St. Louis Area Regional Response System (STARRS)
Healthcare Coalition
Healthcare Subcommittee
Regular Meeting

Meeting Details

DATE:	Wednesday, January 20, 2021	CONVENED: 0930 HRS	ADJOURNED: 1059 HRS
CHAIRS:	J. Campbell C. Minks		

Attendance

MEMBERS:	A. Spier	A. Blevins	E. Hooks	M. Tanton	J. O'Brien	E. Wondell
	H. Sandkuhl	H. Thomas	M. Leasure	R. Charney	S. Icenhower	V. Poston
	N. Corliss	D. Carver	T. Horton	J. Ryan	S. Pratt	
PARTNERS:	B. Zoref	D. Chambers	D. Lohner	A. Taylor	J. Nowak	J. Hauser
	B. Marler	M. Richard				
GUESTS:						

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Call to Order	Meeting called to order at 0930 hours by J. Campbell via Teams.	No further action required.
Meeting Objectives	J. Campbell shared January meeting objectives: 1. Review subcommittee membership roster and organizational representation; identify improvement opportunities 2. Review and approve 2021 Healthcare Subcommittee Goal Development Plan, including goal/project leaders and members 3. Discuss CY2021 subcommittee meeting model for regular business, leadership, and workgroups 4. Identify and approve CY2021 subcommittee liaison representatives 5. Update subcommittee members on coalition/regional initiatives and opportunities	**Objective Complete** **Objective Complete** **Objective Complete** Pending Completion **Objective Complete**
Meeting Minutes	Refer to **Attachment A** of meeting materials packet. C. Minks submitted draft meeting minutes from Wednesday, Nov 11, 2020 for review and approval. **Discussion** No discussion. **Recommendation** Approve as submitted, with members able to submit corrections or revisions by Friday, Jan 29. **Decision** A. Blevins motioned to approve; E. Hooks seconded. Minutes approved as submitted	Members to submit any revisions/edits to Chairs by COB Friday, Jan 29, 2021.

Attachment A

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Announcements		
Healthcare Subcommittee Scope and Focus	J. Campbell presented renewed Healthcare Subcommittee focus on healthcare sector initiatives and scoping of coalition support. <u>Focus</u> Network of healthcare sector partners cooperating to: - Facilitate constructive healthcare EM communication, programming, discussions, and outcomes - Strengthen organizational and industry preparedness - Provide regulatory/accreditation compliance solutions <u>Coalition Collaboration Role</u> Support Executive Healthcare Coalition Committee via: - Providing sector-specific expertise and guidance to regional interdisciplinary EM planning initiatives - Participating in regional training and exercise projects - Performance of healthcare EM roles and responsibilities, in accordance with applicable coalition plans and programs Out-of-Scope activities include: - St. Louis Medical Operations Center (SMOC) administration and management - Interdisciplinary regional strategic planning and coordination **<u>Discussion</u>** Members acknowledged understanding of renewed healthcare subcommittee mission and scope.	No further action required.
New Business		
CY2021 Subcommittee Membership Update	Refer to **Attachment B** of meeting materials packet. J. Campbell presented subcommittee membership overview and related charter definitions: - Currently approximately 50 organizations/agencies represented by ~ 80 individuals <u>Members</u> - Defined as representatives of healthcare organizations compliant with 50% attendance requirement - Healthcare organizations any CMS provider/facility type - Each member has 1 vote in subcommittee matters	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
CY2021 Subcommittee Membership Update cont.	- Healthcare organizations may have multiple member representatives Partners - Defined as representatives of non-healthcare organizations and agencies collaborating on St. Louis regional healthcare EM projects/initiatives - Includes healthcare organization representatives without minimum attendance requirements - Partners do not have voting privileges J. Campbell proposed a Charter revision/resolution to limit individual healthcare facilities, systems, and providers to 1 vote each. **Discussion** A. Blevins suggested establishing clear definitions for "healthcare system" and "hospital" prior to any Charter adjustments affecting vote allocation. **Recommendation** Establish Focus Team to develop Healthcare Subcommittee Charter membership definitions and vote allocation system. Focus Team members: - A. Blevins, J. O'Brien, C. Minks, J. Campbell, B. Zoref **Decision** Recommendation approved.	Focus Team to present draft definitions to members during next Subcommittee Meeting.

Membership Form	J. Campbell shared new electronic membership form designed to establish subcommittee representative "source of truth" and update communication directory.
	
	All current are new subcommittee members/partners are required to submit entries to refresh individual representative status.
	
	Form hyperlink: **Healthcare Subcommittee Membership Form**
	
	Form provides members and partners tool to easily update membership details, such as:
	
	- Organization, facility type, agency, and system affiliations
	- Individual contact information
	- Volunteer support skills/interest areas
	
