ASPR TRACIE Technical Assistance

On May 11, 2020, ASPR TRACIE hosted the webinar *COVID-19: Healthcare System Operations Strategies and Experiences*. During this webinar, presenters from a few of the hardest hit hospitals in NY, LA, and the Western Navajo Reservation (AZ) shared their hospital operations experiences and logistics (space, staff, and stuff) strategies associated with the current COVID-19 response.

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: What changes in your hospital's communication approaches helped most?

Answers:

- **Janice Halloran (NYC Health + Hospitals/ Jacobi):** Communication was our best tool. Once we knew what we were dealing with, we took direction from our Central Office at New York City Health + Hospitals. The Central Office Strike Team conducted conference calls on Monday / Wednesday / Friday, provided daily updates via email, and communicated information on the H + H home page. Jacobi, specifically, utilized this information and disseminated it on our facility homepage, created a COVID-19 information site that was updated daily, conducted facility remote daily morning huddles, departmental twice a day huddles, information boards, emails, and via our internal Jacobi Insider periodical. We erected poster boards in all high traffic areas. The CEO also held virtual manager's meetings so the staff were up to date on newly acquired information. Department heads were equally as diligent about disseminating information to front line staff.
- **William Fasbender (NYC Health + Hospitals/ Elmhurst):** We distributed/forwarded pertinent (and only pertinent) info via e-mail (and encouraged people to check their e-mails at least daily). We distributed handouts to frontline staff that we didn't anticipate would be regularly checking e-mail. We continued to hold daily briefings, and huddles as needed. We mounted posters in high-traffic staff areas (break rooms, locker rooms, etc.) We pushed info onto screensavers.
- **Dr. Jeffery Elder (University Medical Center New Orleans):** We utilized multiple sources – Zoom meetings, leadership calls, in-person director/manager meetings as part of our daily safety huddle, scheduled email updates and a document uploaded in the EPIC resources tab with the latest information for clinicians.
- **Dr. Sara Jager (Tuba City Regional Health Corporation)**: We did NOT communication email. Incident command meetings were very helpful to establish chain of command and the "who does what" list. We use Zoom extensively to connect team members.

Question 2: What patient safety initiatives were in process as the COVID-19 pandemic began and did those or other improvement efforts help with your organization's response?

Answers:

- **Ms. Halloran:**
  - Handwashing was always a top patient and staff safety initiative. This Infection Prevention program initiative paved the way for what would be our most important practice during COVID-19. Infection Prevention has never been more pleased with our staff's hand hygiene practices.
  - Our well-established Staff Wellness programs truly came in handy during the COVID-19 pandemic (e.g., Helping Healers Heal [H3], our Zen Room, Swartz Rounds and our Social Work Disaster Response Team). We were just embarking on our Plane Tree Experience when COVID-19 struck. We did not have re-event the staff support wheel. Those established programs provided staff support daily and we utilized them robustly. We also made sure to honor the staff. We posted a Daily Hero Initiative to shine a spotlight on our hardworking, dedicated staff.
  - Our emergency department (ED) Follow-Up Office's efforts expanded to include follow-up calls for higher-risk COVID-19 treat and release patients to ensure their care was being managed post their hospital visit.
- **Dr. Jager:** We are Joint Commission (TJC) accredited so were following all of their recommendations prior to COVID. TJC arrived on site and did an assessment of our screening and triage on day 10 of our response.
  - **Note: The Centers for Medicare & Medicaid Services (CMS) provided ASPR TRACIE with the following information regarding standard surveys of hospitals:** CMS is requesting and encouraging accrediting organizations (AOs) follow the same guidance that is provided to the State survey agencies. CMS has oversight of AOs but does not have the same legal relationship with AOs as we do with States. CMS cannot direct AO surveys in the same manner. It is our understanding that AOs have suspended standard surveys of hospitals consistent with our guidance and are using their resources to focus and help with targeted infection control as well as immediate jeopardy surveys related to complaints. CMS has regular calls with the AOs to share information and facilitate a coordinated approach across healthcare facilities nationwide. Accrediting organizations have shared that restrictions on travel and the availability of PPE has impacted their ability to conduct surveys during this time. Survey activities by CMS are within CMS' policy purview and may be redirected to QSOG_EmergencyPrep@cms.gov. For more information on CMS' guidance to both State Agencies and accrediting organizations on surveys please review the following CMS announcements
    - Prioritization of Survey Activities
    - CMS Coronavirus FAQ - SA and AO
    - CMS Memo- Suspension of Survey Activities Note: This memo was updated by the Prioritization of Survey Activities CMS Announces Actions to Address Spread of Coronavirus

