COVID-19
Pathways to Recovery

—

Considerations and Resources to Guide Hospitals and Health Systems

June 2020

PREFACE

COVID-19 has been an unprecedented challenge for our nation and the hospitals and health care systems that serve communities across the United States.

We've cheered the heroics of nurses, physicians, emergency medical technicians, orderlies, dieticians and other hospital workers who have cared for their patients under extraordinary circumstances. We've applauded the lab techs and scientists working around the clock to test and develop new innovations and cures. And we've begun to flatten the curve and see a path forward of what will be a new normal for all of us.

As we chart that path together, we want to share a new resource, **COVID-19 Pathways to Recovery**. Development of this compendium has been led by a recently formed AHA Board Task Force with input from many members of the association. While it is not intended to be an all-inclusive resource and will evolve over time as we learn more, it provides important considerations, questions and checklists to review moving forward.

The first part of this resource covers critical areas, including workforce, testing and contact tracing, internal and external communications, and the supply chain. The second part covers additional areas for planning: support and ancillary services, plant operations/environment of care, financial management and governance. It outlines areas for hospital and health system leaders to consider as they work toward a safe, orderly return to providing comprehensive health care services to their communities, while continuing to care for their workforce and begin longer-range planning. The third part of the resource focuses on a new patient experience, transitions of care and risk management, as well as examples of lessons learned from throughout the country (see Appendix 6).

It is important to note that any plans to resume suspended services (see dashboard in Appendix) should be developed concurrently with a plan to modify services should conditions warrant. Where possible, modification parameters should be pre-established and widely communicated before such actions are required. Several examples are included in the report.

We recognize that COVID-19 has affected each community differently, so please use this resource in combination with – and not as a substitute for – other guidance and requirements from professional and accrediting organizations, as well as the federal government and your state government.

Thank you to all of those who contributed to this resource. We welcome your comments as the resource continues to evolve.

CONTENTS

WORKFORCE

COVID-19 has had a significant impact on the health care workforce. As most parts of the country have been expected to social distance and stay at home, our health care heroes have been on the front lines of this crisis. Hospitals and health systems, particularly those that were not in "hot spot" areas, experienced greatly reduced patient volumes as they moved to conform to federal authorities' directives to severely limit non-emergency surgeries and postpone other non-urgent procedures. In addition, community fear of exposure to COVID-19 caused many patients to stay at home, rather than seek needed medical attention. These diminished numbers of patients coming to the hospital for care meant many hospitals had to furlough valued health care providers and administrative staff.

In areas that did experience an influx of COVID-19 patients, and particularly in hot spot areas that had large numbers of COVID-19 patients, there are many workforce challenges, including concerns related to mental health, resiliency, education/training, staffing models and other operational considerations. These challenges also present a unique opportunity for health care organizations to consider how different training, resources and deployment of the workforce might better support our health care workforce meet the health care needs of the future. Below are areas of consideration as hospitals and health care organizations begin to move toward more normal operations.

STAFFING[1]

- Do we have a comprehensive plan and process to strategically bring back workers who were furloughed, considering which services can and should be reopened first? In addition, consider whether some of the furloughed workers can and should be deployed to allow those who have been on the front lines of treating COVID-19 patients to take time off to rest and recuperate.

  – Does this plan include communications to the furloughed workers so they are clear about how the organization is staging their return to work?

  – Have we considered what training needs are necessary to equip the returning workers with information on the new protocols for safely treating patients, including those whose COVID-19 status is either unknown or is positive?

  – Does the plan describe how we will manage those furloughed workers who are receiving unemployment benefits that pay more than their compensation and do not intend to return to work until those benefits are exhausted?

- How are we prepared for potential staffing challenges related to requests for new federal leaves allowing up to 12 weeks of leave related to child care issues?

- Do we have a plan for vacation coverage for employees who were unable to take leave during the outbreak? If the outbreak continues to create difficulties for staff to use their time away, should we consider additional options like buybacks or offering/increasing carryover into 2021?

- Have we considered how we might comply with Centers for Medicare & Medicaid Services (CMS) guidance suggesting that some staff be assigned exclusively to the care of COVID-19 patients, while others are assigned exclusively to non-COVID-19 patients to reduce the opportunity for accidental transmission?

  – Have we considered how to best staff new responsibilities, such as COVID-19 screening, temperature taking and tracing contacts?

- Have we explored how new or emerging COVID-19 roles might be taken by furloughed or staff redeployed from another role?

- Have we considered whether staff who test positive for COVID-19 but are experiencing no symptoms or only mild symptoms might be redeployed to work-at-home roles or other modified duty, taking into account Occupational Safety and Health Administration (OSHA) or workers compensation rules and regulations?

- Do we fully understand the impact of clinicians, who are currently practicing at the top of their license due to waivers, returning to their previous roles? What needs to be done to ensure the timeline and expectations are formally communicated to not only the affected clinicians but also to physicians and other staff who might have relied on higher level of practice during COVID-19?

- Have we established a timeline or threshold when we will return pay practices to pre-COVID-19 levels? Will it be a gradual or all-or-nothing approach?

BEHAVIORAL HEALTH[2]

- Are we prepared to identify and address potentially increased behavioral health needs of our employees due to issues related to COVID-19?

- When a caregiver, employee or family member feels overwhelmed and seeks help, do we have a seamless process to guide them to appropriate resources based on their preference? Is this process well known by supervisors and easy for staff to access?

- Given that many experts believe there will be a potential surge in demand for behavioral health services following COVID-19, do we have a plan to provide needed services, such as telepsychiatry capabilities for our employees and the community?

- How do we equip leaders at all levels, especially those with point-of-care staff, to identify behavioral health needs in staff before they become critical?

- Can we deploy our internal ethics and root-cause analysis resources to address work environment issues?

- Consider using the process of trauma debriefing, a process that is activated when there is some type of traumatic experience staff have — for example, mass casualties, error that results in death, death of a colleague (maybe someone who took care of them), etc. Those involved are traumatized, and the process is to bring in skilled professionals to help staff work through their emotions and the situation. These could be chaplains, experts in facilitating these interventions or other professionals.

RESILIENCY AND BURNOUT

- Are we placing adequate attention to addressing resiliency and burnout for employees?

- Are there programs in place or planned to provide bedside staff, especially nurses, the opportunity to define lessons learned from their experience or to identify opportunities for improvement?

- Are there new leadership models that emerge from this experience, which should be incorporated into organizational plans going forward, e.g., more prevalent dyad models at the clinical unit?

- How do we appropriately celebrate and recognize the accomplishments of the workforce to support hospital workers?

- Are we communicating effectively with employees ensuring that information is flowing from leadership as we continue to transition back to more normal operations?

- How can we best instill or enhance employee trust and loyalty over potentially perceived issues impacting employee safety, such as adequate personal protective equipment (PPE), or with employees who were furloughed?

- Have we considered the impact to staff/teams who prepared for readiness and were not utilized?

- How do we encourage and support people to take time to recover/take time off so they have renewed energy to be ready for a potential second wave of COVID-19?

- Do we have special provisions in place for those work units that have experienced a loss due to COVID-19, e.g., colleague, family member, etc.?

EDUCATION AND TRAINING

- What training needs to be created or revamped to ensure that our organization is better prepared for future outbreaks?

- Have we reviewed and considered potential flexibility or waivers for annual competency reviews or performance appraisals?

- Have we considered other technology training needed to successfully operate new and increased usage of systems, such as those used for telemedicine?

- Are there protocols in place for shifting clinicians via competency-based training to work in critical care units or other areas where they are most needed?

- Do we have education and training for employees on testing protocols and plans as appropriate?

- Have we curated and shared appropriately all the lessons learned from this pandemic?

- When will we reinstate any suspended clinical rotations, internships or other training program offerings?

BACK-TO-WORK TRANSITION[3]

- Are we prepared to communicate and reinforce organizational policies that have been changed during the COVID-19 surge?

- Are there roles or departments that can transition to permanently remote roles? How are we considering expanding clinical remote work options, such as telehealth?

- What technology needs have been identified during this surge of remote work to ensure future remote work is adequately supported?

- What new productivity monitoring tools are needed to support remote work?

- Are there new variable compensation models that would better match remote work models?

- How long will leave of absence (LOA)/quarantine benefits related to COVID-19 need to be extended? Are we prepared for requests from our staff to retain and expand the pay to other highly communicable diseases?

- Is our employee health and wellness function ready to return to normal operations while still responsible for activities related to COVID-19? What will be our timeline?

- Are our workers compensation programs up to date relative to the experienced and expected work environment?

- Is our human resources team prepared to assist staff who may be or have been furloughed, e.g., unemployment claims, COBRA, etc.

- How will we restart our volunteer program(s)?

PHYSICIAN/PROVIDER RELATIONS

- How will physicians/providers and their teams be part of the decision process and prepped to share with patients the prioritization of backlog cases?

- What impact will the reassignment of physicians/providers redeployed to other areas have on bringing back other services?

- How will physician/provider workload be impacted by advanced practice professionals returning to previous duties?

- Do we have defined communications and decision-making processes to meet the needs of both employed and independent physician/provider groups? Have these been developed in collaboration with our medical staff and our employed medical group(s) governance structures?

- How will we support outpatient physicians/providers in ramping up their practices again in coordination with the hospital, ensuring there are appropriate ancillary services to support their work?

- Are we monitoring the Stark waivers and prepared to respond should those waivers be reversed?

INTERNAL AND EXTERNAL PRESSURES

- Is our organization prepared for questions and possible resistance from staff about the return to pre-COVID-19 practices (policies, pay programs, flexible work options)?

- Is our organization prepared for the potential of labor unions wanting to negotiate over issues such as:

  – Nursing salaries, bonus pay and living wage for support employees

  – Paid LOA and quarantine

  – Staff safety, specifically PPE

  – Patient safety-events and patient ratios

- Is our organization aware and monitoring potential workers compensation claims related to COVID-19?

TESTING AND CONTACT TRACING[4]

In addition to the considerations outlined below, the previously released Joint Statement from the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses and the American Hospital Association on restarting non-emergent procedures, as well as the CMS guidelines, can be referenced.