	Current Status
	
	- 28 total entries
	  - 22 member healthcare organizations
	  - 6 partner agencies	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Membership Form cont.	- 17 individual subcommittee liaison volunteers - 17 workgroup volunteers **Discussion** No discussion. **Recommendation** Membership and partners submit membership form entries by Mar 31 to be included in initial data analysis. **Decision** Recommendation to be shared during next meeting.	Representatives submit individual membership form entries via **Healthcare Subcommittee Membership Form**.
CY2021 Goal Development Plan	Refer to **Attachment C** of meeting materials packet. J. Campbell submitted draft 2021 Goal Development Plan and facilitated review of goal details and associated objectives. Overview - 2021 Goal Development Plan is healthcare-sector specific workplan to advance four (4) distinct goals - Modeled from current Healthcare Coalition Strategic Improvement Plan Goals 1. Cultivate an inclusive healthcare subcommittee that is reflective of the St. Louis community and includes representation from all provider types. 2. Deliver healthcare/hospital outcomes defined in St. Louis Healthcare Coalition Strategic Plan. 3. Elevate healthcare subcommittee visibility & accountability via production of semiannual reports. 4. Optimize healthcare subcommittee management via revision/alignment of applicable Charters, Bylaws, & other administrative materials. **Discussion** J. O'Brien asked membership to help determine metrics to define goal and objective success. Goal 1 J. O'Brien emphasized need for regional cooperation and coordination with all healthcare partners, including representation from Missouri and Illinois organizations. B. Zoref agreed and clarified Illinois organizations are valuable partners, but not included within MO coalition/Region C grant scope. J. O'Brien recommended STARRS Healthcare Coalition and IL HOPE Coalition coordinate at least annually, to review mutual	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
CY2021 Goal Development Plan cont.	accomplishments, identify common challenges, and pursue shared solutions for regional preparedness. A. Blevins volunteered to serve as Goal 1 Leader. J. O'Brien volunteered to serve on Goal 1 Workgroup. <u>Goal 2</u> J. Campbell highlighted Goal 2 objectives are aligned to 3 distinct projects: - Objectives A-C focus on healthcare executive engagement with regional coalition - Objectives D-G focus on subcommittee membership interface/portal solution(s) - Objective H focuses on updating the communication directory J. Campbell clarified Goal 2 objectives related to senior leadership engagement with coalition are proactive, and not intended for COVID-19 regional incident analysis or corrective action. M. Tanton clarified "membership portal" context and confirmed description included both static information webpage and interface needs for membership. J. O'Brien recommended "packaging" objectives 2A-2G and volunteered to serve as Goal 2 Leader. V. Poston and D. Carver volunteered to serve on Goal 2 Workgroup. A. Blevins to incorporate objective 2H into Goal 1 scope and lead to completion. <u>Goal 3</u> J. Campbell volunteered to serve as Goal 3 Leader. A. Blevins, E. Hooks, and C. Minks volunteered to serve on Goal 3 Workgroup. <u>Goal 4</u> E. Hooks highlighted the personal and professional growth opportunities associated with administrative document management, and benefits to organizational and regional synergy as an outcome. Goal 4 leader still pending. E. Hooks, V. Poston, D. Carver, and B. Zoref volunteered to serve on Goal 4 Workgroup **<u>Recommendation</u>** Approve as revised, with goal leaders and workgroup members identified.	Chairs to coordinate with A. Blevins for Goal 1 initial meeting. Chairs to coordinate with J. O'Brien for Goal 2 initial meeting. Chairs to coordinate with workgroup members for Goal 3 initial meeting. Chairs to coordinate to identify member leader Goal 4, and partner with workgroup members for Goal 4 initial meeting.

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
CY2021 Goal Development Plan cont.	**Decision** S. Icenhower motioned to approve; V. Poston seconded. CY2021 Goal Development Plan approved as revised.	C. Minks and J. Campbell to update Goal Development Plan with applicable details.

CY2021 Meeting Model	Refer to **Attachment D** of meeting materials packet.
	
	C. Minks presented subcommittee meeting structure for CY 2021.
	
	Regular Meeting
	
	- Unchanged from previous occurrences
	  ○ Bimonthly; 2nd Wednesday from 0930 - 1100 hours
	
	- Focuses on normal business matters and discussions
	  ○ Project reports/updates
	  ○ T/E opportunities
	  ○ Regional partner highlights
	  ○ Regulatory/accreditation updates
	
	Workgroup Meeting
	
	- Occur at least monthly, with each workgroup leader determining specific meeting day/time occurrence
	
	- Focuses on project/objective management activities
	  ○ Progress updates and coordination
	  ○ Task performance and decision making
	
	Chair/HCC Meeting
	
	- Monthly meetings occurring 4th Wednesday from 1600 – 1700 hours
	
	- Focuses on subcommittee leadership, including goal trending, administration, minutes review, and overall management
	
	Discussion
	H. Sandkuhl verified voting on subcommittee administrative and operational materials only occurs during regular meetings. Workgroup and leadership meetings establishing only for program and project development.
	
	Recommendation
	Approve as submitted.
	
	Decision
	A. Blevins motioned to approve; D. Carver seconded.
	CY2021 Meeting Model approved as submitted
		J. Campbell to schedule monthly chairs meeting.
		
		Individual Goal Leaders to schedule monthly workgroup meetings.

Designated Subcommittee Liaisons	J. Campbell reviewed current status of Healthcare Subcommittee liaison appointments and representatives.	

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Designated Subcommittee Liaisons cont.	Team members reviewed liaison representative status for 6 subcommittees: - Mass Fatality - EMResource - Interoperable Communications - Training & Exercise (T&E) - Public Health - EMS **Discussion** Members discussed historical precedent of healthcare representatives on STARRS Mass Fatality Subcommittee, and agreed a liaison was still appropriate. D. Chambers recommended current liaisons representing other regional subcommittees to operation "two-directionally" to maximize coverage. Members agreed. Mass Fatality Coordinate with subcommittee leadership to identify potential representatives able to serve as liaison between teams. EMResource M. Tanton verified team still meeting routinely. A. Blevins volunteered to serve as EMResource Subcommittee liaison. Interoperable Communications B. Zoref confirmed team exists and still meeting, with B. Marler leading. T. Horton volunteered to serve as EMResource Subcommittee liaison. Training & Exercise (T&E) J. Campbell provided overview of T&E Subcommittee activities and experience as previous liaison representative, and indicated group was not developing or providing T&E opportunities/activities for the region. E. Hooks recommended reassessment of T&E subcommittee purpose, service, and scope prior to appointing a healthcare liaison representative. H. Sandkuhl and E. Hooks volunteered to coordinate with D. Chambers for T&E subcommittee review and output assessment.	Chairs and HCC coordinate to complete and provide update during next meeting. A. Blevins to provide update during next meeting. T. Horton to provide update during next meeting. D. Chambers, H. Sandkuhl, and E. Hooks to provide update during next meeting.

