COVID-19 Region 7 Webinar for Critical Access Hospitals and Outpatient Facilities

Presented by Nebraska Medicine and the University of Nebraska Medical Center in collaboration with the Centers for Disease Control (CDC) through NICS (National Infection Control Strengthening for Small and Rural Hospitals)

University of Nebraska Medical Center

Nebraska Medicine

Today's topic:

Guidance and responses were provided based on information known on 12/15/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and jurisdictional guidance for updates.

Margaret Deacy, Moderator

Panelists:

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Acknowledgement:

Today’s presentation is produced in cooperation with Nebraska ICAP (Infection Control Assessment and Promotion Program)

December 2020

Crisis Standards of Care

Rachel Lookadoo & Abbey Lowe

Crisis Standards of Care

- Crisis standards of care (CSC) provide guidance on how hospitals and other healthcare facilities can fairly allocate resources in the event of an overwhelming medical surge
- Worst-case scenario planning
- Currently ~37 states have official CSC plans

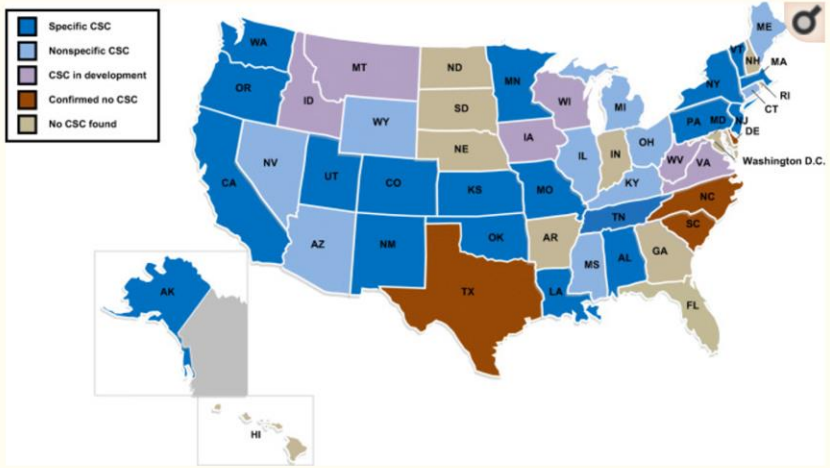

Fig. 2

Crisis Standards of Care across the USA, by status of development as of May 3, 2020

LOE Dashboard Template

Healthcare Surge Capacity & Strategy

Updated: 11/23/2020

Lead: Shelly Schwedhelm
Advisor: Dr. Anthone

BLUF // Bottom Line Up Front

- Nebraska's response to healthcare COVID-19 hospitalization surge requires coordination, collaboration, and communication among coalitions, healthcare facilities, associations, other stakeholders and state and federal agencies.
- Response efforts in patient movement to the right bed at the right time, adequate supply and other resource demands requires efficient and timely communication, coordination and collaboration across diverse stakeholders in the state.

What Success Looks Like

- Maintain a low case fatality ratio of all Nebraskan's from COVID-19.

End of Week Imperative

- Define Opportunities & Barriers for Stuff; Staff and Space by Coalition Region
- Finalize Data Report(s) to Guide Decision Making
- Roll out Crisis Standards of Care Plan, Education & Structure(s)