To effectively reopen services in your organization, you will need to be able to plan for and execute effective surveillance, testing and tracking protocols that cover any number of populations, e.g., patients, staff, vendors, high-risk community populations, etc. This must be done in collaboration and coordination with public health services. In addition, you must have robust data collection, trending and analytic capabilities. The quality, sensitivity and specificity of testing continues to evolve. At this time, high percentages of false negatives are being reported. Testing does not supersede clinical judgment.

To identify and be prepared to respond if there is a resurgence of COVID-19 in your service area, you will need to know that there is a public health plan for testing and tracing and your role in that plan.

Below are areas of consideration for testing and contract tracing.

PLANNING

Testing will require more than just hospital efforts. You will need to coordinate with public health departments, community groups, other providers and relevant government agencies to understand which entity will lead which effort and where resources are best deployed. For hospitals in areas that border multiple state jurisdictions, additional outreach may be needed.

- Define the role of each of the players involved and the resources needed to be effective in ensuring the integrity of the testing plan. Players include public health departments, community providers, community-based groups, clinics, urgent care centers, state and private laboratories, and others.

- Testing sites will need to be identified, supplied and staffed appropriately. When possible, full community resources (including commercial, state and private) should be considered in determining the most efficient and effective plan. The following areas should be considered:

  – Ensuring adequate supplies, including reagents, specimen media, swabs, cartridges and PPE

  – Confirming types of analyzers available and locations

  – Coordinating with regional/state organizations for additional capacity

  – Ensuring all high-risk communities have access to testing

  – Ensuring cultural competency and diverse needs

- Identify the appropriate use of viral versus serology tests, and define in which circumstances each should be used. In each instance, what is the role of the hospital in decision-making and implementation?

- Identify which organization will be responsible for testing to better understand the prevalence of COVID-19 in specific populations, particularly vulnerable population groups (e.g., nursing homes, homeless, minority populations, etc.)

- Discuss the value of centralizing testing to reduce PPE use and staff exposure and ensure appropriate coordination across community sites.

- Identify how testing availability will be communicated, scheduled, and/or prioritized; identify spokespeople and unified messaging across partners; understand and apply nationally recognized testing prioritization algorithms and protocols; consider the need to translate these messages in various languages. See the Appendix for a sample tool provided by Vanderbilt University Medical Center.

- Assign the responsibility for routine monitoring of state and local testing guidelines.

WORKFORCE TESTING PROCEDURES

Together with your employee health and wellness service team and infectious disease specialists, you should define the special testing needs of the health care workforce. Some considerations in this area include:

- Identifying timing/intervals for staff testing

- Defining a process for maintaining awareness of employee/medical staff/contract staff/volunteer/first responder infection status

- Identifying who will test first responders including emergency medical services entering your facility

- Identifying policies on testing and guidance for refusal of testing

- Educating and training staff on testing protocols and plans as appropriate

- Documenting staff testing

DATA COLLECTION AND INFRASTRUCTURE

To predict, identify, address and track outbreaks, testing data must be collected, analyzed and reported across the community. A data collection and reporting protocol should be developed in conjunction with key community partners.

The protocol should identify key partners, responsibilities and resources in three main areas:

1. **Data collection and submission**

   a. Coordinating data collection and submission efforts across sites of care, to minimize data collection and submission burden;

   b. Using standard race, ethnicity and language (REAL) definitions in data collection efforts;

   c. Ensuring frequent data collection and updates

2. **Data analysis and reporting**

   a. Key metrics/performance indicators

   b. Stratification, including by care site, patient characteristics, REAL data elements

   c. Update frequency and data currency

d. Defining reporting models for individual care planning and comprehensive insight into the prevalence of the virus in various communities

3. **Data security**

   a. Ensuring data collected are protected according to HIPAA standards, particularly with regards to substratification

   b. Ensuring results reported are protected according to HIPAA standards, particularly at the site or geographic subdivision

   c. Executing data use agreements as appropriate when sharing data across organizations

SURVEILLANCE AND CONTACT TRACING

Hospitals and health systems should coordinate with state, regional and local health departments (including neighboring states as applicable) for surveillance and contact tracing protocols and execution of these protocols. Coordination should include:

- Defining surveillance, including use of serial testing

- Establishing infrastructure and procedure for tracing and documenting hospital-acquired COVID-19 infections/staff infections

- Considering use of community health workers/community connections to supplement tracing resources needed

- Investigating and identifying appropriate tools for follow-up/monitoring of people quarantined at home, including using technological and telehealth solutions

COMMUNICATIONS: INTERNAL AND EXTERNAL

As health care workers continue to fight the COVID-19 outbreak, it remains unclear how long the practice of social distancing and isolation will continue. As time moves on, the need for safe medical care not related to COVID-19 becomes more important than ever for the communities that hospitals and health systems serve. Emergency, non-emergent and preventive care is still available and safe to access.

Hospitals and health systems will need to communicate to their internal and external stakeholders how their plans and procedures have changed. Communications professionals will need to create post-COVID-19 strategies to inform the community about expanded or reopened services, continued protective measures and strongly encourage anyone in need of emergency care to go to the hospital.

Hospitals and health systems will need to be attuned to the overall mood of the community and shape the tenor of their communications appropriately, sharing accurate health information and helping the public overcome apprehension of seeking care.

Recognizing that recovery of the health care delivery infrastructure will happen on different timetables in different parts of the country, AHA provides a general messaging framework and communications toolkit that will include resources for hospitals to tailor and adapt for their staff and communities.

Hospitals and health systems need to communicate with many different audiences. But all communication outreach should meet certain core objectives that reinforce hospitals are open and care should not be delayed, hospitals and health systems are safe, and the well-being of caregivers and patients is a key priority. The messages below can be customized for different audiences — for example, internal or external, clinicians or patients — but they should reinforce the same objectives.

OVERARCHING COMMUNICATIONS RESOURCES/TALKING POINTS

Hospitals, health systems and clinics are a safe place to seek care, no matter what your health need. Since well before the arrival of the COVID-19 pandemic, the safety of our patients is and always has been our first priority. Our hospitals safely manage infectious diseases every day. We will continue to provide safe, effective, patient-centered care in our facilities.

First and foremost, we are following the guidance and direction of our public health experts, closely monitoring and adopting new findings and following clinical protocols developed by expert scientists and clinicians in every discipline of care.

OVERARCHING MESSAGES ON COVID-19 AND MOVING TO RECOVERY

We are ready, safe and open for you. In coordination with area health care providers, local and state government leaders are returning to pre-COVID-19 operations by DATE. ***IF RELEVANT** This includes immediately resuming procedures such as heart valve replacement, tumor removals and other so-called elective procedures.* As we reinstitute operations, we will follow guidance in the National Coronavirus Response to ensure patient safety and prevent the spread of COVID-19 or a resurgence of the virus throughout the state.

Emergencies don't stop, and neither do we. Do not delay care for heart attacks, strokes, falls and other urgent needs. We will continue fighting COVID-19. We will provide our physicians, nurses, other team members and

patients everything they need to stay safe. And we'll continue caring for you and your family. Thank you for doing your part. We are here to do ours.

We're here to keep you healthy and safe. We have taken extra precautions to ensure our employees and patients are safe. First and foremost, we are following the guidance and direction of our public health experts and closely monitoring key issues and following clinical protocols. *[Be specific about what measures you are taking to keep patients safe.]*

Thanks to our health care heroes. The doctors, nurses, respiratory therapists and entire health care workforce – cafeteria workers, environmental services, and other support staff – who are in this fight on the front lines are facing pressure unlike ever before. They are heroes, and no amount of thanks is enough.

The health and safety of our community – including our workforce – remain the top priority. COVID-19 has enhanced our already intensive patient safety efforts and ensured we are doing everything possible to keep staff safe as well. You will see additional precautions, including intensive cleaning processes, in all areas of the hospital, particularly the emergency department and intensive care units, as well as:

- Increased COVID-19 testing opportunities, including curbside testing

- Social distancing in waiting rooms and mask use in common areas

- Restrictions on visitors

- Limited entry and exit points

- Asking patients to stay in their cars after arrival until called into the office

- Using virtual care when it is available and appropriate

COVID-19 COMMUNICATIONS TOOLS AND RESOURCES

- COVID-19 Communications Resources

- COVID-19 Communications Checklist

FRAMEWORK THROUGH WHICH ALL MESSAGING AROUND "REOPENING" SHOULD BE CONSIDERED

As a guiding principle, ALL decisions will be grounded in science and data and will be made in the interest of delivering safe, needed care.

- Prevention and treatment of COVID-19 will continue – prioritizing the safety and well-being of patients, the health care workforce and the community.

- Communicate openly and often during this time of crisis – sharing concrete examples of safety measures, protocols and national guidelines being followed to keep patients safe.

- Ensure that all community members know that their local hospital is open, safe and ready to provide emergency care whenever needed. Care should not be delayed.

- Consider coordination and collaboration with partners for effective and consistent communications – including providers along the continuum of care, as well as other community stakeholders.

INTERNAL COMMUNICATIONS PLAN AND CHECKLIST

As the cornerstone of the health care community, hospitals and health systems play a crucial role in providing science-backed information and helpful resources to keep the public safe and informed. Communicating early and often with staff will be crucial in efforts to instill confidence in the ability and safety of our organizations. The women and men bravely fighting this virus must feel safe and be supportive of recovery efforts. As many hospitals and health systems have been doing over the past two months, open and transparent communication with staff must be in place before any large public communications effort occurs. It is critical that staff and internal partners, such as trustees, are updated and consulted frequently. Staff play a critical role in creating confidence in the safety and quality of care provided. Providing them with the information necessary to act as ambassadors for this messaging is a high priority. Consider conducting a brief internal communications survey to gauge the effectiveness of internal communications.