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Designated Subcommittee Liaisons cont.	<u>Public Health</u> T. Shaw volunteered to serve as Public Health Subcommittee liaison. <u>EMS</u> J. Nowak volunteered to serve as EMS Subcommittee liaison. J. Campbell inquired if any other regional subcommittee existed that may be supported with a healthcare representative. Members related all applicable subcommittees addressed.	 T. Shaw to provide update during next meeting. J. Nowak to provide update during next meeting. No additional action required.
Workgroup Reports		
Pediatric Surge Planning	M. Tanton reported Pediatric Surge Planning Workgroup met informally once in 2020 to coordinate pediatric-specific COVID-19 planning and response efforts. Membership remains stable with support from Missouri Hospital Association (MHA). M. Tanton volunteered to continue serving as Workgroup leader.	No further action required. M. Tanton to provide update during next meeting.
Cache Sustainment Planning	J. Campbell and B. Zoref reported Cache Sustainment Planning Workgroup has not met during 2020 due to COVID-19 response and recovery operations. J. Campbell recommended workgroup leaders coordinate to reassess project status and prioritization.	 B. Zoref and J. Campbell to coordinate and provide update during next meeting.
Coalition Partner Updates		
Public Health	J. Hauser reported Public Health Subcommittee reduced meeting frequency to allow individual jurisdictions opportunity to focus on COVID-19 response and recovery efforts. Public Health Subcommittee leaders are reviewing/updating membership roster in preparation for 2021 activities.	 T. Shaw and J. Hauser to provide sector update during next meeting.
Emergency Medical Services (EMS)	J. Nowak reported EMS Subcommittee reduced meeting frequency to allow individual jurisdictions opportunity to focus on COVID-19 response and recovery efforts. Next meeting scheduled Jan 20, with objective to develop 2021 goals. Pending EMS Subcommittee goals include: - Review, update, and expand 2021 membership roster - Update EMS cache resources and develop sustainment solutions	 J. Nowak to provide sector update during next meeting.
National Disaster Medical System (NDMS)	No report.	Designated partners to provide sector update during next meeting.

TOPIC Focus	DISCUSSION/RECOMMENDATION Analyze	ACTION ITEMS Develop
Emergency Management	No report.	Designated EM partners to provide sector update during next meeting.
Regional Initiatives		
Complex Coordinated Terrorist Attack (CCTA)	D. Chambers reported second CCTA policy workshop scheduled February 2021. CCTA Virtual Tabletop Exercise (TTX) Initial Planning Meeting (IPM) conducted Jan 19. TTX scheduled March 2021. TTX designed as first component of two-part progressive exercise series culminating in virtual Functional Exercise (FE) during Q2 2021. Exercise series to expand focus from initial response and incident stabilization to broader, mid-term challenges of command transition, fatality management, and reunification. Policy workshop and progressive exercise series completion to conclude CCTA grant activities.	D. Chambers to share final TTX materials with team. D. Chambers to provide update during next meeting.
Healthcare Coalition & SMOC	S. Icenhower reported previous and current Healthcare Coalition Committee Chairs met to coordinate transition and develop goals for 2021. Goals include membership review and bylaw/charter revisions. Next meeting scheduled Feb 19, 2021 at 0900 hours.	S. Icenhower and B. Zoref to provide coalition update during next meeting.
Training and Exercise		
T&E Subcommittee Report	No report.	D. Chambers, H. Sandkuhl, and E. Hooks to provide update during next meeting.
Organizational T&E Opportunities	A. Blevins reported Missouri State Emergency Management Agency (SEMA) 3rd Earthquake Summit is virtual, with webinars scheduled for February 2021. Details and resources accessible via this link. M. Tanton reported St. Louis Children's Hospital (SLCH) hosting MGT-439: Pediatric Disaster Response and Emergency Preparedness, tentatively scheduled from Sep 30 – Oct 1, 2021. Participants are limited to 30 total students. Additional details and registration instructions pending.	No further action required. M. Tanton to provide update during next meeting.
Healthcare Reimbursement Webinar	Refer to **Attachment E** of meeting materials packet. D. Chambers shared details for vendor "Healthcare Reimbursement Webinar". Course topics include federal funding sources, application assistance, and reporting compliance.	Interested members to notify D. Chambers for registration instructions.

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Grant Funding Programs		
ASPR: HPP and PHEP	D. Chambers reported Hospital Preparedness Program (HPP) funding applications and proposals are in development and due Jan 31. Notice of funding applications anticipated in Feb 2021. Federal partners are reconfiguring Coalition Surge Test (CST) exercise requirements; specific details/updates pending. No significant changes from 2020 are anticipated. B. Zoref reported updates to healthcare coalition regional response plan requirements. During 2021, coalitions are required to develop an Infectious Disease annex to supplement existing operational plans. Tentative deadline is Sep 2021.	D. Chambers to provide update during next meeting. B. Zoref to provide update during next meeting.
Open Discussion	No open discussion occurred.	
Action Item Review	J. Campbell reviewed action items from January meeting: <u>Membership</u> - Representatives submit individual membership form entries via **Healthcare Subcommittee Membership Form**. <u>Goal Development</u> - Chairs update Goal Development Plan (GDP) with team leaders and members - Identify Goal 4 leader - Chairs coordinate with goal leaders for initial workgroup meetings. <u>Liaison Representatives</u> - Update roster with subcommittee liaison volunteers - Identify Mass Fatality Subcommittee liaison - Coordinate with partners to reassess T&E Subcommittee purpose and healthcare representation <u>Intake and Report Submission</u> - Develop electronic report submission process	
Next Meeting	Wednesday, March 10, 2021 0930 – 1100 hours Microsoft Teams – *link pending*	J. Campbell to schedule meeting accordingly.
Adjournment	J. Campbell adjourned the meeting at 1059 hours	No further action required

Respectfully submitted,

Jason Campbell
Chair
STARRS Healthcare Subcommittee

Attachment A

STARRS Healthcare Subcommittee
2021 Goal Development Workplan

Goal 1	Cultivate an inclusive healthcare subcommittee that is reflective of the St. Louis community and includes representation from all provider/facility types.				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 1A	Coordinate with local/state partners to identify applicable healthcare organizations and facilities within subcommittee geographic scope.	31-May	A. Blevins	26 - 50%	J. Whitaker preparing list of CMS providers/facilities within STARRS geographic area.
Objective 1B	Review, verify, and update current subcommittee membership roster.	31-May	A. Blevins	26 - 50%	J. Campbell to provide membership details submitted via form during next Goal 1 meeting.
Objective 1C	Develop healthcare subcommittee one-page summary sheet with membership responsibilities, benefits, enrollment details, and FAQs.	31-May	A. Blevins	0 - 25%	
Objective 1D	Distribute subcommittee summary sheet to all eligible healthcare organizations.	30-Jun	A. Blevins	0 - 25%	
Objective 1E	Monitor membership expansion and healthcare facility representation; revise strategy for Goal 1 achievement if/as required.	31-Dec	A. Blevins	0 - 25%	
Objective 1F	Update contact information for all current and new subcommittee members.	30-Jun	A. Blevins	26 - 50%	J. Campbell to provide membership details submitted via form during next Goal 1 meeting.

