patient's pain control during a time of limited patient contact providing treatments necessary for our patient's pain complaints
159	I'm doing a lot of COVID recovery and long hauler work.
160	manejo a pacientes no COVID

ResponseID	Response
161	We started a covid consult service to see which covid patients would benefit from inpatient rehabilitation after they recovered from covid.
163	n/a
164	I collaborates with Case Management and Rehab (OT/PT) on strategies to get patients home from acute hospital.
165	n/a
166	No
168	No
169	Neuro evaluation, Disposition, assess function
170	medication renewals and keeping outpatients out of the hospital.
171	No
176	no
177	No
179	Rehab for patients that we're deconditioned after COVID.
180	No
181	No
182	Meditation
184	No
185	Our program did not add anything to assist
188	rehabilitation in post covid patients
189	All COVID patients receive a PT visit for chest PT and relaxation exercises
191	No
192	Telemedicine calls
194	Unfortunately No
195	Increased inpatient consults

ResponseID	Response
199	Telemedicine services to patient on Covid unit of our SNF and nonCoVID unit when physicians were not allowed in SNF's.
200	Recharge rooms, increased didactic time if on rotations with canceled procedures/clinics
201	We opened an acute COVID inpatient rehab floor for patients who were still but unsafe to discharge
202	An MSK urgent care run by physiatrists
204	PM&R service assisted with recommendations for discharge home for less acute patients in order to free up beds for potential surge.
205	not yet
206	Loss of nebulizer treatments. Streamline discharge instructions with family members Interaction with family members
209	correspondence alone was very helpful
210	-We assisted the ICU by having 2 PM&R residents as family liasons to help improve communication. -Research completed and now published on post covid outcomes
211	appropriate ventilation systems
212	No
213	Nothing.
216	no
218	Ability to document from home
223	Education on PPE
224	No, just manpower
225	Yes. As one of the few professions who stand up for the disabled as a minority, it was key that we continued to provide ESSENTIAL medical services throughout the entire pandemic, and ignore the implication that Physiatry is a "luxury" specialty. Our office has not missed a regular clinic day, fully staffed, to be available to assist our patients, Yet, despite the devotion by my entire staff, and their efforts to portray a strong front in implementing an example of adherence to the recommendations to limit the spread of COVID-19, we still lost one of our spinal cord patients during this pandemic. We will continue to do our best for all our patients, even with limited resources.
226	Rehabbing Covid patients

ResponseID	Response
228	Free Calm app for meditation and provided with laptops to be able to work from home if/when needed.
230	No
232	No
233	No
234	Not sure
236	No
238	education to other staff about disease process add to sense of calm during time of loss of control
241	Nope
242	no
245	no
247	no
249	No
251	No
252	No
253	N/A

44. How can physiatry frame itself as essential during and after pandemic?



ResponseID	Response
8	multiple residual deficits of covid patients- endurance, neuro residual, etc
11	Inpatient rehab, occupational medicine
13	We focus on function. We can address helping people maintain optimal function in isolation, and after being ill with COVID.
15	Have flexibility. We are doctors first and pmr second. I also had to care for adults.
16	Make the right diagnosis, avoid surgery, avoid hospitals.
18	Both covid and non-covid patients essentially need physiatry services.
19	?
20	Physiatry provides care for people with disabilities that is absolutely essential. Involvement with critically ill can minimize the long term effects of the illness.
21	can help off load patients from acute care hospitals and provide necessary rehabilitation care to help improve patient function.
22	During- helpful consultation to discharge to IPR to make more beds available for CIVID patients After- Rehabilitation of critically ill patients to regain independence and avoid readmission from complications associated with the infection
23	Promote personal wellness to get through acute illnesses. Education for impaired patients on how to avoid COVID-19.