EMPLOYEE BACKGROUNDER

Provide employees a concise reference document or location (intranet) with links to relevant clinical guidelines, resources and documents. As the pandemic continues and our recovery efforts evolve, new information will become available, and it will be helpful to provide staff a single source for updated content and guidance. This single source should be designed with the input of various disciplines throughout the hospital, including but not limited to human resources, risk management, clinical specialties, such as infectious disease and employee health and wellness. This information could include:

- National guidance on non-emergent procedures

- Internal policy on resuming non-emergent procedures

- Centers for Disease Control and Prevention infection control recommendations

- Safely Caring for COVID-19 Patients: Tools for Your Workforce

- Isolation protocols

- Training needs and offerings

- Testing procedures

- PPE supply status

- Staffing plans

- Wellness services

- Employee assistance programs

- Work from home assistance when appropriate

INTERNAL COMMUNICATIONS PLAN

During times of crisis and uncertainty, it is more important than ever that hospital and health system leaders provide clear and frequent updates to ALL staff members (clinical and otherwise). Communications should be designed to offer timely day-to-day messages, in addition to information on future planning and what staff can expect to see. Members have reported that a daily huddle for leaders to share updates, to hear a common message

regarding status, and to problem-solve is a powerful way to keep the organization aligned with priorities and next steps. Consider recording these messages and making them available for staff who might not be able to be present. Through coordination of talking points, communication dissonance can be avoided or at least minimized.

Proactive communication with staff is critical; share information about steps being taken to ensure the safety and well-being of staff and patients, outline guidance and protocols for staff, and offer recognition and appreciation. Hospital employees serve as influential messengers with patients and within the community.

Below is a general framework for consideration as part of any internal communications plan. Please tailor this framework to meet the needs of your own organization and community and to align with your internal communication strategy during the COVID-19 crisis and progress toward recovery.

WHO TO COMMUNICATE WITH	
AUDIENCE	**EXAMPLES**
Clinical staff (communications should go to leaders as well as font-line workers.)	• Doctors, nurses, techs and all other front-line caregivers
All hospital staff (all departments)	• All staff including environmental services, engineers, food services, pharmacy, etc.
Other clinical partners	• Community physicians • Providers along the continuum of care • Key vendor partners
Human resources	• HR must have up-to-date information, particularly as it relates to any staffing changes
Trustees	• Many boards do not meet frequently; consider more frequent communications throughout the COVID-19 crisis
Auxilians	• Volunteers must be aware of all new COVID-19-related protocols
Key community partners	• Consider keeping community organizations, medical or otherwise, affiliated with the hospital/health system abreast of current practices, including local business leaders (for academic health systems, this will include faculty and staff, residents, fellows, students, etc.)
HOW OFTEN TO COMMUNICATE ***This may depend on where states/communities are in the pandemic.*	
FREQUENCY	**EXAMPLES**
Daily: Overcommunication is key during times of uncertainty.	• Staff emails • Text messages
Weekly: Highlight key dates so staff feel informed and engaged in any new processes.	• Intranet postings • Staff meetings • Leadership messages

Monthly (or bi-monthly): Share data, accomplishments.	• Leadership video messages • Success stories, vignettes

HOW TO REACH INTERNAL AUDIENCES

COMMUNICATION VEHICLES	EXAMPLES
Traditional staff email	• Communicate often, share relevant information and solicit feedback
Newsletters/Weekly overview	• Compile key information/ reminders of key information
Intranet	• Since the situation may change rapidly, provide staff a single source for updated resources
Text messages	• Offer relevant and timely updates
Video messages	• Leaders can share message of inspiration, pride and thanks
Interactive video meetings	• Interactive meeting platforms offer a good opportunity for Q&A with staff
Signage	• Reinforce key messages, checklists and protocols on visible signage
Staff meetings	• Share information during department meetings
Website updates	• Spotlight staff, highlight successes and reinforce key messages; consider including a way for the community to express gratitude and support
Social media posts	• Spotlight staff, highlight successes and reinforce key messages, including appreciation
Outdoor signage	• Look for opportunities to spotlight your health care heroes – could include banners, outdoor signage, elevator wraps, etc.

WHAT TO COMMUNICATE ABOUT

TOPICS	EXAMPLES
Status of PPE supply	• Share information about availability of PPE; if relevant, share efforts underway to secure additional PPE • Offer instructions on PPE usage
Availability of tests	• Share information about testing capability/options • Criteria for testing
Plans to reopen/resume services	• Offer clear guidance on the plans to resume non-emergent surgeries • Guidelines for determining readiness to reopen • Process under which surgeries will be scheduled
Infection control processes/guidelines	• Review infection control checklists, highlight any new practices
Clinical processes/protocols	• Share guidelines for resuming non-emergent surgeries; highlight any new practices, workflow patterns, etc.

Safety steps/checklists	• Highlight measures being taken to ensure both staff and patient safety during the continued COVID-19 crisis
Workforce/staffing considerations	• Proactively share information about staffing changes, furloughs and reductions in pay
Solicit feedback	• Encourage employees to share their feelings, what they need or are concerned about
Recognition, wellness and resiliency	• It is important to show signs of thanks, from leaders and also patients and community members • Recognize the dedication of staff members • Provide resiliency and well-being resources for team members • Routinely spotlight wellness resources, mental health hotlines, etc. at the bottom of internal messages
Share success stories	• Keep morale up by sharing success stories, examples of things going well, progress being made • Engage staff to help identify success stories/moments of pride

WHAT TOOLS ARE AVAILABLE FOR EMPLOYEES	
RESOURCES	**EXAMPLES**
Online forum	• Consider an online community or forum with a Q&A function for staff to ask questions, get advice from leaders and also peers
Resource center	• Develop a place to house all relevant documents, tools and resources related to COVID-19
Talking points/Messages for patients	• Consistency of message is important; share topline messages and guidance to patients so clinicians are able to share information about the hospital/health system practices
Printable signage for clinician offices	• Provide collateral materials with consistent messaging to be shared with patients and used in clinician offices
Discounts/Specials	• Share information about current discounts and specials available for health care workers

COMMUNICATIONS ASSESSMENT FOR LEADERS

As key members of the health care community, hospitals and health systems play a crucial role in providing accurate information based in science that will keep the public safe and informed. Caregivers, staff members and internal partners will be turned to as credible sources of information. It is essential that they have the information needed to do their jobs well, keeping patients and themselves safe and healthy.

This self-assessment is designed to help hospital and health system leaders evaluate how they are communicating internally, what mechanisms are in place and working well, along with potential opportunities to enhance communication efforts.

PROTECTING YOUR HEALTH CARE WORKERS

- Communicate often; frequency should increase during a crisis.

- Be transparent with staff as it relates to what measures are being taken to ensure their safety and well-being.

- Share updates on any new guidance or clinical protocols that should be followed.

- Outline and remind staff what ongoing processes are in place to keep them safe.

- Share patient- and public-facing communications internally to ensure staff are aware and can be consistent in their own responses to patient questions.

HOSPITALS ARE OPEN AND SAFE, AND NEEDED CARE SHOULD NOT BE DELAYED

- Clinicians and hospital employees are valued sources of information within a community; make sure they know current operational status and are able to share key messages.

- Provide employees with easy-to-relay messages about what safety precautions are in place and status of full operations.

NON-EMERGENCY PROCEDURES ARE RESUMING

- Share guidelines for how the restart of non-emergent procedures will be determined, following state guidelines as well as internal hospital policies.

- Share guidelines on types of surgeries considered non-emergent procedures.

- Provide employees with easy-to-relay messages about what measures have been taken and what they can expect when they come to the hospital.

ESTABLISH TWO-WAY COMMUNICATION WITH HEALTH CARE WORKERS

- Create mechanisms to solicit feedback from employees; understand how they are feeling during these uncertain times.

- Establish a clear path for employees to share concerns and for organizational follow-up to those individuals.

- Ensure you communicate timely and proactively about any new changes or policies so staff are able to ask questions and raise concerns.

- Consider hosting in-person or virtual staff meetings that allow questions from staff.

PROVIDE COMMUNICATIONS RESOURCES FOR STAFF

- Develop and share basic messages, tips and to-dos that health care workers can easily relay to patients and to community members.

- Ensure that staff know how and where they can access all relevant materials, from clinical guidelines and safety protocols to talking points and posters.

RECOGNIZE AND ACKNOWLEDGE STAFF

- In addition to sharing information, people need encouragement and inspiration.

- Don't hesitate to send thank-you messages to your team.

- Acknowledge the battle health care workers are fighting and the toll on them and their families, and let them know they are appreciated.

- Be certain to compile and share messages of gratitude and pride sent by others, in addition to resiliency and well-being resources and support services.

ENGAGE A FULL SPECTRUM OF CONSTITUENTS

- Providing high-quality care takes a full team; when appropriate, consider tailoring communications resources for the variety of work units within the hospital.

- Provide communications resources to employed and independent clinicians so patients receive consistent messages.

- Share communication resources and updates with your governing board and other important stakeholders within your community.

CONSIDER NEW MECHANISMS TO COMMUNICATE WITH STAFF

- This is a stressful time. Consider new mechanisms to conveniently communicate with staff and then do it again. It is worth sending a message more than once or in different ways.

- Explore different platforms to communicate with staff, including digital platforms, webinars and virtual town halls, among others.

- Embrace video as an engaging way to deliver messages from leaders, staff, patients and the community.

CELEBRATE THE POSITIVE

- We have a long road ahead of us; share the success stories and positive outcomes.

- Consider engaging staff to share messages of hope, lessons learned and if appropriate patient vignettes.

EXTERNAL MESSAGING

Communication efforts should first demonstrate how hospitals and health systems are continuing to fight the COVID-19 pandemic while stressing that taking measured steps enables the field to move safely toward providing care to those with health care needs beyond COVID-19. This is an opportune time for hospitals and health systems to emphasize their roles as the trusted resource for their community, to seize the conversation and control the narrative. Consider naming a small number of spokespersons to assure consistent messaging, regardless of the communication channel. Through coordination of talking points, a consistent message can be sent.

The field is able to protect the healthy and at the same time care for the sick and injured. While we know that has always been the case, both the public narrative and the public health precautions we have been taking may result in public anxiety about returning to hospitals for needed medical care. With enhanced safety protocols in place and appropriate supply of PPE and by following national and local guidelines, hospitals and health systems can ensure that it is appropriate and safe to resume all levels of care.

There is a need and an opportunity to show strength as a field, uniting with consistent themes of safety and readiness, grounding all action in science and guidance by public health and clinical experts, and demonstrating the clear and concrete examples of what hospitals do (always and specific to this pandemic) to keep patients safe.

Recovery is going to happen on different timetables across the country, but the general messaging framework and elements of communications should be consistent.