Goal 2	Deliver healthcare/hospital outcomes defined in St. Louis Healthcare Coalition Strategic Plan.				
	Description	Deadline	Workgroup Leader	Completion	Notes
Objective 2A	Develop and distribute electronic survey to determine and rank specific membership portal needs/features.	31-May	J. O'Brien	0 - 25%	
Objective 2B	Analyze and report membership portal survey results within during May meeting.	30-Jun	J. O'Brien	0 - 25%	
Objective 2C	Identify potential portal solutions that support/resolve critical needs, as defined by survey results.	30-Jun	J. O'Brien	0 - 25%	
Objective 2D	Establish portal solution for subcommittee membership and verify resolution of critical gaps.	30-Sep	J. O'Brien	0 - 25%	

STARRS Healthcare Subcommittee
2021 Goal Development Workplan

Goal 3	Elevate healthcare subcommittee visibility and accountability via production of semiannual reports.				
	Description	**Deadline**	**Assigned Group/Leader**	**Completion**	**Notes**
Objective 3A	Coordinate with HCC Coordinator and partner subcommittee chairs to identify content/data to maximize report utility and relevance.	31-May	J. Campbell	26 - 50%	
Objective 3B	Develop DRAFT report outline and dashboard for review/approval by appropriate regional partners/leaders.	31-May	J. Campbell	0 - 25%	
Objective 3C	Distribute initial subcommittee report to full membership and designated partner recipients.	30-Jun	J. Campbell	0 - 25%	
Objective 3D	Incorporate applicable report revisions/improvements and distribute annual report to all recipients.	31-Dec	J. Campbell	0 - 25%	

Goal 4	Optimize healthcare subcommittee management via revision/alignment of applicable Charters, Bylaws, and other administrative materials.				
	Description	**Deadline**	**Assigned Group/Leader**	**Completion**	**Notes**
Objective 4A	Verify all applicable documents are included in subcommittee review/revision scope.	30-Jun	C. Minks	0 - 25%	
Objective 4B	Review current subcommittee Charter; document recommended edits and submit revised version to subcommittee for review/approval.	30-Jun	C. Minks	0 - 25%	
Objective 4C	Coordinate with HCC Coordinator and ESF-8 Committee Chairs to strengthen alignment of approved Healthcare Subcommittee Charter with applicable coalition/STARRS administrative documents; support revision as appropriate.	30-Sep	C. Minks	0 - 25%	
Objective 4D	Verify all applicable coalition and healthcare subcommittee management materials are aligned for optimal administrative coordination for upcoming year.	31-Dec	C. Minks	0 - 25%	

The Express: February 2021

This issue of *The Express* highlights the following new resources:

- Planning Considerations for Monoclonal Antibody Administration
- Identifying and Overcoming Healthcare Communications Vulnerabilities: Nashville, TN
- Infection Prevention and Control (IPC) and Environmental Health and Safety for COVID-19 Isolation and Quarantine Hotels
- Cybersecurity Resource and Upcoming Webinar
- Southeast Michigan 2020 COVID-19 Lessons Learned

We are thinking of our stakeholders in states hard hit by winter storms. Please refer to the recently updated HHS emPOWER Program for guidance on protecting the health of individuals who live independently and rely on electricity-dependent durable medical and assistive equipment and devices, and/or essential healthcare services. The article Going with No Flow: Coping with Hospital Water Supply Issues and resources in the Lessons Learned: Extreme Cold and Plans, Tools, and Templates: Extreme Cold sections of our Natural Disasters Topic Collection may also be helpful.

Please continue to access our Novel Coronavirus Resources Page, the National

Attachment C

Institutes of Health Coronavirus Disease 2019 (COVID-19) Treatment Guidelines, and CDC's Coronavirus webpage, and reach out if you need technical assistance.

New: Planning Considerations for Monoclonal Antibody Administration

This tip sheet describes monoclonal antibody therapy for COVID-19 patients and highlights considerations for providers and for planning and allocation. The ASPR TRACIE presentation on Michigan's Approach to Administration of Monoclonal Antibody Treatment and the ASPR NDMS Monoclonal Antibody Infusion Information Material (available on TRAIN.org) contain related information.

New: Identifying and Overcoming Healthcare Communications Vulnerabilities: Nashville, TN

While the Christmas morning recreational vehicle blast outside the AT&T transmission facility in Nashville did not cause a mass fatality incident, it significantly impacted healthcare communications throughout the region. This article describes the impacts, lessons learned, strengths, and challenges faced by two professionals with different perspectives of the Nashville healthcare system.

New: Infection Prevention and Control (IPC) and Environmental Health and Safety for COVID-19 Isolation and Quarantine Hotels (Webinar)

The speakers in this webinar highlight how they prepared for, selected, and maintained operations and safety at hotels set aside to treat clients in COVID-19 quarantine and isolation (this document contains more information). Access the rest of the Healthcare Operations During the COVID-19 Pandemic speaker series for related recordings.

Southeast Michigan 2020 COVID-19 Lessons Learned

This document describes the role of two Michigan trauma regions during the first months of the COVID-19 pandemic. It can also be found on ASPR TRACIE's COVID-19 Regional Support Resources pages.