Initiative	Owner	Status	Update	Impact *Why this matters*	Next Steps	Support Required
Surge Capacity Strategies	Hospital CMO & COO's & Coalitions & Agencies (NHCA; NHA; Leading Age)		• Coalesce regional (by coalition) and state surge plans (stuff; staff; space) appropriate to conventional-contingency-crisis levels • Cadence for MEOC is M-W-F @5pm	• Creates an "all in" expectation and defines actions taken at each surge level by each stakeholder group by region in the state. • Builds capacity and resilience.	• Prioritize coalition needs related to Space, Stuff, & Staff • Share innovative strategies across MEOC group (staffing) • Continue to vet and refine bed data and reports • Expand Transfer Center Strategy • Implement Monoclonal Antibody Tx in LTCs this week. • Advance Federal Asset request for staffing support. • Finalize vetting of Staffing Strategies (eg. ESAR-VHP; Team Rubicon; others)	• Healthcare Leaders; Coalition Coordinators • CHI Transfer Center • MEOC • NE Associations
Crisis Standards of Care (CSC)	Ethics Leader(s) CMO Group		• Crisis Standards of Care decision to adapt Massachusetts plan for NE • Identifying potential legal issues to solve for having the state adopt plan.	• Implementation of crisis standards in a consistent way using an ethical framework is essential.	• Socialize concepts with key stakeholders in each coalition region • Define strategy to educate others • Build support from Associations	• Dr. Doran; Abbey Lowe; Rachel Lookadoo; CMO or CCMs

Crisis Standards of Care

- CSC Plan drafted and reviewed by numerous clinicians and stakeholders across the state
- CSC plan is based on the Massachusetts CSC plan
- 11/24/2020 – Nebraska Hospital Association and Nebraska Medical Association both endorsed the final plan
- Pediatric and EMS specific plans are being developed
- Education on CSC is occurring across the state
- Coalition planning initiated on CSC triage and how to operationalize the plan regionally across the state

What are the guiding principles underlying Crisis Standards of Care?

- The medical community aims to provide the best care for the most patients possible in Nebraska.
- Healthcare planning must do everything possible never to need CSC.
- The goal is to provide equitable and consistent treatment throughout the state, no matter where patients live or what health care facility they visit.
- CSC have the joint goals of extending the availability of key resources and minimizing the impact of shortages on clinical care.
- CSC strive to save the most lives possible, recognizing that some individual patients will die, who would survive under usual care.
- Implementation of CSC will require facility-specific decisions regarding the allocation of limited resources, including how patients will be triaged to receive life-saving care.

What decisions are involved in Crisis Standards of Care?

- If parts of Nebraska need to activate the Crisis Standards of Care, the medical community is faced with the most undesirable task of rationing care.
- There will most likely be scarcity among intensive unit care (ICU) beds and ventilators. It is possible that some patients who need these resources will not receive them because there are not enough.
- These are extremely hard choices to make. Health care organizations will make these decisions based on medical ethics and who can benefit most from intensive care treatments. Factors such as gender, race/ethnicity, ability to pay, or disability will not be considered.

Care Continuum

Incident demand/resource imbalance increases
Risk of morbidity/mortality to patient increases

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility non-patient care areas (classrooms, etc.) used for patient care; Physical space no longer available for clinical care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
Standard of Care	Usual care	Functionally equivalent care	Crisis standards of care

Normal operating conditions

Extreme operating conditions

Indicator: potential for crisis standards

Trigger: crisis standards of care

What factors will the medical community consider in decisions to ration care?

- As providers across the state work to put Crisis Standards of Care guidelines in place, we will need to determine what factors the medical community will use to ration care if absolutely necessary during the COVID-19 pandemic.

How will the medical community address bias in decision-making when rationing care?

- In other states' Crisis Standards of Care guidelines for the COVID-19 pandemic, experts include the following key principles to prevent bias in the rationing of care.
  - Hospitals will work to ensure that the bedside care team (physician, nurse, respiratory therapist, etc.) is not involved in triage decisions about its own patients.
  - A Crisis Standards of Care triage team will make decisions based on medical condition. These standards have been drafted to avoid discrimination based on factors such as age, sex, gender, race, ethnicity, ability to pay, disability status, national origin, immigration status, sexual orientation, gender identity, religion, veteran status, or criminal history. Demographic data will only be considered where it is medically relevant to COVID-19 survivability.