Question 3: Were there any things you spend time and effort preparing for that you might prioritize as lower and that might free up attention for other higher priorities?

Answers:

- **Ms. Halloran:** During any disaster scenario, there is always a request for numerous surveys to be filled out and during this pandemic it was no different. In fact, there seemed to be many more surveys that needed to be completed and the information in those surveys was constantly changing. I realize this a priority for the data analysts but for the folks like myself, who are juggling many duties during this pandemic, this really felt like a lower priority compared to what we were doing on the front lines.
- **Mr. Fasbender:** No, unfortunately not; we recognize that the advent of this pandemic does not preclude the possibility of weather emergencies (e.g., we're entering hurricane season), traffic/transit mishaps, utility failures, IT disruptions, terrorist attacks, etc.
- **Dr. Elder:** We had to put aside many of our scheduled projects that were not critical to immediate operations to make time for COVID response priorities. We are starting to get back to these delayed projects.
- **Dr. Jager:** We did ventilator management refresher training for medical staff that were more out of touch with vents, but never used it.

Question 4: In what roles were non-medical staff (temps/volunteers) used? And how were they selected/screened?

Answers:

- **Ms. Halloran:** Human Resources managed the entire screening and hiring process. Temporary staff were onboarded based on existing agency contracts. Many of these folks were hired to work for the ED, outpatient clinics, as patient Escorts, in patient transportation, as lab runners, or in materials management and environmental services.
- **Mr. Fasbender:** Temps were hired through existing agency arrangements. Based on their previous training/experience supplemented by just-in-time training, they were used for food distribution, donation management, decedent management, materiel management/ distribution, housekeeping, clerical work, etc.
- **Dr. Elder:** We utilized agency nursing to augment staffing and contracted EVS workers, security, and supply chain/logistics staff to expand capacity.
- **Dr. Jager**: Because we did not want to risk volunteers getting infected, and we needed to conserve our PPE, we did not accept volunteers or temps or learners (new nurse grads, residents, etc.). We sourced internally.

Question 5: Were your organizations able to augment inpatient staff with outpatient staff who were otherwise not working? Any strategies that helped in this regard?

Answers:

- **Ms. Halloran:** This was an all hands-on desk staffing effort. Staff were redeployed from shuttered areas to work in areas that needed support. This included both clinical and ancillary support staff. This was achieved by all re-deployed staff being assigned a mentor(s), just-in-time training and constant oversight.
- **Mr. Fasbender:** Yes, we were. We just had to acknowledge/accept that initially, they were a little out of their element, and required some just-in-time training.
- **Dr. Elder:** Yes – the key is to have designated leaders to manage the labor pool full time in order to bring in outpatient staff and underutilized inpatient staff to help with inpatient staffing.
- **Dr. Jager:** Yes. Do this early. Outpatient CMAs need to go to inpatient units to help with ADLs, labs, answering the unending phone calls. Family medicine outpatient physicians filled gaps in ED/urgent care areas. I also used outpatient medical staff to track down guidance regarding convalescent plasma, acquire all 3 types of tests (Sonora Quest, Cepheid, and Abbott platforms). Pediatricians were repurposed to epidemiological response and Chief Medical Officer work. Physical therapists did screening and contact tracing. Optometrists were put in charge of calling patients to share results. Dentists sewed gowns at the local church.

Question 6: How did your healthcare coalition support you in your response?

