ASPR TRACIE Technical Assistance

On June 2, 2020, ASPR TRACIE hosted the webinar, *Ensuring Healthcare Safety Throughout the COVID-19 Pandemic*. During this webinar, presenters from healthcare systems who have planned, implemented, and managed operational adaptations in their organizations described how these adaptations can strengthen healthcare resilience and maintain safety.

Due to the large number of questions received during the question and answer session, speakers were not able to respond to all of the questions during the webinar. These questions were sent to panelists and their answers are provided in this document.

Questions for All Panelists

Question 1: Did you have to lay off or furlough staff due to low census or patient complexity?

Answers:

- *Dr. Terry Fairbanks, Vice President, Quality and Safety, MedStar Health (Maryland/Washington DC)/ Founding Director, National Center for Human Factors in Healthcare:* We have been able to avoid this thus far, however, we have used certain mechanisms such as voluntary personal time off (PTO), mandatory PTO in some instances, and an advance PTO program that allowed people to carry negative PTO balances.
- *Dr. Mark Jarrett, Senior Vice President and Chief Quality Officer, Deputy Chief Medical Officer, Northwell Health (New York):* No, we used every staff member to fill in gaps as we had such huge spike in census and some staff (although, thankfully, few) were out due to the disease.
- *Dr. Richard Nesto, Chief Medical Officer, Beth Israel Lahey Health (BILH, Massachusetts):* We did furlough a small percentage of non-patient facing staff and they were able to use PTO. Senior team (hospital presidents, SCPs, and VPs) and executive system-level team took 10% and 20% salary cuts early on. It is clear that non-patient facing labor force levels may have to be trimmed given the huge financial shortfalls, despite federal stimulus money.

Question 2: Was there an emphasis on physical security of staff? Did you feel the need to take extra precautions to secure staff?

Answers:

- *Dr. Fairbanks:* We track our workplace violence events and there was a significant decrease. We have focused on emphasis of safety in every way but have not found the need for increased physical security to be one of those needs. We already had a security presence in some of our hospitals in Washington, DC and Baltimore.
- *Dr. Jarrett:* This was not a problem. The more difficult aspect was decreased public transportation and the need to set up alternative ways for staff to get to work.
- *Dr. Nesto:* This was not an issue for BILH. For the most part, our hospitals and patient care facilities are located in safe areas. But we did focus on colleague safety with frequent and evolving on personal protective equipment (PPE) levels across our sites to

ensure that all staff had equal access to PPE. We also set up colleague wellness hotlines for staff who were stressed by the demands of caring for patients.

Question 3: Were there shortages of sedatives and paralytics or other drugs? How did you handle with that on a local system or regional basis?

Answers:

- *Dr. Fairbanks*: Yes, and we adjusted distribution between hospitals and increased supply chain avenues.
- *Dr. Jarrett:* With over 800 ventilated patients, we did start to run out. We came up with standardized alternatives and pushed the supply chain.
- *Dr. Nesto:* BILH did experience shortages of blood gas kits and some pump tubing, but supply chain on our daily incident command call kept up with these shortages and balanced supply levels across all our hospitals. We also provided local hospitals not affiliated with our system with supplies on an as-needed basis.

Question 4: How did you ensure infection prevention care standards were being followed by workers?

Answers:

- *Dr. Fairbanks:* Local leaders were expected to supervise, but multiple avenues were used to increase awareness (e.g., screensavers, break room posters, videos, emails, social media, and virtual town halls).
- *Dr. Jarrett*: Actual observation of use of PPE, etc.
- *Dr. Nesto:* BILH used similar tactics as noted by the other speakers.

Question 5: How did you address screening workforce members, patients, patient support, visitors, contractors, etc.?

Answers:

- *Dr. Fairbanks:* We are using different approaches. At the door screening, for example, we use a homegrown app that shows a color red (not permitted to enter) or green (permitted to enter) on the person's phone as they walk by a trial temperature screening check. We use signage to remind all persons of social distancing measures. We have a strict no visitor policy with exceptions only made by the Chief Medical Officer or Chief Nursing Officer, and there is zero exception for household contact of a COVID-19 patient until two weeks out. We only allow one visitor for labor and delivery which includes a private doula or private lactation specialist, and we are not allowing any contractors to enter except those performing clinical tasks.
- *Dr. Jarrett:* Vendors were not allowed in the buildings and New York State stopped all visitors except for maternity as a support person and pediatrics. Workforce and patients are screened for symptoms and fever.
- *Dr. Nesto:* We have strict visitation policies are in place. Currently, only one visitor is allowed to see a patient. The visitor must have their temperature checked and wait outside the hospital until called in to see the patient. All staff have to do a daily attestation on their temperature, any symptoms, contact with known COVID-positive

persons, and submit their attestation electronically before coming to work in a patient care area.