Register Today! Healthcare System Cybersecurity Response: Experiences and Considerations Webinar

This webinar (March 18, 1:30-2:45 PM ET) will feature presenters discussing their experiences and lessons learned from recent cybersecurity incidents. It builds upon our recently released Healthcare System Cybersecurity: Readiness and Response Considerations document and accompanying overview presentation that walks readers through the resource. **Register today**!

Save the Date: Association of Healthcare Emergency Preparedness Professionals (AHEPP) Annual Virtual Conference

Check out the agenda for this year's AHEPP conference and join ASPR TRACIE on March 2, at 1:10 PM ET for our panel on Patient Distribution Issues and Strategies During COVID-19.

Subscribe to the Division of Critical Infrastructure Protection's Bulletins

ASPR's Division of Critical Infrastructure Protection (CIP) offers a variety of bulletins to keep stakeholders informed during emergency response and steady state. These bulletins inform stakeholders about the most significant issues facing the Healthcare and Public Health Sector including cybersecurity, medical supply chains, COVID-19, and more. If you are interested in receiving CIP bulletins, visit the CIP bulletins subscription webpage.

COVID-19 Clinical Rounds Peer-to-Peer Virtual Communities of Practice are a collaborative effort between ASPR, the National Emerging Special Pathogens Training and Education Center (NETEC), and Project ECHO. These interactive virtual learning sessions aim to create a peer-to-peer learning network where clinicians from the U.S. and abroad who have experience treating patients with COVID-19 share their challenges and successes; a generous amount of time for participant Q & A is also provided. Access previous webinars and special topic sessions and sign up today to receive information on upcoming events.

U.S. Department of Health & Human Services,
Office of the Assistant Secretary for Preparedness & Response
200 C Street, SW Washington, DC 20024

Attachment C

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Designated COVID-19 Hospitals:
Case Studies and Lessons Learned

Health systems and communities across the U.S. have implemented innovative approaches to respond to the COVID-19 pandemic. One strategy has been to designate a facility within the system or area to exclusively treat confirmed COVID-19 patients. This designation may "help standardize care, optimize resource utilization, and protect non-COVID-19 patients and healthcare workers."[1]

Between September 9, 2020 and October 20, 2020, the ASPR TRACIE team interviewed decision makers and lead physicians at four designated COVID-19 hospitals. The interviews focused on the facilities' decision-making processes, operations and logistics (space, staff, stuff), and general lessons learned. These facilities were already operational or existing hospitals; they were not "Alternate Care Sites." Additionally, the entire facility was designated to solely treat COVID-19 positive patients; all other patients were transferred or directed to nearby hospitals.

1 Moulick, A., Kilcoyne, M., Do-Nguyen, C.C., and Stevens, R. (2020). The Case for Designated COVID-19 Hospitals. CTS Net.

This document does not discuss the pros and cons of designating a COVID-19 hospital. There was unanimous agreement among the facilities interviewed that designating one hospital within the health system or community was ideal for their circumstances and helped focus COVID-19 care and expertise, personal protective equipment (PPE), and processes/standardized care in one location. It is important to note, however, that this model was applied when a healthcare system had multiple hospitals in a geographic area and could ensure that others could provide emergency and other services without risk to the community. The volume of COVID-19 cases also needed to be high enough to justify continued dedication of the facility. **The following summary of the lessons learned and key planning considerations are relevant to all hospitals designating units for COVID-19 care.**

I. Site Selection

Typically, a designated hospital within the system or community naturally stood out as ideal due to its:

- Location: Interviewees selected sites that were centrally located or easy to transfer COVID-19 positive patients to from other hospitals, were located near numerous post-acute care facilities, or typically served a population at high-risk for COVID-19 complications.
- Existing services provided, patient census/acuity: Sites selected by interviewees already had a robust on-site infectious disease services including lab, and/or they were able to transfer patients more easily to other hospitals due to lower census or lower acuity patients admitted.
- Existing infrastructure: Interviewees considered sites that were able to easily repurpose/reconfigure the existing layout to treat COVID-19 patients, or had recently updated systems/equipment (e.g., ventilation).

II. Coordination of Care

These considerations focus on patient transfers and coordination of care within the health system. Note that none of the facilities interviewed accepted patients transferred from outside of their system. Examples of how interviewees coordinated care include:

- Patient transfer evaluations from another site to the hospital were done over multiple phone calls with a COVID hospitalist. Facilities assigned a hospitalist as the consultant for each case and once the patient was diagnosed COVID positive, they would be transferred to the hospital. Cases were kept within the health system except pediatric critical patients or cases requiring extracorporeal membrane oxygenation (ECMO).
- All transfers required communication to the transport team and the receiving facility to notify them of confirmed COVID-19 status, allowing for necessary infection control procedures.
  - Facilities did not transfer COVID unknowns; these patients were kept as persons under investigation (PUIs) until test results were complete.
- The hospital established and required transfer criteria to be followed.
  - Transfer Criteria/ Inclusion Criteria:
    - Laboratory evidence of acute infection with pandemic virus (e.g., COVID-19 positive RT-PCR from respiratory specimen)
    - Expected length of stay >24 hours
    - Expected survival >24 hours
    - Medically stable for transfer
    - Medical Orders for Life-Sustaining Treatment/ Healthcare Proxies (MOLST/HCP) required to be in medical record prior to transfer
  - Exclusion Criteria:
    - Patient requires an urgent/emergent procedure or study unavailable at the designated COVID-19 hospital (e.g., cardiac catheterization, ECMO, hypothermia protocol)
    - Age – some COVID facilities only accepted adult patients

We closed on a Thursday, terminally cleaned the hospital, then built/created this COVID-only hospital in 10 days. We did not open an emergency room and only allowed direct admits from hospitals within our healthcare system.

III. Space

All the facilities interviewed had to reconfigure or build out within their current space and install new equipment to safely care for patients. The degree to which this occurred and the related timeframe varied depending on the existing infrastructure.