CONSISTENT TOP-LEVEL MESSAGES

- Hospitals and health systems are able to protect the healthy, while at the same time care for the sick and injured.

- Hospitals are open to ALL patients, and delaying diagnosis and treatment can put patients at great risk. If you are experiencing a medical emergency, do not be afraid to come to the hospital for immediate care.

- Long before this current health crisis, hospitals and health systems have had both workflow and infection control processes in place to ensure the safety of patients and health care workers. Facing challenges is not new for health care workers; in many ways, it is what they train for.

- In response to this specific health crisis, safety protocols have been enhanced and adapted to best meet the needs of the staff and patients. [Be specific about what measures you are taking to keep patients safe.]

- Your community hospital is carefully following national, state and local guidelines, and taking measured steps to ensure it is appropriate and safe to resume non-emergent elective procedures.

SUGGESTIONS FOR MASS COMMUNICATIONS

While we know the COVID-19 pandemic is far from over, hospitals and communities will begin to move through different phases of "recovery," and it will be crucial that you maintain frequent communications with your community. A sample of ad content, social messaging, print media approaches, press releases and public service announcements is included in the Appendix. Consider the following as tactics to update the community with reliable health information.

- Video messages from hospital leaders and physicians

- Virtual town hall meetings

- Radio interviews/PSAs

- Open letter in newspaper

- Media briefings with different experts

COMMUNICATIONS ASSESSMENT FOR LEADERS

As a key member of the health care community, hospitals and health systems play a crucial role in providing accurate information based in science that keeps the public safe and informed. Hospital leaders, health care workers and community partners will be turned to as credible sources of information. Be sure your team has the information needed to assure patients and communities about the preparedness of hospitals to provide needed care – whether that be emergency care, COVID-19 care or diagnostic and preventive care.

This self-assessment is designed to offer a basic framework that hospital and health system leaders can use to evaluate how they are communicating with the public, what mechanisms are in place and working well, and where there are potential opportunities to enhance communication efforts.

ALL DECISIONS ARE BASED ON SCIENCE AND GUIDED BY PUBLIC HEALTH

- Provide frequent reminders that the hospital field follows federal and state guidance to effectively prepare and respond to anticipated COVID-19 challenges.

- Be transparent in sharing the guidance you are currently following.

- Share updates on any new guidance being followed or practices being put in place.

A DELIBERATE AND TIERED APPROACH IS BEING TAKEN TO RESUME NON-EMERGENT PROCEDURES

- Be transparent in sharing the framework for when and how your hospital will shift to "recovery."

- Share guidelines for how the restart of non-emergent procedures will be determined.

- Outline the steps, milestones and timeframe that will dictate these changes.

- Share guidelines on what type of surgeries are considered non-emergent.

HOSPITALS ARE OPEN AND SAFE, AND NEEDED CARE SHOULD NOT BE DELAYED

- Communicate clearly that hospitals are prepared for COVID-19-related needs, while also ready to care for other health care needs.

- Emergency care should NOT be delayed.

- Provide employees with easy-to-relay messages about the importance of not delaying emergency care and the protocols in place at the emergency department to ensure patient and visitor safety.

- Continue to share stories that demonstrate patients are getting safe, needed care.

HOSPITALS HAVE TAKEN STEPS TO MITIGATE RISK AND MAKE CARE SAFER

- Hospital and health systems have long been ready to care for illness and prevent the spread of infection. Remind patients of existing safety practices.

- Clearly communicate what additional steps hospitals have taken to make care safer and what patients can expect to see:

  - Limited points of entry

  - Screening for all patients before entering the facility

  - Restrictions on visitors

  - Separate triage and treatment for COVID-19 patients

- Telehealth visits may still be appropriate and preferred for some patients.

PROTECTING HEALTH CARE WORKERS

- Be transparent about what measures are being taken to ensure the safety and well-being of caregivers.

- Share updates on any new guidance or clinical protocols that should be followed.

- Emphasize hand hygiene, new guidelines for PPE and other infection prevention protocols.

MANY NEW SERVICES ARE NOW AVAILABLE

- Remind patients about new screening tools or hotlines for questions related to COVID-19.

- Remind patients that telehealth options remain for those who feel more comfortable with it or find it is more convenient.

- Remind the community about any new hotlines that have been created – mental health and others.

HOSPITALS HAVE MANY POSSIBLE MESSENGERS, IN STAFF AND OTHER COMMUNITY STAKEHOLDERS

- Clinicians and hospital employees are valued sources of information within a community. Make sure they are able to share key messages.

- Coordinate or consider aligning communications related to "reopening" with state or local health departments.

- Consider partnering with other community providers (even other hospitals) to offer consistent messaging about safety and the importance of not delaying emergency care.

- Share key messages and tools with local clinicians to be used in offices and with patients.

- Share key messages with trustees.

- Consider partnering with other community organizations or specialty groups, as there may be alignment in messaging, specifically as it relates to not delaying certain medical needs (heart attack, stroke, maternity care, immunization, etc.).

- Share communication updates with key vendors and other partners.

STRENGTH IN CONSISTENCY OF MESSAGE AND COORDINATION WITHIN THE FIELD

- Consider working collaboratively with other providers to share messages of safety and encouraging patients to not delay care.

- Share consistent messages reinforcing and encouraging patients and communities to follow public health guidelines.

- Coordinate with local and state legislators.

SUPPLY CHAIN

The following are a number of key considerations when evaluating the supply chain resources necessary for hospitals to provide non-COVID-19 services:

- Provide routine communication with the state health department and officials to keep them informed and comfortable with the availability of supplies; comply with any state orders regarding par levels and capacity requirements. Some municipalities have defined reporting requirements. See the Appendix for an example of the Kansas City report.

- Develop comprehensive essential product category lists, build and maintain alternative products lists, and document how changes in use of one supply, e.g., ventilators, increase the need for other supplies, e.g., consumables, such as HEPA filters and O2.

- Establish "surge demand" service level agreements with key suppliers and key products.

- Establish protocols and controls to minimize waste in routine practice, as well as crisis contingency plans to conserve resources. Provide clinicians with evidence to inform guidelines for use of scarce resources and provide training in advance to minimize front-line health care worker distress when standard protocols are changed during a crisis.

- Define reuse/reprocessing protocols for key supply categories, e.g., PPE.

- Consider centrally storing and managing PPE levels in anticipation of hot-spot surges and/or a COVID-19 reoccurrence with the oncoming flu season.

- Evaluate supply chain dependencies, i.e., how many of each type of procedure can be performed based upon the availability of not only PPE (if these are not available, are there reusable products that can be utilized?), but also other critical items including linens, medical-surgical supplies, implants, instruments, equipment, pharmaceuticals and infection control resources.

- In addition to supplies on hand, consult with vendors to ensure they have adequate capacity and inventory to meet expanding demand, given the continuing restrictions that COVID-19 has had on both manufacturing and transportation capacity.

- Assure the logistics capabilities required to stock all locations of care delivery, considering that ambulatory and clinic locations may be used differently than pre-COVID-19. What textiles are needed for reopening clinics; can laundries provide reusable products for the disposable items that are not available?

- Determine equipment availability in the operating room, particularly if it was repurposed, e.g., anesthesia machines to ventilator use.

- As patient census increases, due to restart of non-emergent surgeries, where are the linens for patient beds, patient gowns, and terry for the bath? Laundries have reported a substantial decrease in laundry production since mid-March, and many are concerned that this may mean that some hospitals destroyed linen from COVID-19 patients. It is essential to determine where the linens are and what is fit/ready for use. This is best achieved through a linen inventory. Who has access to the textiles to complete an inventory? Can laundry personnel access the hospital, and if so, what are PPE requirements for them?

ANCILLARY AND SUPPORT SERVICES

During the height of the COVID-19 pandemic, care for non-COVID-19 patients may have been postponed while physicians, nurses and other providers prepared for and cared for COVID-19 patients. As the incidence of COVID-19 in hospitals and health systems becomes more stable in many areas of the country, hospitals will begin to move into a "new normal" of caring for patients — some with COVID-19 and some without. Non-COVID-19 patients with medical needs requiring procedural care (surgeries and procedures), chronic disease management, and preventive services may have experienced delayed care during the initial response phase. Facilities that can do so safely can now resume providing care for these patients needing non-emergent, non-COVID-19 health care to prevent worsening of other health conditions or preventable deaths.

Many hospital functions straddle multiple clinical and non-clinical areas to enable the work of the entire organization. Some are referred to as ancillary services, and others are support services. Many ancillary and support functions also may have been scaled back or had resources redirected to activities related to COVID-19. Ancillary services — including therapeutic, care delivery and diagnostic services — are vital parts of care for patients. Support services — such as health information technology (IT), telehealth, quality and medical staff services — ensure the appropriate functioning of the organization, including care delivery, clinical services and revenue cycle management.

Temporary federal and state regulatory waivers that were intended to give hospitals more flexibility to respond to COVID-19 will likely evolve as the pandemic unfolds, and hospitals will need to monitor and respond to those changes.

To support hospitals and health systems in designing a "new normal" for various ancillary and support services, considerations for each are described below along with those that apply to resuming these services. As hospitals balance resuming services not related to COVID-19 with preserving capacity to handle surges of COVID-19 patients, these considerations can help guide your organization. Hospitals should be able to treat all patients without crisis standards of care. Maximum usage of telehealth modalities is strongly encouraged when possible to meet patients' needs and protect patients and caregivers.

CONSIDERATIONS FOR RESUMING ANCILLARY AND SUPPORT SERVICES

Beyond the decision about when to resume non-emergent and non-urgent procedures, hospitals also have to weigh which particular ancillary and support services can be resumed, and at what time it makes sense to resume them. Teams also should carefully consider how resuming services will affect the organization's readiness to provide care in case of a surge. It is important that hospitals closely monitor and adhere to requirements and guidance from the CDC[5] and other authorities[6]; any resumption should be authorized by the appropriate municipal, county and state health authorities and discussed with local emergency and COVID-19 response teams.

The following practices related to rigorous infection control and prevention impact all ancillary and support services, and should be considered:

- Establish non-COVID-19 care (NCC) zones.

- Establish screening and segregation protocols, following national and local guidelines, for all individuals entering the facility, including patients, visitors and staff.