CDC and Vaccination Updates 12/14/2020

- Post Vaccine Considerations for Healthcare Personnel
- Post Vaccine Considerations for LTC Residents
- Alternatives to 14-Day Quarantine- Described in the recently posted scientific brief
- Clinical Resources for Each COVID-19 Vaccine
- COVID-19 Vaccine Communication Toolkit

- FDA Press Release
- Pfizer-BioNTech COVID-19 Vaccine EUA Letter of Authorization
- Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Health Care Providers
- Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Patients

Nebraska ICAP Acute Care Services and Support

Nebraska Medicine

Nebraska ICAP Acute Care Support and Services

Infection Preventionists can be reached at **(402)552-2881**
During the hours of 8 AM – 10 AM and 2 PM- 4 PM, Monday – Friday
Infection Preventionists can also be reached via email at
nebraskaicap@nebraskamed.com

ICAP
Infection Control Assessment and Promotion Program

The Nebraska ICAP (Infection Control and Assessment Promotion) Program is a grant funded team that works through a CDC grant for Biopreparedness. The ICAP Team is proud to announce they have Infection Prevention and Control support for acute care facilities in Nebraska.

The Nebraska ICAP Team is composed of Infectious Disease Physicians and Infection Preventionists that have a background in the acute care setting. They are committed to helping facilities review and identify infection control needs and help to provide support and resources as needed to those facilities.

While Nebraska ICAP works closely with CDC, Nebraska DHHS and other State Agencies, they are not a regulatory reporting agency. Nebraska ICAP is meant to be a resource to assist facilities with their infection control and prevention questions and will keep any facility information confidential to the ICAP Team. Any information used for presentation of grant deliverables or other data will be de-identified before use.

General Infection Prevention and Control Office Hours

Call with questions regarding general Infection Prevention and Control

- PPE
- Hand Hygiene
- Sharps Safety
- Waterline Maintenance
- Environmental Cleaning
- Hazardous Waste Management
- Sterilization and Disinfection
- Respiratory Hygiene / Cough Etiquette

Prevention and Control Facility Review COVID-19 Infection

Call to schedule a time with an Infection Preventionist for a virtual infection control facility review and interview with your team. Plan 90 minutes for assessment and a separate 30 minute virtual meeting to discuss operationalizing the feedback.
Acute Care Infection Preventionists:
Karen Amsberry
kamsberry@nebraskamed.com
Jody Scebold
jscebold@nebraskamed.com

Limited availability
Due to COVID-19, this review will be completed through a phone or Zoom interview until further notice

COVID-19 Response

Call with specific questions regarding COVID-19 response in the dental setting

- COVID-19 safety for Staff and Patients
- Testing
- Contact tracing
- Isolation and Discontinuation of Isolation Guidelines

COVID-19 Infection Prevention and Control

Call with questions regarding COVID-19 specific Infection Prevention and Control

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Outpatient Infection Preventionists:
Lacey Pavlovsky
lpavlovsky@nebraskamed.com
Sarah Stream
stream@nebraskamed.com

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Nebraska ICAP Dental Support and Services

Nebraska Medicine

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The Nebraska ICAP Team is composed of Infectious Disease Physicians and Infection Preventionists that have a background in both medical and dental fields. They are committed to helping facilities review and identify infection control needs and help to provide support and resources as needed to those facilities.

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COVID-19 Infection Prevention and Control Facility Review

Call to schedule a time with an Infection Preventionist for a virtual infection control facility review and interview with your team. Plan 90 minutes for assessment and a separate 30 minute virtual meeting to discuss operationalizing the feedback.
Dental Infection Preventionist
Sarah Stream
sstream@nebraskamed.com

Limited availability
Due to COVID-19, this review will be completed through a phone or Zoom interview until further notice.