ResponseID	Response
24	Stress our ability to manage conditions without surgery
27	Promote ARU for patients recovering from covid, aid in maintaining hospital throughput for patients transitioning to rehab, help with acute care patients as needed
28	Focus on recovery and aggressively promoting
30	Identify unique and long term needs for post covid patients, ie they take longer in the IRF than current RAND numbers would indicate due to having no codes for covid
31	post recovery care
32	Irf setting is best place for post-covid patients
33	Emphasize how physiatry is essential for improving quality of life
34	I don't no. I was the only one in my area aggressively trying to get back to doing EMG's
37	Post infection Rehabilitation
39	Helping at all levels of care where we are essential. We can see patients in acute care/ICU and ensure they have rehab. We can do EMGs and diagnose any neuromuscular issues. We can refer and care for them in IRF, LTAC, or SNF. We can follow up with them in the outpatient clinic setting to deal with any "long hauler" symptoms.
40	Increasing post covid functionality to the respective patients
42	there seems to have been a lot of critical illness myopathy and/or neuropathy resulting from this
46	Whole person oriented care
48	As a medical home for patients who have had complex medical course with functional impairments, to help people recover from illness and return to a full functioning life
49	Pediatric patients are not having as much long term effects as adults related to the pandemic but we are seeing an increase in violent injuries including abusive trauma/negligence and we have seen some MIS-C patients needing rehab. In summary, patients continue to have life altering diagnoses that require ongoing rehab.
52	Post Covid patients need rehabilitation to help with the deconditioning that happened with prolonged hospital stay. Help with strength building by getting them active again. Nutrition, skin healing with ambulation than immobility and even reduction in risks for DVT. Some need pulmonary rehab which will help with building and/ or managing pulmonary fibrosis. Helping with patients limited lung capacity, and building endurance is where rehab plays an important role.

ResponseID	Response
53	Covid pts clearly are at risk for significant functional impairment after the acute illness phase is over. We have an opportunity here to help pts manage these major functional changes, and to unburden an overstretched acute hospital system
56	Focus on a research base for understanding and treating the sequelae of so-called "long COVID" e.g. deconditioning, cardiopulmonary complications, neurocognitive deficits, cryptogenic stroke/?ongoing risk
57	good pulmonary rehab
58	No
59	By reminding people how broad an area of expertise we cover. Many of us are rehab, pain, and neurological specialists while still being capable of treating standard acute medical patients
61	Better and faster guidance on elective procedures next time. I think the societies were slow to give guidance
63	Emphasize our expertise on improving and returning function, pain management, and preventative measures for patients with long hospital/icu stays.
65	Yes , beacuse it is very important for the care of COVId patints
66	Key player in post covid rehab, Continuing to do the regular work we do
67	Open up to more inpatient rehabilitation for those affected by COVID
69	.
70	- Establish post-COVID comprehensive care clinics for those with persistent functional impairments - Help diagnose disabling conditions in the survivors, especially neurological issues - Partner with acute care hospitals in creating future emergency plans -
72	The sickest patients with COVID-19 really need Inpatient Rehab guided by a physiatrist. They have multi system issues and their rehab needs to be adjusted by a physiatrist to avoid further complications. In addition we need to do electrodiagnostic testing to evaluate pain, weakness, and numbness that the patients have due to critical illness myopathy and neuropathy.
74	Assisting with the recovery of individuals looking to regain their function and quality of life. We are essential for this.
75	Why? It either is or it isn't essential, it shouldn't need to be framed.
78	Studies on how physiatry reduces complications and readmisssions and how physiatry increases customer satisfaction with their medical care and followup.

ResponseID	Response
79	Could help patients with physical car and mental care.
81	Take a wholistic look and approach with our patients. Many of my patients are stressed, anxious and depressed which takes a toll on their physical health. We need to address all of their problems to best provide care to our patients.
82	The neurologic rehab of long haul COVID pts is an oppportunity to develop care plans and deliver both virtual and inperson rehab services
83	being able to address spine/msk care without procedures or surgery
84	We continue to be the physicians of function and education and will always be the best advocate for patient well being and maximal functioning.
85	In caring for the many physically deconditioned casualties of COVID-19, both in IPR and outpatient
86	its important that we become primary care for our patients.
87	Physiatrists are excellent at "thinking outside the box". We pride ourselves in returning patients to optimal function, whether that's after a devastating illness and prolonged hospitalization due to COVID-19 or after an athlete is unable to participate and train as usual and needs to return to high level training while avoiding or managing injuries.
88	Sell
90	We have a wide skill set to help manage a lot of the sequela of covid19. Peripheral nerve issues, cardiac and pulm rehab, general debility from prolonged hospitalizations, etc
92	Providing education on exercise and improving physical and general health functions including treatment and optimization of pain conditions, impairments and disabilities.
94	--continued care of outpatients for MSK and pain, virtual PT --special rehab needs post Covid for those who do inpatient work
95	Training on Inpatient Telehealth which is unique. Outpatient Telehealth does not prepare you for inpatient Telehealth.
96	I'm sure we will need to work with COVID19 patients with functional deficits when out of acute care
97	Yes. We are TEAM players
98	Follow up Covid 19 recovery
100	Physiatry can provide essential rehabilitation services in the acute care setting - as consultants providing titrated therapy services.