- One interviewee took these steps to reconfigure a four-floor hospital:
  - Turned existing 21-bed intensive care unit (ICU) into all negative pressure. This unit was on the top floor of the hospital and able to be segregated from the rest of the hospital. This unit is still operational now that the hospital is fully open to both COVID-19 positive and non-COVID patients.
  - Created a secondary ICU in the Emergency Department (ED), which was recently remodeled with the ability to convert to negative pressure.
  - Converted to COVID-only in phases. Initially started with the fourth floor and then to the third floor, etc. At the end, all inpatient rooms were transformed to negative pressure rooms.
  - Designated one room in each unit as a staff break room to increase space available for staff to maintain social distance while eating.
  - Designated one unit solely as on-call or shower rooms for hospital personnel.
  - Created equipment rooms from scratch each time a new unit was developed so supplies were inside the isolation area.
- One system used a long-term acute care facility as the COVID-19 designated hospital, and they:
  - Relocated 35 patients to other hospitals in the system.
  - Removed windows from 40 rooms, added blowers, and created negative pressure rooms.

Being able to open up all ED rooms to negative pressure rooms was a really great thing. Doctors and other staff felt safer working here with negative flow rooms. Would recommend this as a best practice for other facilities. We also knew that we had the flexibility to be able to make them all ICUs if needed.

We did surge up. We went from about 26 beds to over 40 and we need to really look at our respiratory surge. We are an old building, and we need to have better high flow capabilities. And we need to know where we can expand well, but we need to be able to stretch out and then compress very easily.

We were not ready for the amount of equipment needed for each patient. It was a logistics nightmare on where to put all the equipment (e.g., isolation cart, ECMO). They mostly were in the hallways in front of each patient's room and the facility size we have today was inadequate. Our hallways were no longer hallways, they were pathways from one room to another.

We felt that it was important to show staff that we really care about their safety. We showed the staff all the money and resources we put into ensuring staff and patient safely.

We recommend other facilities conduct simulation trainings to shake down what is a best practice and then potentially make it a standard practice.

I am convinced that one of the reasons we had low mortality is because we used nurse anes thetists for airway teams (they were available 24/7). This was expensive, but it paid off.

  - Used regular heating, ventilation, and air-conditioning (HVAC) system and standard care for COVID patients who were not in the ICU and did not require aerosol-generating procedures.
- One facility had a large pediatric unit that was converted to care for adult patients with COVID-19. They were assigned pediatric providers a practice partner, enabling them to care for older patients.
- Other strategies used by multiple health systems include:
  - Using existing or rented monitors for ICU rooms.
  - Installing nursing alarms for other units and adding a secondary alarm system so nurses could hear ventilator alarms from outside of the rooms amid the increased noise.
  - Developing zones within facilities:
    - Upon entry, all staff were screened and temperature checked.
    - **Green zone –** infection free area, no patients allowed, staff screened before entering, no PPE use. Used for administrative work and breaks.
    - **Yellow zone –** patients could be transported for tests, staff wore masks and gloves, patients wore masks, maintained as clean environment.
      - One hospital originally used runners to move equipment, labs, and the like from yellow to red zones but there was a concern that they could be exposed.
      - "Hall monitors" guarded the yellow zone to keep clinicians from red zone out. When a patient moved through the yellow zone transporters / runners "handed off" between providers in Red and personnel in Yellow.
    - **Red zone –** COVID-19 positive patients under treatment.
      - Staffed by those keenly aware of good infection prevention techniques
      - Staff in zone did not need to change their PPE from room to room. They could go about the unit freely. This was more efficient and allowed timely care for very sick patients as well as PPE preservation.
      - Post signage and ample training to instill confidence in staff working in the red zone.
      - As an extra layer of protection, use specific checklists (and "PPE buddies" as available) to for donning and doffing to protect against self-contamination.

IV. Staff

Staffing was one of the key constraints and challenges faced by all facilities treating COVID -19 patients. However, as a COVID-19 designated facility, the interviewees felt that they were able to focus training, PPE, specialization, and standardization of care to one facility rather than spreading these things out across multiple hospitals. Strategies for meeting staffing challenges include:

- Bringing staff from other hospitals within the health system to work in the designated facility. For example, one system closed a surgical center due to the decrease in elective procedures and those staff worked at the designated COVID hospital instead. Another system put out a call for volunteers to work in the hospital and one did a survey of staff to determine who was available, willing, and able to work at the designated COVID hospital to bolster staffing numbers.
- Other facilities assessed nurses to determine skills and where/how they could be deployed to the COVID hospital.
- The practice and education team made up their own PPE for training, so they did not burn through actual supplies during donning and doffing training. They train staff virtually each time there are updates to procedures.
- Recruiting issues:
  - Getting out of state staff licensed was challenging, particularly for respiratory therapists.
  - It was much harder to onboard traveling providers.