COVID-19 Response

Call with specific questions regarding COVID-19 response in the dental setting

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COVID-19 Infection Prevention and Control

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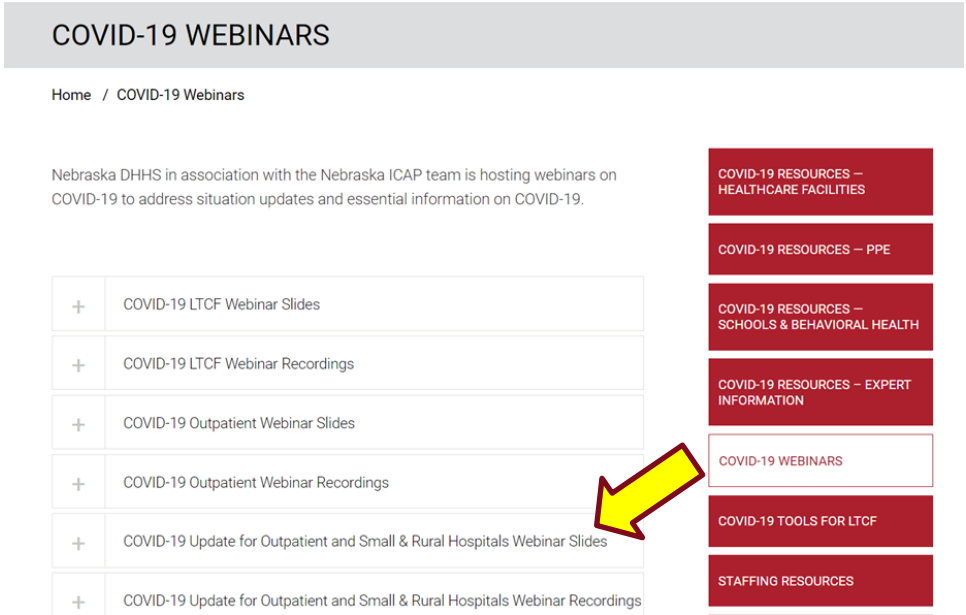
Question and Answer session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator; in the order they are received. A transcript of the discussion will be made available on the ICAP website



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NETEC – NICS/Nebraska DHHS HAI-AR/Nebraska ICAP
Small and Critical Access Hospitals-Outpatient Region VII Webinar on COVID-19 12/15/2020

1. **How Nebraska Medicine has planned operationalizing and instituting crisis standards of care? How did you identify stakeholders who needed to be part this discussion and who did those folks end up being? How will we know when crisis standards of care need to go into effect? Who makes that call and how is that communicated to the rest of the team?**
   Rachel Lookadoo explained that when she and Abbey Lowe were working on this, they really wanted to make sure that this was a document that was adaptable for a lot of different health systems. The way this looks in practice at different hospitals will be different. Rachel said she cannot speak specifically to Nebraska Medicine's process, but different hospitals will have different triggers. For some, that will be at a healthcare coalition level. If a certain hospital within the coalition is no longer able to meet the needs in the community, Rachel thinks there will be some resource sharing between hospitals and facilities within a given coalition. The coalition may trigger that. But larger hospitals like Nebraska Medicine or other larger systems will probably have trigger points within their own facilities. She knows this is a little confusing, but it needs to be a little bit malleable based on the needs and the size of the facility or the hospital.

   In terms of the stakeholders who they engaged on this; when they were doing the review, they wanted to have a pretty broad representation of clinicals specialties and geographic locations, looking at the plan. As she mentioned during the slides, they had reviewers across the state of Nebraska looking at this. They had individuals who were involved in critical care, infectious disease, EMS, pediatrics, and it was quite a large crew. It was interesting to Rachel that in putting this plan together, they were fortunate to have the foundation of the Massachusetts Plan to build off of. Time is a little bit of a luxury in this COVID response, and its not necessarily something we have. In November, as you likely recall, our numbers were getting pretty high and so the group was getting about the risk of having to use this plan. They wanted to get something in place as soon as possible. But the group was fortunate to have another plan that they could build from, where the people who created the Massachusetts plan had years to put this together and had years to vet things out. It was nice for this group to be able to take a fairly vetted plan and just adapt that for our needs. It was important when they had stakeholders review it, just to have a broad breadth of people who could look over this and make sure that they had adapted it appropriately to the needs of Nebraska.