- Implement social distancing in all staff, patient and public spaces.

- Routinely verify compliance with environmental cleaning protocols through rigorous assessment; retrain staff as necessary.

- Provide and require appropriate usage of PPE by all patients, visitors and staff.

- Provide volume-appropriate supplies of hand sanitizer and disinfectant for use by patients, visitors and staff.

- Modify visitation practices to enhance infection control and prevention while considering the needs of certain patient groups, e.g., maternity, end-of-life.

- Consider bringing back or recruiting volunteers for former as well as new assignments, e.g., wayfinding.

In addition, the impact of implementing these practices within each of the ancillary and support services outlined below also should be considered in light of:

- Incidence and trends for COVID-19 in the area.

- Medical necessity and time sensitivity of the care based on the clinical needs of the population.

- Available supply of PPE.

- Volume-appropriate supply of hand sanitizer and disinfectant.

- The extent to which the services can be resourced (appropriately credentialed and privileged staff, facilities, supplies and equipment) to resume operations; the impact of the draw on those resources that may be needed in treating COVID-19 patients, at various demand levels, such as critical care clinicians, ventilators and oxygen supply.

- The emotional health of staff members who have been under stress.

- Established lines of supervision for unlicensed or noncertified staff, students and volunteers, if applicable.

- Capacity to ensure adequate cleaning and disinfection of all spaces, facilities and equipment.

- Patient flow and workflow limitations related to the redesign of all areas of the hospital, including care delivery areas and waiting rooms, to enable social distancing and establish NCC zones.

While we have provided certain considerations for select clinical and support services, this framework for assessment can be applied for all operational areas.

CONSIDERATIONS FOR CLINICAL SUPPORT SERVICES

DIAGNOSTICS AND THERAPEUTICS

Reliable, accurate and timely diagnostic and therapeutic capabilities are at the core of hospital inpatient and outpatient services. At the height of the COVID-19 pandemic, the vast majority of hospital laboratory and imaging services, as well as therapeutic services, has been dedicated to urgent COVID-19 response needs. Many non-emergent and/or ambulatory diagnostic lab tests, imaging studies and therapies may have been dramatically scaled back — or even temporarily suspended — either to conserve PPE or due to a lack of demand.

Sufficient resources should be available to the facility across phases of care, including a healthy workforce, PPE, facilities, supplies, testing capacity, and post-acute care, without jeopardizing surge capacity.

IMAGING/RADIOLOGY

- Standardize protocols for decontaminating imaging rooms after caring for a COVID-19 patient, including one hour of downtime for passive air exchange; review and practice with staff.

- Evaluate numbers of staff involved in the care of each patient procedure, and limit to the smallest number possible for every visit when scheduling non-emergent procedures.

- Follow hospital screening, testing and isolation protocols for staff and patients, with attention to changes in these protocols as the hospital moves through the stages of the pandemic; educate staff routinely.

- Follow hospital visitation policies; ensure that staff are educated on these policies and that patient scheduling and registration procedures reflect current practices.

- Inform patients of established, predetermined visitor guidelines before they arrive for their exam; provide clear instructions for patient drivers; screen patients upon scheduling and arrival, if required for imaging procedures.

- Evaluate and streamline registration, check-in and check-out processes to limit the amount of time that patients are in the facility.

- Modify changing rooms and waiting area seating to meet social distancing guidelines.

- Adjust scheduling times to limit and monitor the number of patients in registration areas, waiting areas and changing areas for all modalities. Work with the centralized scheduling center to adjust patient load when working with shared areas for multiple modalities, such as computed tomography (CT), nuclear medicine, mammography, MRI, ultrasound and X-ray.

- Adjust scheduling times to allow for appropriate cleaning of imaging room and equipment.

- Allow for procedural recovery time, discharge instructions and patient ride considerations; designate location to accommodate patient drivers, while adhering to social distancing guidelines.

OUTPATIENT IMAGING RAMP-UP GUIDELINES:

Phase 1

A. Allow limited schedule slots when screening and diagnostic volume levels could be increased. Many radiology administrators are considering an initial increase of 25% to 50% over the volume experienced during COVID-19. Determining the phase 1 volume target should be in consultation with the incident command center and departmental physician leadership to ensure the increased volume can be managed safely, while also continuing to manage the needs for COVID-19 patients.

　i. This may include screening exams such as mammograms, DEXA (bone density) studies, CT lung screening, and CT coronary calcium scoring.

　ii. This may include routine diagnostics such as diagnostic cardiology, X-rays, CTs, ultrasounds, MRI, nuclear medicine and diagnostic mammography.

　iii. Invasive procedures should continue to be limited to only those performed in mammography.

B. Consider scheduling routine appointments that were previously deferred into these limited slots.

C. Pre-surgical testing should be prioritized to accommodate a return to non-emergent surgical procedures, even if those tests drive overall volume beyond levels anticipated above.

Phase 2: The same date that the facility resumes non-emergent outpatient surgical procedures.

A. Allow limited schedule slots for invasive procedure volume to be increased by 25% to 50% over the volume experienced during COVID-19.

B. Consider expanding hours/shifts to ensure that the additional volume is spaced out properly in this phase.

C. This may include invasive procedures such as:

    i. CT- and ultrasound-guided biopsies

    ii. Lung biopsies

    iii. Certain MRI that requires general anesthesia

    iv. Arthrograms (MRI, CT, etc.) procedures

    v. X-ray-guided joint aspiration procedures

    vi.   Lumbar puncture procedures

    vii. Thyroid biopsies

D. Consider removing scheduling prioritization criteria put in place during the COVID-19 pandemic.

Phase 3: Timing undefined, evaluate at least every seven days; allow limited schedule slots for invasive procedure volume to be increased by 50% to 75% over the volume experienced during COVID-19.

Phase 4: Timing undefined, evaluate at least every seven days; allow limited schedule slots for invasive procedure volume to be increased by 75% to 100% over the volume experienced during COVID-19.

PATHOLOGY/LABORATORY

As hospitals consider broadening pathology and lab services to support increased patient volumes, planning should consider the following:

COVID-19 TESTING

- Maintain close contact with the hospital's overall plan for community, staff and inpatient testing; ensure adequate resources (e.g., staff, PPE, supplies, data analytics) to meet these plans.

- Ensure compliance with national and state reporting requirements.

- Evaluate the physical layout; consider options and appropriateness of segregation of COVID-19 sample collection and testing.

- Provide training/education on COVID-19 testing protocols and procedures for full staff.

STAFF

- Evaluate opportunities for continuing telepathology as allowed.

- Evaluate physical layout to ensure social distancing.

- Evaluate staffing needs for maintaining inpatient testing needs and reopening outpatient testing.

OUTPATIENT TESTING

- Review historical lab schedule and consider impact of phased reopening of on-demand lab services.

- Prioritize testing for urgent, previously delayed care needs, such as biopsies.

THERAPY SERVICES

As hospitals begin to phase in non-COVID-19 services, therapy services should be reevaluated to ensure provision of high-quality care while maintaining the hospital's infection control and prevention practices. For all therapies, ensure that staff are trained on current hospital testing, use of PPE and social distancing policies. The following also should be considered:

SPEECH THERAPY AND AUDIOLOGY

- For outpatient services, determine whether to reopen some or all locations (which depends on demand for services, PPE, etc.).

- Communicate with referral networks about availability and scheduling.

PHYSICAL/OCCUPATIONAL THERAPY

For patients with COVID-19, physical therapists can provide critical assistance in positioning patients to improve oxygenation. In addition, these patients may be in the ICU for prolonged periods; therefore, during recovery, the exercise, mobility and rehabilitation services provided by a physical or occupational therapist are important to ensure the patient can safely transition home.

Inpatient considerations:

- Clean all equipment, devices and surfaces between each patient interaction, per CDC recommendations.

- Discontinue the use of equipment that cannot be or has not been cleaned and disinfected between patients.

- Create a designated area for all rolling stock equipment for cleaning and disinfection.

Outpatient considerations:

- Employ telehealth or other virtual tools to conduct patient assessments, make recommendations and provide care when possible.

- Evaluate treatment and waiting room space to practice social distancing. Communicate widely the revised space layout to minimize changes/reworking the space.

- Maintain contact with patients unable to attend regular sessions/appointments; provide coaching and instructions to minimize patient deconditioning.

- Adjust scheduling to minimize the number of patients waiting; consider asking patients to wait in their vehicles to ensure social distancing.

- Provide group therapy only when it can provided while practicing social distancing.

SPEECH PATHOLOGY

The CDC has recommended that each facility and practice setting complete a risk assessment to determine guidelines for speech language pathology services and explore alternatives to face-to-face visits.

Considerations:

- Reassess the scope of services to ensure all original characteristics of the program remain intact: patient population, age, activity limitations, cultural backgrounds, demographics and types of services needed.

- Evaluate the potential for increased volumes of certain tests and modifications of other treatment protocols as a result of COVID-19 prevalence, e.g., patient cognitive ability assessments after COVID-19 treatment.

RESPIRATORY THERAPY

During the COVID-19 pandemic, many respiratory therapists have been working in hospital ICUs and general units with patients who have breathing difficulties related to COVID-19. In some hospitals, respiratory therapists have been working in partnership with operating room technicians to provide sufficient support in the care of COVID-19 patients. As hospitals phase in non-COVID-19 care, operating room technicians will return to the operating rooms, leaving the respiratory therapy technicians to care for COVID-19 patients while providing routine support for non-COVID-19 patients.

Considerations:

- Establish a plan for addressing all patients with needs for breathing support in the event that a resurgence of COVID-19 occurs.

- Assess the current availability of critical breathing support supplies, such as suction tubing, suction canisters and metered dose inhalers, to ensure their availability before conducting non-emergent surgical procedures and also periodically as surgeries and other procedures continue to expand.

- Consider whether any of the care protocols that were developed during the COVID-19 crisis to assist patients with breathing difficulties were sufficiently effective that they should become a more routine part of hospital care protocols with appropriate approval from FDA. For example, strategies that were used to prevent the need for a patient to be put on a ventilator — such as the use of BiPAP machines or other, less invasive forms of breathing support — might be effective as part of a series of protocols for patient care.

- Document and validate sterilization of all respiratory equipment by the sterile processing department, processed in accordance with manufacturer instructions and facility policy.