ResponseID	Response
101	By communicating with other services more and being decision makers determining when therapy is needed and in what setting(telehealth, video, in person) we can assist with quicker discharges and reduce readmission risk.
102	Available to meet patient demands in the long recovery process
103	Physiatry is able to address multiple aspects of patient's life besides just the pathology/diagnosis. A patient's overall well-being is reviewed and physiatrist uses multi-disciplinary approach to solving these issues.
105	As an outpatient service seeing virtual visits as appropriate for ongoing care
107	Mindful of COVID related seqeulea that may impact function
108	During = expertise on on managing post-ICU deconditioning, cardiovascular/pulmonary rehab focus. After = focus more on population health and "pre-hab" is keeping the population healthier
109	COVID patients are going to have functional limitations that need rehab.
110	I think it is as essential now as it was before the pandemic.
111	By doing research into after effects of the virus.
112	Managemtn of chronic Post-COvid sx
113	Patients who required extended hospital stays due to COVID-19 infection and related complications have significant medical and functional impairments that will require Physiatry specialization in order to help return to their prior functional levels.
115	substantial functional impairment and disability and prolonged recovery course in patients recovering from covid more so than with general debility after complex medical hospitalization not due to covid
116	Continued effective outpatient treatment prevents the need for more emergency room and inpatient treatment need.
117	Assist in decreasing length of stay thru care coordination and decisions regarding discharge location. Assist in transitions between services settings. Help in instruction in home cares/exercise for those not requiring hospitalization. Decrease burden on surgical specialties through symptom management if operations are postponed. Help in management of post-covid symptoms, or "long haulers" through clinic setting appointments.
118	Proning teams, post COVID follow up, inpatient rehab post covid

ResponseID	Response
119	For musculoskeletal care, we can help primary care with managing MSK symptoms. We will see more MSK complaints due to remote work and improper ergonomics. Also, we will continue to see rising pain complaints as pain is associated with depression and anxiety.
120	Address residual issues of "long haulers"
121	care coordination and discharge planning
122	Like any patient with prolonged and complicated illness, physiatry is essential to recovery. I always say we have the best job in the world. "The doctors in acute care saved your life but we will send you home."
124	Care for post COVID rehab needs.
125	Importance of rehab post ICU deconditioning for patients
126	Function as the providers in a step down setting for people with COVID who can not leave the hospital and can't go to an outside SNF
127	Demonstrate to others that we can accept patients with activity restrictions due to COVID-19 and improve them
131	As physicians we can at least offload and treat medically complex patients (not COVID) to relieve other physicians first. Debility is a major long term issue that physiatrists have more knowledge with.
133	Physiatry should be involved in the care of ICU patients
136	Keep getting the word out that exercise and nutrition are important. Tell the public what we do
137	We are the most equipped to evaluate the patients who have developed long term sequelae after hospitalization
138	Same as prior.
139	Allowing for closely monitored recovery of the COVID19 ill patients.
141	I do SCI. Essentially all the bad post-Covids look externally a lot like patients with incomplete tetraplegia: weakness, vent/trach weaning, dysphagia, wounds, contractures, pain, bowel and bladder incontinence. The cognitive changes look a lot like what TBI PM&R deals with. This is exactly what PM&R is trained to do: deal with complex, multi-faceted, high burden-of-care individuals and coordinate the village it takes to get through this. Therapy, psych, nursing, nutrition; training, equipment, transition home. There was no script for guiding patients and families through what to expect, but we're used to that, too.