Answers:

- **Ms. Halloran:** The Bronx has the oldest healthcare coalition known as the Bronx Emergency Preparedness Coalition, established in October of 2001 of which I am the Co-Chairperson. Although we pride ourselves on being a response coalition (bus accidents, train derailments, active shooter events) that was not the case in this pandemic. Since the entire city was responding to this disease at the same time, there was very little opportunity for the coalition to mobilize. The coalition did communicate throughout the event, provide emotional support, and in a few cases, supplies to one another.
- **Mr. Fasbender:** They provided ongoing/updated situation awareness; offered SMEs on infectious diseases and infection prevention/control; assisted in sourcing needed supplies/equipment; and, in concert with New York City's Office of Emergency Management, arranged for hotel accommodations for employees, temps, and discharged patients with special household situations; arranged for food service for employees; etc.
- **Dr. Elder:** Communications – Healthcare systems and providers were able to communicate on a schedule to share information and clinical pathways.
- The Arizona Healthcare Coalition has a limited role in response efforts. For COVID-19, the HCC does provide the state with daily updates for overall bed, ICU, and ventilator availability; coordinates with EMS on patient transport; and assisted in procuring PPE for coalition members.

Question 7: How active will your organization be in out-of-hospital integration for testing and decompressing surges of community spread so that it's not an unknown?

Answers:

- **Ms. Halloran:** New York City Health + Hospitals will be extremely involved in this but currently this is an ongoing effort that is still evolving as we move into the next phase of our disaster response. Rest assured H + H will support the community as it is one of our major missions in general and during this pandemic we maintained this mission.
- **Mr. Fasbender:** We anticipate a large role, but that is still evolving.
- **Dr. Elder:** Our health system has been working closely with the local health department and parish (county) leadership to perform community testing in multiple neighborhoods throughout the metro area. This data is utilized by local and state leadership to make decisions on opening business, schools, etc.
- **Dr. Jager:** VERY! We are doing the planning for all of the blitz testing in our area – this a huge drain of hospital resources to make this happen but no one else is coming to do it and we know it will be important for squashing this surge as well as future outbreaks. We are also very active in public health nursing, delivering food and water to patients and community members. We know where the needs are and are working with the chapters (sort of like a county) to get needy people supplies.

Question 8: How has the interface for discharging patients to nursing homes worked?

Answers:

- **Ms. Halloran**: Initially, the nursing homes pushed back when we tried to discharge patients back to them. New York State did initially publish guidelines that forbade nursing homes from refusing hospitals discharges. 20 / 20 hindsight suggests this may have been a catalyst for the current outbreaks in many of the nursing homes. The nursing homes have been given revised guidelines that they must now follow to protect their residents and the staff which requires, in part, staff to get by-weekly COVID-19 testing, PPE requirements, visitation restrictions, family notifications of positive residents, and the non-cohorting of positive, negative, and unknown patients. Hospitals have also been given discharge guidelines, in part, to follow when transferring patients to nursing home and acute care facilities. Hospitals are not allowed to discharge patients to a nursing homes or acute care facility unless the facility administrator has first certified that they are able to provide that patient with adequate care. In addition, hospitals must test any patient who may be discharged to a nursing home or acute care facility for COVID-19, using a molecular test for SARS-Cov-2 RNA. No hospital shall discharge a patient who has been diagnosed with COVID-19 to a nursing home or acute care facility, until the patient has received one negative test result using such testing method (See 10 NYCRR 415.26 for the full guidelines). COVID-19 proved to be a very tricky virus that is still offering us opportunities to learn.
- **Mr. Fasbender:** Discharging to nursing homes is currently permitted if and only if the nursing home is confirmed to have appropriate mechanisms/resources/facilities in place to safely accommodate candidate patients.
- **Dr. Elder:** The State of Louisiana has put out guidance for inpatient discharges to nursing homes / group living facilities. Additionally, LA set up a medical monitoring

station that allowed for discharge of patients to this state facility pending negative testing required for placement. This has continued to be a problem with patient requiring higher levels of care.