PHARMACY

Pharmacy services provided during a patient's stay, upon discharge and in outpatient and clinic settings are critical components of providing safe and high-quality patient care while maintaining new post-COVID-19 standards for infection prevention and control.

Inpatient considerations:

- Use telehealth or other virtual tools to conduct medication history/reconciliation by pharmacists or pharmacy staff upon patient admission.

- Assess or reassess sedation medication supply and implementation guidelines accordingly.

- Consider outsourcing to external vendors when critical drugs are in shortage.

- Implement guidelines for limiting the reuse of certain medications to reduce possible contamination and spread, e.g. multidose insulin.

- Consider using metered dose inhalers (MDIs) with a spacer rather than nebulizers, which are aerosol-generating. Also assess MDI supply, which may be limited; if so, ask patients and families to bring in-home inhalers if possible.

- Consider implementing policies for remote medication order processing to maintain workforce capacity and limit exposure.

- Assess compounding procedures to ensure conservation of PPE;[7] include limiting the number of personnel conducting sterile compounding activities, reducing sterile compounding activities by reassessing the need for sterile compounded products and implementing procedures for remote/video verification of sterile compounding by the pharmacist.

- Establish social distancing practices in all pharmacy areas by spacing out workstations by 6 feet if possible.

- Use telehealth or other virtual tools to provide medication counseling by pharmacists upon discharge.

Outpatient/Ambulatory Pharmacy Services Considerations:

- Create a curbside pickup service for outpatient pharmacies to improve medication access and reduce exposure risk for individuals in pharmacies and in waiting areas.

- Consider using telehealth modalities for continuing ambulatory pharmacist visits such as warfarin clinics, which can optimize the critical management of chronic conditions, especially if patients are concerned about exposure and might skip clinic visits.

- Ensure enhanced cleaning of all waiting and treatment areas.

- Provide volume-appropriate supply of hand sanitizer and disinfectant for use between patients.

- Consider alternate methods, in addition to phone or electronic surveys, to assess patient engagement.

SOCIAL WORK

Social work services are a critical component of care delivery. As a member of the multidisciplinary care team, the social worker's role is well established as attending to the psychosocial needs of patients and families to promote overall well-being; this is especially important during periods of increased stress and worry, as associated with the COVID-19 crisis. Addressing the routine issues of discharge planning and patients' social needs is an additional and important area of focus for social workers and discharge planners. As hospitals resume non-emergent services, social workers and discharge planners will begin caring for non-COVID-19 patients in addition to COVID-19 patients.

In resuming care for non-COVID-19 patients, it is important to consider changes that have occurred in the field and how we can adapt practices and protocols.[8]

Considerations:

- **Staff**

  – Embrace social workers as essential workers who provide mental health services during this crisis to support patients, patients' families and colleagues.

  – Evaluate ability to provide social work services safely in-person or via remote technologies such as telemedicine to avoid COVID-19 exposure when possible.

  – For social work staff who serve as preceptors for social work students, determine if it is safe to resume field instruction.

- **Discharge planning**

  – Discharge planning should begin upon admission; visitor restrictions may limit patients' families or other support systems from engaging in discharge planning at the bedside, requiring additional communication (e.g., phone calls, emails) from discharge planning staff.

  – Evaluate changes to patient resources including family support, financial resources (including insurance, ability to pay) and transportation resources; if resources have changed, assess impact on discharge plan.

  – Consider patients' living environments and abilities to adhere to infection control and prevention recommendations, including isolation and transmission risk to and from household members.

  – Reassess relationships with community and additional providers within the health care continuum of care, including skilled and long-term nursing facilities, home care, hospice and palliative care, mental health services, substance abuse services, shelters, transport services and community centers.

  – Assess if frequently used resources are open, accepting new patients or have additional requirements.

  – Evaluate if there have been changes to referral, intake or admission processes.

  – Social work staff may need to supplement services typically offered by community services providers due to new priorities and/or closures from COVID-19.

- **Patient care**

  – Social work staff may be needed to provide additional counseling around grief and loss due to COVID-19.

  – Social work staff may need to spend additional time with patients and family members to review care plans and changes in care plans due to COVID-19.

  – Educate social workers on changes in policies and requirements to increase flexibility, including CMS waivers that require hospitals to provide a comprehensive list of or quality data on post-acute facilities, and CMS changes to telehealth policy.

  – Determine how social work can support the workforce during the COVID-19 crisis; empower social workers with tools and resources to lead debriefings and facilitate discussions around COVID-19.

– Create a partnership between social workers and staff support services to optimize emotional support services available.

– Determine how social work staff can partner with ethics or pastoral care staff to best support health care workers.

CONSIDERATIONS FOR ANCILLARY CARE DELIVERY SERVICES

Ancillary care delivery services include many hospital-based and freestanding skilled and long-term care nursing facilities, hospice and palliative care services, home health, dialysis and social work services — those that are part of the health system and those that are independent or community based. These services have played a vital role during the public health emergency, providing care for individuals who otherwise might have been hospitalized as well as for those with chronic conditions who require ongoing attention. Waivers of federal and state requirements enabled many of these practice sites and health care workers to provide services not routinely offered and to deliver care through new approaches, such as telehealth. As hospitals and health systems begin to return to offering non-COVID-19 care to patients, plans to reactivate these sites of service to support potential new surges must be maintained. All care delivery resources must remain prepared for any eventuality.

This is an excellent time to further develop relationships and partnerships between hospitals and independent care providers along the continuum of care. Post-COVID-19 assessments of patient flow and decision criteria are recommended.

Hospitals and health systems should consider the following in their planning and next phase of service approaches:

SKILLED NURSING AND LONG-TERM CARE FACILITIES

Skilled nursing and long-term care facilities provide important services as part of the continuum of care delivery. During the pandemic, this includes treating confirmed and suspected COVID-19 cases, as well as supporting other providers that refer non-COVID-19 patients to other nursing and care facilities to create additional acute care space to treat COVID-19 patients. These facilities treat a wide array of conditions. Skilled nursing facilities focus on patients requiring a higher-level of nursing and rehabilitation to restore or prevent deterioration of function. Long-term care facilities are more residential in nature but also offer dietary, social and therapy services. In assessing services post-COVID-19, consider recommendations from the CDC[9] as well as the following:

- Determine needed staffing and other resources as the clinical needs of patients being referred to skilled nursing and long-term care facilities evolve.

- Evaluate staff wellness and revisit employee health practices.

- In collaboration with the acute care and emergency medical transport providers, review and update acute care discharge and transfer criteria for confirmed and suspected COVID-19 patients.

- Evaluate infection control and prevention policies and practices including social distancing, screening, testing, surveillance and isolation; ensure all resources (appropriately credentialed and trained workforce, supplies, space) are available to comply with these policies and practices.

- Implement ongoing use of telehealth for patients with COVID-19 and other diseases.[10]

- Develop new scheduling strategies to limit staff and exposure to patients with infectious diseases.

- Communicate with patients and their families about changed practices and policies.

- Provide patient and family education on best practices on infectious disease mitigation.

HOSPICE/PALLIATIVE CARE

Careful planning is required to resume inpatient and home care of palliative patients and those at end of life.[11,12,13,14,15] Considerations include:

- Establish protocols for safe delivery of home care when possible, including screening patients and families for COVID-19 and provisions for prescribing practices; using functional virtual care and telehealth platforms is recommended whenever possible.

- Develop protocols for engaging patients, families and caregivers in conversations around care plans and advanced directives.

- Assess community care partners that have delivered services in the past, such as Meals on Wheels. Are their services interrupted? Do they have the resources needed? Can partnerships be strengthened to assure continued services?

- Can new resources be mobilized, such as ministers or other volunteers who might make calls?

- Communicate with patients and their patient families about changed practices and policies.

- Provide patient and patient-family education on best practices on infectious disease mitigation.

HOME HEALTH

Home care services may be provided as part of a health care system or may be an independent entity. Every effort should be made to ensure that home care plans that were in place prior to the current quarantining protocols are implemented. Particular communication by the home health provider with patients and families will be necessary to build confidence that their safety is being protected so these patients do not refuse care at this time. New home health patient populations also are emerging, including patients who would previously have been admitted for non-emergent care, i.e., patients who are medically stable and can receive care at home.

Home health providers are encouraged to create policies and procedures that reflect their own operations, capabilities and community/patient needs, including lessons learned from the pandemic experience to date, which can serve to improve home care services into the future.[16] The following also should be considered:

- Provide PPE for the patient and patient's family.

- Develop protocols for engaging patients, families and caregivers in conversations around care plans and advanced directives.

- Assess community care partners which have delivered services in the past, e.g., Meals on Wheels. Are their services interrupted? Do they have the resources needed? Can partnerships be strengthened to assure continued services?

- Can new resources be mobilized, such as ministers or other volunteers who might make calls?

- Continue to collect acuity and other data to assist with planning for staffing requirements, e.g., therapies, nursing, dietary, etc., and to ensure the patient meets eligibility requirements for home health services.

- Develop appropriate protocols and policies to guide testing and contact tracing when resources become available.

- Develop an assessment protocol for accepting COVID-19-positive patients, to include at least:

  – household availability of necessary PPE and ability to follow precautions (hand hygiene, respiratory hygiene and isolation needs)

  – availability of separate bedroom and bathroom

  – availability of appropriately skilled and trained caregivers in the home

  – food and other necessary resources

- Establish a process for conducting a screening call prior to a home visit to a COVID-19 patient to determine:

  – clinical status of the patient and other household members

  – needed PPE, medical supplies

  – recent travel and visitor history for patient and household members

- Communicate with patients and their families about changed practices and policies.

- Provide patient and family education on best practices on infectious disease mitigation.

- Conduct a continuous assessment of staff wellness.

- Consider potential modifications of scheduling protocols to enhance infection control and prevention, such as scheduling COVID-19-positive patients at the end of the day.

URGENT/CONVENIENT CARE

Non-COVID-19 care as provided by urgent or convenient care centers can be offered to patients as clinically appropriate, when state and local authorities allow and when providers have the necessary resources to provide such care without interfering with the ability to respond to a potential surge in COVID-19 cases.[17] The following considerations should be part of the planning process for activating such care:

- Communicate with patients about changed practices and policies.