Question 6: How were community-based healthcare provider, physicians, group practices, clinics, and urgent care centers included in the COVID-19 response?

Answers:

- *Dr. Fairbanks*: All in our system were treated with our system standard.
- *Dr. Jarrett:* Urgent care was critical to keep the emergency department (ED) flowing. Most ambulatory sites closed (600 out of 800+). We used a lot of telehealth visits.
- *Dr. Nesto:* We invited three "safety net" hospitals affiliated with (but not members of) our system to our twice daily huddles to assist in patient and ventilator load balancing across our system's and the safety net hospitals. We did not interact with physician groups outside our system as they belonged to other systems but there was a city-wide huddle with all the intensive care unit (ICU) chiefs to exchange information.

Question 7: How did the systems utilize home care and hospice?

Answers:

- *Dr. Fairbanks*: We focused on both of these with a single system vice president leading efforts.
- *Dr. Jarrett*: Mostly as a very tight follow-up for our COVID-19 discharged patients. Our home health providers also had their regular (non-COVID-19) patients and we continued care with appropriate PPE for the staff.
- *Dr. Nesto:* Behavioral health, home care, and hospice leaders were on daily incident command calls. Our orthopedic specialty hospital in our system was converted into a medical and psychiatric hospital for COVID-negative patients to create more room for the surge of COVID-positive patients.

Question 8: What sort of advice would you have for significantly smaller hospitals, which may be up next fighting the pandemic?

Answers:

- *Dr. Fairbanks*: One of our hospitals is a small, critical access hospital, however, they benefitted from shared resources with the system, so I don't have immediate advice. Perhaps partner in a consortium of smaller hospitals or partner with larger system for certain aspects.
- *Dr. Jarrett:* Temporarily partner with larger health systems – don't go at it alone. Pooled thinking works best.
- *Dr. Nesto:* We invited three "safety net" hospitals affiliated with (but not members of) our system to our twice daily huddles to assist in patient and ventilator load balancing across our system's and the safety net hospitals. We did not interact with physician groups outside our system as they belonged to other systems but there was a city-wide huddle with all the ICU chiefs to exchange information.

Question 9: How did your hospital communicate with your state and local emergency operations centers (EOCs)? Did you have liaisons in those EOCs? And was there a local public health liaison available to your hospitals?

Answers:

- *Dr. Fairbanks*: Our emergency managers in the command chain managed communication and liaising with us on this part.
- *Dr. Jarrett:* We talked to the New York State Department of Health constantly.

Question 10: In regard to ensuring healthcare safety, has anyone talked about patient video recorded healthcare? For example, a surveillance camera in a nursing home could ensure quality of care or expose abuse and neglect, especially for vulnerable populations.

- *Dr. Fairbanks:* We support this use of patient-facing telehealth.
- *Dr. Jarrett:* This is planned for the future. We also have to involve unions in the approval process.

Question for Dr. Mark Jarrett

Question 11: How did you balance the administrative and the clinical representation of the hospital incident command system, or HICS teams? Also, how many back-ups did you have for each section?

Answer: We had two back-ups. The balance depended on the area. Facilities involved administrative staff with clinical input, and clinical operations involved clinicians.

Question for Dr. Terry Fairbanks

Question 12: On slide 29 (Relevant Guiding Principles)- What does SUO stand for?

Answer: Serious Unanticipated Outcome. We used this as a metric to require reporting, and then another metric in our safety portfolio includes time of event until time of first report of the SUO. Then we do an event review, note the traditional root cause analysis, and once the event review is complete, we determine whether the SUO qualifies as a serious safety event, which is our final metric. There be a violation in MedStar standard of care combined with moderate to severe injury or death in order to qualify. The advantage of the SUO as a metric is that we learn from everything and it gives us the immediate ability to provide care for the caregiver and hold immediate transparent conversations with the patient and family. We usually do not know what happened when we first make this contact, but we garner more trust when we start by saying we will be open and honest. We have shared our event review process, which we produced to become part of the Agency for Healthcare Research and Quality (AHRQ) candor product.