- Onboarding training included:
  - In-services and observation of PPE donning and doffing. Safety was key and staff were watched carefully until leadership was confident that they could don and doff properly.
  - Powered Air Purifying Respirator in-service training sessions
  - Cleaning techniques (PPE, equipment, surfaces)
  - Retraining staff to make sure they donned proper PPE before running into rooms in response to alarms
  - Conducting simulation training for CPR and intubation best practices and collaborating with other facilities around the state to be consistent on practices.
  - Refresher training as needed for electronic health records and other hospital procedures.
- Surge staffing plan considerations:
  - Repurpose/redeploy staff such as certified nurses and anesthetists to be ICU personnel.
  - Add Certified Registered Nurse Anesthetists (CRNAs) and pharmacists to the team.
  - Conduct daily check out rounds to include nursing, pharmacy, and physician teams.
  - Use ancillary staff and do not over burden nurses. One facility noted that they initially asked nurses to do work typically done by ancillary staff (e.g., housekeeping and food delivery), but discovered they were getting burned out quickly. The organization ended up needing more nurses and had to reassess procedures and staffing.
  - Adjust staffing to patient acuity.
    - A typical ICU plan will not work. One facility noted that COVID patients are very sick and that nurse to patient ratios had to be adjusted to 1:1 or 2:1 at times.
  - Consider traveling staff if able; they are often available for a competitive fee.
  - Have an efficient bed management lead.
  - Designate at least one proning team.
  - Consider creating a procedures team that focuses on insertion of invasive lines and airway interventions.
- Human resources considerations:
  - Track staff redeployment.
  - Streamline identification badging and credentialing for redeployed staff.
  - Expedite the onboarding of volunteers.
  - Assist with recruitment of staff shortages in key areas like respiratory therapy.
  - Cross-train staff.
- One of the facilities shared their staffing plan:
  - On the clinical side of things, we set up our provider staffing to mimic the Society of Critical Care Medicine (SCCM) pandemic response guidelines.
  - At our ICU's peak census (45 patients), one medical intensivist oversaw the care of roughly 15-20 patients per day, in concert with 1-2 of our advanced practice providers (APPs) or non-ICU doctors per ventilator unit (ICU, ED, ASU).
  - Night coverage was provided by 1-2 APPs or non-ICU doctors per each of these units with the availability of tele-intensivist backup.
  - We used tele-medicine technology for some specialist consultations, and we continue to use tele-medicine now when our system staffing does not allow for a medical intensivist to be physically on campus.
  - We contracted with a nephrology team, who in addition to providing/directing care related to intermittent hemodialysis and continuous renal replacement therapy issues, essentially performed as a quality control team from a pure internal medicine standpoint.
  - The nephrologists stayed primarily in the green zone and used our physical exam findings and input via phone as their care guide.
  - The team maintained a COVID standards of care document that was updated periodically as new literature warranted.
  - Several intensivists participated in a weekly city-wide ICU directors call with directors from other healthcare facilities.

One major strength of our staff was their willingness to redeploy and take on alternate care roles. We posted our medical students in non-clinical areas that helped immensely. Another strength was the restructuring of our residents. Our surgical teams should be highlighted. They were routinely brought to the floors to prone patients, as IV teams, and were sent to the ED and other medical care floors to help with critical care patients.

One of the areas that worked well was that we made sure our residents were still able to maintain their residency and doing things that were appropriate for the residency (even though their electives were canceled).

We had a difficult time recruiting respiratory therapists. Average ratio is 10:1, at one point we had them at 30:1. Recruited first year anesthesia residents were reassigned to respiratory therapy and they were able to supplement the therapists.

We spent a lot of money/ spared no expense and felt that we did it the right way. We spent over $24 million on hazard pay and PPE, furloughed 1,100, and will take a nearly $100 million loss this year but wouldn't do a thing differently.

- We had a proning team and nurse assist with just-in-time training.
- We had specifically trained staff on a donning/doffing team.

V. Stuff (Equipment and Supplies)

All interviewees reported PPE shortages, but none had ventilator shortages. Many received more donations than they needed and partnered with local durable medical equipment (DME) companies/ businesses. Some facilities also relocated all necessary equipment to treat COVID patients from other hospitals in their healthcare system.

- One facility partnered with a local university to design a gown that could be printed on a 3D printer. The staff did not like that they were heavy and warm, but they were a good substitute until the facility was able to acquire more gowns. These gowns were only reused on the same patient/room.
- One facility created a central supply, under badge swipe and cameras, that was only accessible by a designated supply chain person under incident command.
- Through donations, one facility gave house and respiratory therapy staff PAPRs. Staff found PAPRs more comfortable and easier to communicate in.

We found that we problem-solved new ways to manage our case load every Monday morning. The census and balance of ICU and med/surg patients changed each week which changed our focus for discharges. For example: If the number of ICU patients was very high, we concentrated on the med/surge patients.

VI. Communications

Interviewees agreed that regular communication is key to ensuring staff are informed, stressing safe practices, sharing new procedures and policies, and setting priorities for the day. All facilities conducted at least daily meetings or made announcements during peak patient census times. Also, communication with loved ones (from both the patient and staff) was key.

- One facility noted they created a WhatsApp group text for the ED group; this is still active today. They found group text to be a better way to communicate rapid changes.
- One facility noted they required daily communication to the patient's loved ones to be done by a team member (ideally the attending physician, but this was not always possible). They provided a standard template for what was communicated to loved ones.
- One facility shared their categorized communication structure:
  - System level- daily call with all service lines to make sure everyone was on the same page.
  - Critical care- daily call with intensivists and others on that team (e.g., environmental services, nutrition).
  - Clinical therapeutics team- discuss reviews of new treatments and related findings
- Interviewees found telemedicine/ virtual communications useful for consults (e.g., cardiology, nephrology, infectious disease). Surgeons would see patients in-person. iPads were used extensively by all staff:
  - At the bedside to help communication with loved ones and nursing staff.
  - For translation services.

Establishing a pandemic communications program, pre-approved messaging, and scripts for various stakeholders ensured that not only did we get critical information to staff and patients, but to supply chain staff and vendors.

VII. Case Management

All interviewees noted difficulty in placing patients to post-acute care facilities after discharge. Many nursing facilities and long-term care facilities (LTCs) were reluctant to take back patients and placing patients took a long time. Patients who came from group home settings were also difficult to place. This section highlights some unique solutions and lessons learned.

- Because many COVID-19 patients require extensive physical therapy, one facility designated a transitional unit to help with mobility issues and other transitional needs.
- Another facility used a Congregate Living Committee to review all discharges to make sure they were done safely and to prevent spread to nursing homes.