- Provide patient education on best practices on infectious disease.

- Evaluate services provided, overall need for care and availability of resources (credentialed and trained staff, space and supplies) to restart needed activities.

- Ensure adequate access to PPE, testing supplies, medications and other medical supplies for anticipated patient load.

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

RETAIL CARE

Non-COVID-19 care as provided in retail centers can be offered to patients as clinically appropriate when state and local authorities allow and when providers have the necessary resources to provide such care without interfering with the ability to respond to a potential surge in COVID-19 cases.[18] The following considerations should be part of the planning process for activating such care:

- Maximum use of all telehealth modalities is strongly encouraged and/or restricted opening to only needed services based on facility capabilities and local conditions.

- Evaluate services provided, overall need for care and availability of resources (credentialed and trained staff, space and supplies) to restart needed activities.

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

- Allow for social distancing in waiting areas; minimize wait times, keep chairs 6 feet apart and maintain low patient volumes.

- Practice current best practices for infection control and prevention, for staff and patients.

- Consider recommending that older adults over age 65, those with underlying health conditions and other individuals with higher risk for COVID-19 seek care outside of a retail space.

DIALYSIS

There are two types of dialysis, hemodialysis and peritoneal dialysis. Peritoneal dialysis is either continuous ambulatory (CAPD) or automated (APD). While hemodialysis can be done in a hospital, in a dialysis center that is not part of a hospital or at home, peritoneal dialysis is generally done at home. The following considerations should be part of planning for services provided in dialysis centers, whether part of a hospital or an independent center.[19] For home dialysis services, please refer to the Home Care section of this document.

Considerations:

- Can the facility accommodate segregation of care based on COVID-19 positive or suspected positive status? If so, should staffing plans accommodate best practices for infection control and prevention?

- Allow for social distancing in waiting areas; minimize wait times, keep chairs 6 feet apart and maintain low patient volumes.

- Practice current best practices for infection control and prevention for staff and patients, including social distancing in all waiting areas and encouraging patients to wait in their vehicles until their treatment room is available.

- Consider having patients call ahead and triage patients with fever or respiratory symptoms, with additional screening upon arrival at the center.

- Communicate with patients about changed practices and policies.

- Provide patient education on best practices on infectious disease.

- Ensure adequate access to PPE, testing supplies, medications and other medical supplies for anticipated patient load.

- Assess the number and placement of isolation rooms not being used for hepatitis B patients.

- Use isolation rooms when possible; if none are available, consider a designated dialysis station away from the main flow of traffic to cohort patients with suspected or confirmed COVID-19 patients.

- Minimize the number of health care providers in the isolation rooms or designated stations.

- Assess policies regarding those who might accompany patients for their treatment, considering best practices for infection control and prevention.

CONSIDERATIONS FOR GENERAL SUPPORT SERVICES

INFORMATION TECHNOLOGY

Hospital and health system IT departments have played a critical role in the COVID-19 response. Departments have redirected resources to meet COVID-19 needs for increased telehealth, temporary sites of service, data reporting and emerging needs for testing and tracing. As departments consider how to return to normal operations, considerations should include:

- Evaluate IT staffing to ensure there is sufficient staff to support normal patient care operations and respond, if needed, to supporting additional surges of COVID-19 patients, especially in continuing to support telehealth capacity.

- Prioritize and plan to make routine maintenance, patches and updates that were planned but delayed due to the strain on IT services during COVID-19.

- Reassess potential cyber vulnerabilities of new technologies rapidly deployed to support COVID-19 response, such as telehealth and telework platforms.

- Plan, prioritize and undertake the necessary work to reinstate system enhancements, and new release changes; consider resuming projects that were in progress but then suspended, including regulatory mandates that require IT system changes.

- Reconfigure systems to provide support for rescheduling and managing any patient backlogs.

- Collect data for metrics that are important to national and state COVID-19 tracking.

TELEHEALTH

There has been a dramatic increase in telehealth flexibilities for COVID-19 and other care during the public health emergency. In response, hospitals and health systems have moved a significant portion of in-person visits to virtual platforms and created new ways of connecting patients with providers. While it is still unclear which of these flexibilities will remain in place after the pandemic, CMS has indicated its interest in preserving the ability to treat patients via telehealth. **See the Ancillary and Support Services Appendix for the impact of telehealth waiver options.** As CMS determines how to do so, hospitals and health systems should:

- **Monitor federal and state requirements for the use of telehealth for both COVID-19-related and other care.** Hospitals and health systems should take careful note of CMS' and states' treatment of telehealth

services, including originating and geographic site restrictions, HIPAA privacy and security requirements, cost-sharing and consent for telehealth services and remote patient monitoring (RPM), using telehealth to fulfill certain face-to-face requirements; using virtual check-ins and e-visits for new patients, and using RPM for acute conditions.

- **Monitor federal and state licensure requirements.** Today, there exists a patchwork of state licensure rules that, to varying degrees, allow providers licensed in one state to provide care via telehealth in another state. Hospitals and health systems should stay up to date with each state's limits on out-of-state practice as well as any federal developments on this issue.

- **Evaluate telehealth capacity to meet current and future demand for virtual services.** Even after the current emergency ends, patients may be wary of returning to in-person visits. Additionally, there will be high demand for telehealth services during any subsequent waves of COVID-19 outbreaks. Hospitals and health systems should take stock of their telehealth infrastructure and any areas where they may need to increase telehealth capacity, including equipment and workforce. Specifically, hospitals and health systems may need to train additional providers and support staff to deliver services via telehealth. Acquisition of new equipment to connect with patients and new devices to enable patients to send information to their providers also may need to be acquired. Hospitals also should consider mechanisms to track quality/outcomes for patients receiving services via telehealth.

- **Mitigate cybersecurity risks.** In scaling up capacity, hospitals and health systems should pay close attention to cybersecurity weaknesses and work to close those gaps. Cyber adversaries may look for hardware, software and/or network technical vulnerabilities in these platforms to capture and steal protected health information or other sensitive information in transit during telehealth visits. They also may look for telehealth vulnerabilities and network connections to penetrate main hospital networks and electronic medical records to steal data, launch ransomware attacks and/or conduct espionage operations targeting medical research. As such, hospitals are required to ensure proper security design features are in place. Based on the most current risk assessment, this may include encryption in transit and at rest, and multifactor authentication and network segmentation to mitigate risk to patient safety, security and privacy of patient data.

- **Determine which services each and every payer will reimburse when delivered via telehealth.** CMS has added over 80 new services to the list of Medicare telehealth services in Section 1834(m) of the Social Security Act, but it is not clear whether these changes will become permanent. Moreover, Medicare, Medicaid and commercial insurers may cover different sets of telehealth services and may make changes to those coverage rules over time.

QUALITY AND PATIENT SAFETY

There is wide variation in the scope and composition of hospitals' central quality and patient safety offices. Prior to the pandemic, these offices generally focused on meeting federal and state quality measure reporting requirements, preparing hospitals for CMS and accrediting organization surveys, conducting patient safety event investigation/mitigation, and supporting high-priority quality improvement projects. Because of the pandemic, many of these departments had to refocus their activities on supporting their organization's COVID-19 planning and response. As hospitals resume a fuller set of services, these departments can:

- **Monitor federal and state requirements/requests for reporting of COVID-19-related and other quality and safety data.** At the federal level, hospitals have been asked to report certain data daily,[20] and quality departments may help support this activity. At the same time, CMS has suspended required reporting in its

quality/value programs for the first two quarters of 2020. This exception could be extended, depending on the pandemic's progression. Hospitals and health systems should plan now for reestablishing these reporting requirements.

- **Monitor federal and state requirements related to accrediting organizations/Conditions of Participation and state surveys.** CMS and accrediting organizations have largely suspended on-site survey activities, but those activities will resume in the future. In addition, your state may have its own requirements/schedules for survey activity.

- **Evaluate and reprioritize previously identified improvement priorities.** Pandemic response may mean deferring some improvement initiatives, or redeploying process improvement/data collection expertise to supporting safe practices in areas of the hospital where services are resuming. For example, quality staff may help with monitoring infection control practices.

- **Ensure flexible and timely safety event reporting and investigation processes.** As services resume, hospital staff may encounter unexpected issues. A mechanism to quickly identify and respond to these issues will ensure services resume as safely as possible.

- **Ensure a high-functioning quality management system.** Make sure that leadership is in alignment and that guidance is quickly communicated throughout the hospital and health system. No matter the size of your organization, in times of crisis it is even more important for leaders to be able to come together quickly, make decisions swiftly and communicate and follow-up on needed actions expediently.

REVENUE CYCLE MANAGEMENT

As hospitals begin to scale up services that may have been suspended due to the pandemic, many revenue cycle practices should be reviewed to assure compliance with individual governmental and commercial insurer requirements as well as modified workflow imperatives. For example, coding and billing requirements have been altered to reflect new treatment and diagnostic care modalities.

Additionally, many hospitals may have held back claims for the initial surge of COVID-19 patients, due to strained administrative capabilities and ever-changing insurer billing instructions. To navigate these challenges, hospitals should consider:

- **Monitor policy updates of major insurers.** As a result of the strain that the pandemic placed on the health care delivery system, CMS and many other payers removed a significant number of reimbursement requirements for patient care. As providers begin to increase services and return to providing a wide spectrum of services, they should expect insurers to begin retracting waivers or readjusting care requirements. To ensure that care is provided in the appropriate manner to receive payment, providers need to closely monitor insurer information regarding policy changes.

- **Track billing rules and requirements related to the location where patients obtain care.** Many of the traditional payment rules and billing requirements related to the setting in which a service takes place have been altered as a result of the pandemic (e.g., inpatient care allowed at off-site locations). Payers have varied in both the services allowed and methods of billing for care performed at non-traditional settings, and hospitals should ensure that they are billing appropriately based on insurer policies to receive optimal reimbursement.