- **Dr. Jager:** We don't have any nursing homes or skilled nursing facilities here. Initially, families were reluctant to take their members home (or were unable because the younger caretaker was also sick). Consider a step-down unit; patients should be able to do activities of daily living (ADL) and have minimal oxygen requirement. Food delivery, laundry, and bathrooms will be step-down unit hurdles. We have not yet been able to implement this.

Questions for Janice Halloran, NYC Health + Hospitals/ Jacobi

Question 9: Can you speak more about the command center PPE distribution process that you used at Jacobi? I am curious specifically about the distribution prioritization methods used and security/tracking processes.

Answer: Jacobi operated a 24/7 ED Command Center adjacent to the ED ambulance entrance. The Command Center Staff worked 12-hour shifts (8am to 8pm and 8pm to 8am). This was a secure location, with hospital police posted outside the Command Center, and where staff essentially reported to a bank teller type window, swiped their facility ID, and were provided all levels of PPE prior to reporting to their ED work assignment. This included all levels of ED staff: RN's, MDs, PCA's, radiologists, respiratory therapists, clerical staff, environmental, dietary, patient escort, etc. The swipe allowed us to run reports and keep track of who was provided PPE and how often. What also helped managed staff flow was having PPE pre-packaged so that we would just have to hand out a pre-packaged PPE set so we were not looking for various supplies when staff presented. This pre-packaged set included a mask, bonnet, booties, gown or scrubs and face shield or goggles. This became a best practice for the ED.

The "house" obtained PPE via the materials management team, who provided PPE to the inpatient unit staff and to the isolation carts. This was harder to manage and our corrective action includes creating a "Facility PPE Command Center" (mimicking the ED PPE Command Center inclusive of the ID swipe). This too would run 24/ 7 with a 12-hour shift change over. We would expand the capacity to 3 staff members / windows to be able to manage the staff surges and ensure staff are not waiting on long lines for PPE delaying them from getting to their work assignments.

Question 10: What did you do as a hospital/system to get as many staff members on board with the ever-changing PPE guidelines?

Answer: Jacobi Medical Center never seems to have an issue with staff wanting to work here and the pandemic did not dissuade folks. We followed the CDC guidelines, kept up with those changes and communicated those changes robustly with the front line and newly hired staff. We also never ran out of PPE because we managed the dissemination of it very strictly. Staff were satisfied that the process was clear, and we cared about their protection.

Question 11: Do you recommend developing a COVID-19 response plan or to convert into a general pandemic plan?

Answer: What I have done is create a specific COVID-19 Playbook based on what actually happened and what we did. This is currently an ever-evolving document as new considerations are still happening (e.g., the new onset of the multisystem inflammatory syndrome associated with COVID-19 / Kawasaki Disease-like or toxic-shock syndrome-like associated with COVID-19 in our pediatric-aged patients). I am also updating my pandemic/epidemic plan to include lessons learned from the COVID-19 experience. I think both plans are equally important. The COVID-19 Playbook will be our "bible" in preparation for the 2nd wave and the Pandemic / Epidemic Plan will include all special pathogen considerations.

Note: I thought it was important to mention that when considering the 2nd wave of COVID 19, should that wave come in fall / winter, it would likely coincide with flu season which would not only complicate adult patient flow, but could be a game changer for the pediatric population. It would be important to consider this should you be looking to ramp up pediatric locations within your facilities for an adult surge. Since COVID-19 appeared to not affect the pediatric population until now, we might not have the same surge options with these locations as we did with the first round.

Question for Dr. Sara Jager, Tuba City Regional Health Corporation

Question 12: What does a PPE Doffing Monitor do?

Answer: A PPE monitor is someone assigned to your doffing room that walks the frontline provider through the appropriate PPE removal steps (hand sanitizer, shoe covers, hand sanitizer, gown, hand sanitizer, shield, hand sanitizer, mask, wash shield for re-use, put N95 in paper bag, wash hands). I know this seems unnecessary, but PPE removal is one of the highest risk activities that we do ALL the time. It needs to be done correctly to prevent healthcare worker infection. And, not everyone that goes into COVID units is accustomed to PPE (IT personnel to hook up phones in patient rooms, construction teams to make negative pressure rooms, etc.).