ResponseID	Response
143	we have remained essential during this pandemic as we manage many patients with pain and do injections for those patients with significant pain and manage spinal issues that can be urgent or emergent and handle rehab needs for neuro/brain injury/trauma and even covid related rehab issues and have continued to do EMG's during this pandemic.
144	By being more flexible, nimble and adaptable to telemedicine. By being adopters of innovative ways to evaluate and engage with patients
145	to help look at the entire picture and help set the stage for what to tackle next in the road of recovery
147	no idea
150	Super important for the long haulers
151	Provide both in and out pt rehab for post COVID patients with impaired adls and mobility
153	Instill the need to still see patients to help treat their pain and to help keep them out of the emergency room and hospitals, so we can preserve bed space and essential supplies.
155	Patients in pain do not want to wait to get procedures months later or be denied medications to help with management of pain symptoms
156	1) physiatry can provide necessary in patient and out patient rehabilitation services for patients who have had severe deficits following COVID- 19 infection. 2) Physiatry is part of the medical service that provides continued pain management services during COVID- 19.
159	Well obviously we are all about recovery and reconditioning , I've been doing a lot of that kind of work
160	Debe estar simultaneamente atendiendo a los pacientes desde su ingreso para prevenir la discapacidad resultante en corto tiempo y lograr el retorno a sus AVD
161	All covid patients who are admitted will require at least some rehabilitation afterwards from decompensation from being hospitalized, cardiac or pulmonary issues depending on the severity of their illness.
162	Safe medical oversight for recovering patients who are off precautions
163	We treat deconditioning and muscle aches.
164	I honestly think many of us are not essential to a pandemic unless we're redeployed. We can help keep patients moving through the system and help with discharge strategies. There may also be a role for some recovering from severe COVID illnesses.
165	Important in order to manage quality of life and function of patients

ResponseID	Response
166	With covid, a growing population of patients are experiencing physical effects of critical illness, including myopathy and polyneuropathies. High quality rehab is essential in allowing these individuals to return to home.
168	Focusing on continuing good examinations and focused care
169	Assessing patient functional outcomes, neuro evaluation and disposition
170	keeping non-emergency patients and services out of the hospital.
176	Chronic pain treatment
177	Be present and helpful within the acute care hospital during surges
178	After acute phase of Illness, physiatry is essential in patient's recovery and functional return
179	Certainly essential in helping not only Covid patients that have suffered significant critical illness from the inpatient standpoint, but also reassuring those with MSK issues they can be worked up for acute on chronic pain using telemedicine and still receive adequate care.
180	I'm too tired to think of an answer this question/It's too soon to answer this question.
181	I assume medical care is essential.
182	Information about changes and n Medicare and Commercial payer Coding
185	COVID caused a number of sequela, namely debility, that hospitalized relatively young and healthy patients. Physiatry is essential in targeting this population as well as the more vulnerable populations to ensure musculoskeletal and cardiovascular recovery.
188	longer stays at the hospital lead to disability and functional changes. rehab specialist has a critical role in during and post syndrome
189	All hospitalized COVID patients need rehab . People working from home need ergonomic advice. I am seeing lots of periscapular pAim from poor biomechanics
191	Treating the whole patient not just systems approach
192	Not an issue in our practice
194	Can help moving patient out from the hospital more effectively
195	Medical and neuro rehab have been in demand. Improved wellness to decrease obesity as a risk factor for Covid
197	Need for recovery of function after major medical illness

ResponseID	Response
198	Accepting patients who did not want to go to skilled nursing facilities, or taking on patients when the hospital was not able to discharge to nursing facilities or other post acute care institutions. Helping patients recover post infection from stroke, critical illness myopathy, etc.
199	Debility amongst our elders! Helping to prevent and treat it. They aren't getting out and especially in SNF's becoming much weaker even if they didn't get CoVID
200	Remains essential for optimizing function and community/life re-integration for patients with and without COVID-19
201	Prevents morbidity from disease, may be important for new findings of myocarditis
202	Inpatient/outpatient COVID rehab, spasticity management, outpatient procedures and MSK Telehealth follow up.
204	We are the "exit door" for hospitals. Patients can come in, fill beds, overwhelm our IM colleagues, but sick patients can't "leave" the acute setting with assistance from the rehab team. The "entrance" to the hospital system has been hyper focused on historically and during Covid, but the "exit" is just as important. Covid creates the opportunity for the medical system to value our role in keeping the "flow through the exit doors" steady.... without us the entire system bottlenecks.
205	post acute care, lots of shoulder pathology, what is neuro effect and rehab needs post covid
206	Many physical deficits result from covid-19 infection other than loss of endurance. Some patients have vitamin deficiencies as consequence of altered appetite, etc
209	continue current efforts, broad and varied scope of practice
210	Rehab is a huge part of this - we knew there was going to be a big need for rehab! We can assist as we usually do in consultations, and not be stubborn in including unnecessary inperson visits, or having residents in person for no reason when there are other alternatives. It was scary to have decreases but it was not unique to us and we knew they would need to come to rehab after, so we would have our "time to shine" soon enough
211	long term sequela management especially impacting the neuro/musculoskletal systems
212	Tele rehab?
214	Post covid patients that are hospitalized need rehab services....going to iru once covid negative I did request forming a covid positive rehab unit Which was declined by the powers that be at my hospital
216	care for pain, disability in a less exposure facility. keep out of ER, urgicare, hospital