- One facility opened a COVID positive transitional facility due to difficulty finding transitional placement. It had 24 beds, and the most patients at one time was 14 or 15. They closed this facility in September.
- Interviewees suggesting developing processes for obtaining DME for patients, arranging transportation for COVID patients, and determining how to obtain home services without in-house assessments. Community providers can help facilities determine what services are available.
- One facility noted the following lessons learned:
    - Our department had to completely change the way we conducted our daily work. Once the safety zones were in place, we were part of the green zone. Prior to COVID, we were on the units, met with patients and families regarding their discharge plan. Once COVID hit, we no longer had that ability. Maintaining flexibility when faced with these obstacles was the key to our success.
    - The care managers successfully transitioned 500 patients either to home or another facility after their acute episode.
    - We established criteria for discharges to LTCs and assisted living:
        - If a patient is discharged to an LTC or assisted living facility AND transmission-based precautions are still required, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.
        - If transmission-based precautions have been discontinued, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
        - If transmission-based precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions, based upon their history of COVID-19.
    - The decision to discontinue transmission-based precautions should be made using a test- based strategy or a non-test-based strategy (i.e., time since illness onset and time since recovery strategy). Meeting criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge.
    - The test-based strategy was reserved for patients who remained hospitalized, were severely immune compromised, or were being discharged to a LTC facility. Patients had to demonstrate resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath).

We had three patients that needed long-term care and did not have insurance. The state was able to extend Medicare coverage to them.

VIII. Other Considerations

This section includes other lessons learned or considerations specific to testing, fatality management, and operations the interviewees shared.

- One facility noted that they had the first in-house fully validated COVID test with results within 24 hours starting March 12. They have conducted more than 200,000 tests and extended this service to neighboring nursing homes, hospitals, and other community partners.
- Another interviewee noted the morgue capacity in the hospital quickly filled up. They had three refrigerated morgue trailers at one point, but many families were unable to claim their loved ones' bodies or could not afford the $750 cremation fee. One hospital reconfigured the trailers to hold more decedents and kept them on-site (instead of transferring to a state facility or funeral home) while giving loved ones more time to get organized.
  This helped show the community the hospital's good will and trustworthiness.
- Other general recommendations:
    - Conduct intra-facility crisis planning and develop a plan based on volume triggers.

We need a dashboard. We need to get this information out in real time. We're giving reports still to this day to as many as seven different governmental institutions, and each report is formatted differently. They have to be done, they're taking a tremendous amount of time and energy, and we really need a COVID dashboard. Things like admissions, length of stay, discharges, mortality outcomes. Some thing that can be pushed out immediately to our stakeholders, our community, and to our governmental organizations.

    - Keep adapting based on changing circumstances; rapid planning was a real hallmark to this response.
    - Do not get too bogged down in the bureaucracy; make decisions and keep adapting the best that you can.
    - Consider making regular announcements (e.g., over the loudspeaker) that emphasize employee safety and quality of care are the hospital's top priorities.
    - Make sure to take employee behavioral health needs and self-care seriously.
        - Set up an employee assistance program onsite.
        - Set up times automatically for staff to talk with a behavioral health professional (they can reschedule or opt-out).
        - Consider setting aside spaces where staff can receive services like acupuncture sessions, aromatherapy sessions, and religious/spiritual support.
- One facility shared their list of facility upgrades, equipment, and technology they made to their COVID-designated facility (which cost nearly $3.4 million):
    - Renovations
    - Repurposing/modifying existing spaces
    - Architectural fees related to modifying interior spaces related to National Fire Protection Association (NFPA) and other codes
    - Purchasing and installing prefabricated walls and structures
    - Interior and exterior construction
    - Expanding capacity within the facility
    - Making modifications to increase the morgue capacity
    - Temporary generator rentals
    - Computerized tomography (CT) scanner rental
    - Modifications to the building's electrical systems
    - Modifications to the HVAC systems
    - Using free standing and portable HVAC units to supplement the main HVAC systems
    - Engineering consulting to assist with modifications to the existing HVAC, structural, and plumbing systems
    - Building equipment/systems repairs necessary to support interior safety zoning due to COVID patient intake
- The costs did not include the following or rented equipment other than the portable generator and mobile CT:
    - Post-acute care center
    - Infusion clinic modifications (e.g., architectural and engineering fees, equipment, and construction)
    - Increased utility expenses due to the increased amount of medical equipment beyond average daily usage pre-COVID
    - Hotel for temporary staff housing

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Attachment D

IX. Resources

ASPR TRACIE COVID-19 Resources

Dhake, S. et al. (2020). COVID-19 Hospital Designation: Effect on Emergency Department Patient Self-Selection and Volume. Journal of Hospital Administration. Vol 9, No. 5.

This article provides the results of a retrospective analysis of ED volumes and COVID-19 ED visits between March 12, 2020 to April 30, 2020 at Glenbrook Hospital. The authors concluded that the declaration of Glenbrook as a COVID hospital had significant affects to their ED visits.

Edwards, J. et al. (2020). Lessons Learned at a COVID-19 Designated Hospital. The American Journal of Surgery.

This editorial article highlights the surgical department's lessons learned from the State University of New York Downstate Health Sciences University, the only COVID-19 designated hospital in Brooklyn.

Liebman, D., Patel, N. (2020). To Save Staff and Supplies, Designate Specialized COVID-19 Referral Centers. Health Affairs.

This blog describes benefits of, and options for, operationalizing a COVID-19 referral center, or dedicated care center for positive COVID-19 patients.

Moulick, A., Kilcoyne, M., Do-Nguyen, C.C., and Stevens, R. (2020). The Case for Designated COVID-19 Hospitals. CTS Net.

The authors of this article identify the benefits of a dedicated COVID-19 hospital and categorize them by supply allocation; infrastructure, personnel, and patient management; and COVID-19 sequestration and public health. They also provide a list of steps to achieve a COVID-19 hospital.

Robbins, A. et al. (2020). Transforming a Long-Term Acute Care Hospital into a COVID-19 Designated Hospital. Surgical Infections. (Abstract Only).

This article describes lessons learned from M Health Fairview Bethesda Hospital's conversion of the LTACH facility into a hospital dedicated to treating COVID-19 positive patients.

Wu, X., Zheng, S., et al. (2020). Contingency Nursing Management in Designated Hospitals during COVID-19 Outbreak. Annals of Global Health. 86(1):70.

This article describes the nursing management program at Shantou Central Hospital, a COVID-19 designated treatment hospital in Guangdong Province. It includes strategies for initial set up, establishing a technical support team, staffing, detailed nursing duties for each shift, and behavioral health services.