   Abbey added that as they have been working on this, that the task has been really engaging across the state. They did that through the healthcare coalitions, primarily, to understand the needs of facilities across the state. In Omaha we think of some of the larger healthcare institutions, but they are really thinking about critical access hospitals, and thinking about a critical access hospital in relationship to a regional hospital, and what the transferring looks like out of that, once they are at a point when they can no longer take patients. It's a different

schema than what we face here in Omaha. Thinking about some of that has really been, in terms of operationalizing and supporting how plans are put in place for somewhere like the Panhandle, is quite different. The schema that they have to work with is quite different than what we have to look at here in the Omaha coalition. Some of these plans, while they are similar, across the board, if you look at the plan for Massachusetts, its not all that different from the Colorado plan, which is not all that different from the Minnesota plan. One of the things she has noticed is that their capturing of an urban space versus a rural space is quite different. That has been some of the biggest work, thinking about operationalizing it an dhow different stakeholders think about what it means to operationalize the plan in their region of the state.

2. **How does palliative and hospice care fall into the Crisis of Standards of Care Plan?**
   Abbey said one thing to consider is that palliative is a really key of any Crisis Standards of Care Plan, because you do foresee that palliative care will be a big need, given what we are talking about and the next kinds of decisions we are talking about. A lot of times, the algorithm for Crisis Standards of Care specifically indicate that if the decision is no here, then to move to palliative care, in terms of this plan we had several palliative care physicians reviewing and revising the plan with us and making sure that the plan met the needs of palliative care in our state. She does think that one of the recommended best practices for facilities is to think of palliative care resources as it relates to their individual facility-level plan. That is in order to ensure that they have kind of thought through if a surge happens and there are a lot more patients who would need palliative care, if they have thought about what that means in terms of staffing. She hopes that starts to answer the question and asked the audience to feel free to follow up if they didn't get the complete answer they sought. Rachel agreed with Abbey's answer to the question.

3. **Jody Scebold asked a question in relation to emergency preparedness plans that we have been encouraging facilities to develop and modify as new information is released by the CDC and the FDA. Regarding the emergency preparedness plan, how would an organization incorporate this Crisis Standards of Care in the context of their local health department, and their healthcare coalition? What resources do they have to update that emergency preparedness plan if they have not done that already?**
   Rachel said that this actually lends itself fairly well to being integrated into a given hospital or facility emergency preparedness plan. In a lot of those plans, you talk about a medical surge event. Crisis Standards of Care plans are just a natural extension of those plans. This can fit in well with some of the planning efforts that have already occurred. For resources, she advises tapping into your healthcare coalition is probably your best bet. As Rachel mentioned before, she and Abbey have been working really closely with each of the healthcare coalitions across the state to help the operationalize the plan for their region. Any given facility could reach out to their healthcare coalition coordinator to get an idea of how they can be involved in that planning and how they can incorporate this statewide Standards of Care Plan that we have developed into their own plan.

   Rachel said she does not know if the local health departments would have as much to assist in this, but she thinks the healthcare coalition is really the facility's best bet. That is just a great

resource and a great way to connect with other facilities in your region and share resources and information. She would encourage anyone to reach out to their coalition and to find out how they can be involved in the Crisis Standards of Care planning that is going on at that level.

4. **Regarding the vaccine against COVID 19, has any more information been released regarding the Moderna such as the fact sheet for healthcare providers or for patients?**
   Jody Scebold said the key to all of that information is that the EUA has to be approved and released by the FDA. Once that is determined, that is when all of the information will be released. This is similar to what was done with Pfizer. The EUA has to go through and then the FDA does a press release on that. That foretells all of the information that will follow that. Once Moderna goes through the whole process with the FDA, the information will be released.

5. **Final thoughts?**
   Abbey added a plug for the Crisis Standards of Care planning. In our state, as Rachel said, that healthcare collation has been the primary access point as they have been doing a lot of the planning and education around the state. If you, at your facility, think you would like a little more education on it and would like some more guidance as you develop your own facility plan, please feel free to either reach out to Rachel and Abbey or work through your healthcare coalition. They are happy to work with sites and facilitate the launching point from the state plan to a facility plan. They are a resource for that.