ResponseID	Response
217	Ability to provide care involving neurology/rheumatology/sports medicine/msk and allowing more patients to be seen and treated
218	Post covid recovery. Pulmonary therapy.
220	Playing a leading role in post-acute care of patients with COVID-19.
221	Rehabilitating patients after disuse myopathy from long ICU stay. Rehab of poor cardio pulmonary function after COVID 19
223	Community education on rehab after COVID
224	By transferring as much of the care to telemedicine and do follow up to their patients, when times calm down make up for the lost time for didactics
225	We can post data on how vulnerable our patient population is to this virus and similar illnesses. It is imperative that rehabilitation efforts persist in face of other cut-backs so that we aid our patients efforts to survive this pandemic.
226	We are rehabbing Covid patients. That is essential
228	Pulmonary rehab, lead in research regarding MSK or neurologic complications of the disease.
230	Provide easy experience of getting patients through rehab with comprehensive inpatient to outpatient journeys
232	same as always, need to return to full function
233	We will have an impact on the recovery of patients who have been hospitalized for a prolonged period to support their integration.
234	From a sports medicine perspective, I have been helping youth sports teams/organizations with return to practice/play/competition/travel protocols during the pandemic and educating them on the risks of COVID, including sequelae that non-medical people in the community may not know about, such as the cardiac manifestations we have seen in some athletes. This has been great to help build relationships and trust with youth sports organizations/teams and show them what the sports medicine side of PM&R can do.
236	Not sure
238	by addressing the long term consequences of this disease

ResponseID	Response
239	rehabilitation needs are always there. as a ramification of covid in people who were NOT ill, I am now seeing functional impairments and injuries associated with decline in function and limitation of function in elderly in particular from staying home during covid. ie, more falls, associated fractures, increased debility overall with decline in function, inability to care for self at home, etc. so we are essential before, during, AND after the pandemic and it is essential for us to emphasize maintaining access to care in the spectrum of rehabilitation settings- acute, subacute, and long term.
240	Physiatry practice covers a large area: assiting in patient disposition and stratification in hospitals, providing needed diagnosis. Patients with disability continue to have needs and issues unique to Physiatry Practice
241	Focus on rehab and prehab.
242	We will need to educate on cardiac and pulmonary rehab and injuries from COVID and will need to be integral in getting patients back to their prior level of function if possible.
244	We are experts on recovery after complex medical conditions. People need to recover some how and they need us to help guide that recovery.
245	They all need rehab. We have to show how we can offload the acute services to help with rehab and open beds
246	The significant debility associated with extended hospital stays for those severely affected by COVID-19 makes our specialty invaluable to the current and future pandemics. We should continue to raise awareness about how our specialty has made a significant contribution to those most severely affected.
247	with pos covid patients
249	Unsure
251	Improving patient function after a COVID illness, non-operative option for MSK and spine management when surgery is not possible
252	Importance to patients' quality of life.
253	People who get sick often have rehab needs (whether it's IPR vs pain management vs diagnostic evaluations)
255	The effects of the virus are not known long term but have been shown to cause functional declines acutely with likely lasting effects, and there is no other specialty trained and equipped for that. As people often say, "Surgeons (or critical care physicians in this case) may save their lives; we give them your lives back."
256	most patients coming out of COVID need rehab due to increased weakness, fatigue, decreased function.

45. What would you prefer to be called, if any term was available? - Text Analysis

No data to display