- **Monitor and apply rapidly changing coding/billing instructions.** Hospitals and clinics should stay apprised of the latest coding/billing instructions, including new ICD-10-CM, CPT or HCPCS codes and modifiers, National Uniform Billing Committee announcements and other instructions. Coding professionals should

follow the ICD-10-CM Official Coding Guidelines for COVID-19 and monitor the ICD-10-CM frequently asked questions for COVID-19 for reliable interpretation of ICD-10-CM codes and guidelines approved by the AHA and AHIMA.[21] Ensure that you have the necessary codes to bill for COVID-19 testing. Multiple methods of testing for COVID-19 have been developed. Hospitals and clinics should ensure that they are using the appropriate CPT/HCPCS code(s) for the type(s) of COVID-19test(s) being conducted and that individuals responsible for charge capture are aware of the differences among the tests.

- **Develop a process for flagging positive COVID-19 test results for coding professionals if results are not available at the time of coding.** Often, COVID-19 tests are inserted into a billing system prior to the results of the test being known. To ensure appropriate codes are applied, hospitals should develop an internal method of flagging positive test results for coding professionals as waivers and payments can be based on the coding of confirmed diagnoses of COVID-19.

- **Be prepared for accelerated payment withholdings.** If your health system received any CMS accelerated payments, ensure that your billing systems and accounting staff prepare for and document the withholdings on CMS claims payments occurring 120 days or more from the date of the initial payment. These withholdings will be reflected in remittance information in the PLB segment.

- **Update utilization management protocol.** Many insurers have suspended or changed utilization management/prior authorization requirements for services, the specifics of which are largely dependent on the insurer. As providers begin to perform a broader range of services, they should check with relevant insurers regarding any utilization management requirements that may have suspended so as to avoid delays in care due to unnecessary pre-care procedures.

PROVIDER STAFF SERVICES

As hospitals and health systems return to full operations, waivers related to licensing, supervision and collaboration requirements will expire, accreditation surveys will resume and credentialing and re-credentialing schedules will need to be updated. Hospitals and health systems will need to develop a coordinated plan for returning to full credentialing and privileging while providing support and education to the provider staff.[22] Considerations include:

- Review licensure, collaboration and supervision requirement waivers:

  - www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-retired-licensees-in-response-to-covid19.pdf

  - NCSBN | List: Nursing Licensure Waivers in Response to COVID-19

- Review accreditation requirement waiver sunset dates.

- Review appropriate privileging for telehealth (see Telehealth section of this document).

- Update records to prepare for resumed accreditation surveys.

- Identify protocols and prioritization for resuming full credentialing functions.

- Update (cancel or continue) any disaster privileges granted.

- Identify and share education and resources for providers on requirements for maintenance of certification, licensing, continuing education and supervision agreement changes.

- Consider interactions with providers via multiple channels, e.g., town halls, intranet postings, department/ section meetings, etc.

- Consider inclusion of well-being resources in re-credentialing materials.

Also refer to the Workforce section of this document for considerations regarding telework and social distancing.

PLANT OPERATIONS/ENVIRONMENT OF CARE

The following represents a number of considerations when evaluating the condition of the facility to provide non-COVID-19 services:

RESTORE FACILITY TO NON-SURGE USE CONDITION

- Remove temporary airborne infection isolation partitions and all extensions of utilities into COVID-cohorted units, including medical gas and vacuum, electrical power, distribution water fixtures, and nurse call and communication systems.

- Ensure contaminant removal per CDC airborne contamination table. Remove all negative pressure devices and ensure room pressure and air changes per hour are returned to normal for that unit. Reverse all temporary security measures, such as access control to unit or room, video surveillance cameras, elopement and abduction alarm systems. Purge digital temporary access privileges for temporary/surge health care workers into sensitive areas, refresh access control codes and badge access. Reopen all closed or rerouted emergency egress pathways.

- Perform terminal cleaning of all surgical suite and procedure rooms. Clean and disinfect all COVID-cohorted units including ICU, CCU, ED, waiting/triage areas, and fixed and portable equipment including patient transport devices and lifts. Consider usage of UV disinfection or H_2O_2 fogger and equipment.

- Implement social distancing requirements in public areas such as waiting/triage areas throughout the facility through signage, flow and furniture arrangement. Consider any and all procedures and/or policy updates to minimize the use of waiting areas and to separate various at-risk populations; establish capacity notices.

- Evaluate public areas, including food services spaces, and establish flow patterns that enhance social distancing.

- Conduct an inspection tour of the areas serving COVID-19 patients and support areas by Environment of Care team, including the chief operating officer and section leaders from risk management, infection prevention, facilities management, safety, security, nursing and medical staff.

- Conduct physical inspection and engineering assessment of any leased buildings; ensure these have been terminally cleaned prior to reoccupying.

- Evaluate any work spaces which have used cubicles or open seating to identify infection control and prevention enhancements. Refer to the Workforce section of this document for considerations of work-at-home as well as other work practices and procedures.

- Evaluate patient flow through the facility (e.g., from ED to inpatient unit, from inpatient unit to diagnostics, etc.) for both COVID-19-positive patients and non-COVID-19-positive patients to identify infection control and prevention enhancements. Expedite COVID-19 positive and suspected positive patients through public spaces.

- Make necessary changes to wayfinding, including print materials and signage.

- Recognize that public perception will be influenced by the physical facility as well as by messaging. Work to minimize dissonance between continuing certain infection control and prevention practices, e.g., social distancing, testing "tents," and the assurance that it is safe to come to hospitals and clinics for care.

CRITICAL INFRASTRUCTURE RESTORATION AND REPAIR

- Inspect and verify operational capabilities of all key utility systems including medical gas, clinical air and vacuum, potable water, HVAC, normal and essential electrical power supplies, communication systems (wired and wireless networks), smoke detection, fire alarm and suppression, and vertical transportation systems.

- Inspect filters on all air-handling units that supplied areas serving COVID-19 patients, and replace filters that were negatively impacted from the mitigation efforts. Consider deep cleaning coils if necessary. Return the building automation system to normal seasonal settings by clearing any lockouts or system programing work-around. Flush any water systems that may have been left dormant during the surge. Assess any stress or accelerated wear on vacuum pumps, medical air compressors, and bulk oxygen systems due to heavy usage during the surge.

REESTABLISH NORMALIZED OPERATIONAL STANDARDS ON:

- Temperature and humidity control, patient comfort and patient transport.

- Environmental hygiene, supplies, waste streams and linen.

- Security procedures for visitor screening.

FACILITY COMPLIANCE ASSESSMENT

- Evaluate suspended inspection, testing and maintenance to establish priority, timeline and resource requirements needed to restore equipment and systems to TJC/DNV standards, CMS Conditions of Participation, and state and local codes.

- Contact authorities having jurisdiction to proactively review these plans and timelines for achieving compliance and document those contacts.

- Arrange a facility walk-through by local authority and/or state authority and property insurance underwriter to objectively assess the facility's environmental safety; include your risk management, workers compensation and infection control professionals in these walk-throughs.

FACILITY MODIFICATIONS MADE FOR COVID-19 CARE

- Document all facility modifications made in planning for and during the care of COVID-19 patients; conduct an assessment of those changes as to effectiveness.

- Prepare a staged plan for returning the facility to surge status should that be necessary.

- If licensure requirements were modified in any way, such as additional beds added, consider post-COVID-19 licensure states and coordinate with the state and/or CMS appropriately.

The American Society for Healthcare Engineering also has released a resource to aid in recovery planning and execution.

FINANCIAL MANAGEMENT

ISSUES TO CONSIDER DURING REOPENING PHASES

COVID-19 VOLUME RAMP-DOWN

- **Debt servicing:** Are we at risk of failing to meet debt service payments and/or triggering debt covenants?

- **Alternative financing:** Do new sources of funding need to be explored to cover shortfalls or anticipated gaps, considering any federal or state requirements or limitations on the use and repayment of such funds?

- **Cost of financing in a crisis:** Revolver debt demand for gap planning may be needed to fund immediate medical and working capital, which may increase cost of financing.

POST-COVID-19 RECOVERY

- **Recovery planning:** How do we prioritize and ramp up non-emergent surgeries, outpatient procedures and clinic visits? Refer to the clinical guide issued by the AHA, in partnership with the ACoS, ASA and AORN. Complement with a financial analysis of revenue/margin models under various case-mix scenarios.

- **Post-COVID-19 marketplace:** Assess organizations and community needs to determine whether there are opportunities for short- or long-term collaboration or other arrangements to provide or bolster financial stability and organizational integrity, with due consideration for state and federal antitrust laws and policies.

- **Capex deployment:** Prioritize strategic initiatives and maintenance projects in light of cash pressures.

TOOLS TO MINIMIZE SHORT-TERM DOWNTURNS

- **Scenario Planning and Financial Modeling:** Undertake scenario planning to better understand how the COVID-19 crisis will affect financials in the short term and how operations may rebound with proper management intervention. Model future state scenarios to understand potential funding gaps.

- **Cash Forecasting and Liquidity Management:** Employ rolling receipt and disbursement forecasting to help manage liquidity in the short term – cash forecasting and modeling provides decision-makers with a tactical tool to manage short-term liquidity, and provides insight into the sources and uses of cash including working capital movements.

- **Performance Improvement and Operating Model Transformation:** Activate high priority and other levers to adjust the operating model to a new norm and to carve the path back to financial stability. Adopt a phased approach to maximize the degree and the pace of impact.

- **Financing and Capital Structure Alternatives:** Actively engage with your financing partners to ensure your lines of credit remain available, and to explore new or additional options, should you require them.

- **Use of Philanthropy:** Actively engage with your development office to determine:

  - Can existing endowed funds be utilized to supplement other sources of cash? This may require initiating discussions with individual donors for repurposing original conditions of the gift.

– Can a community capital campaign be initiated or, if there is a campaign currently underway, can it be modified, to address COVID-19 impact on the hospital or health system?

- **Tax Planning:** Implement tax planning to identify tax refunds, credits and grants that can provide cash flow benefits as well as identify tax processes that can be outsourced to reduce costs by utilizing technology.

FINANCIAL IMPACT CALCULATORS AND MODELING

Advisory Board, Covid-19 Elective Surgery Cancelation Impact Estimator: Consider using this estimator to model the revenue your organization may lose from postponing or canceling non-emergent surgeries during COVID-19. Incorporating several customizable inputs, the tool provides a way to assess potential non-emergent surgery revenue loss across varying timeframes, crisis acuity levels, and hospital capacity scenarios based on past facility volumes and capacity.

OTHER RELEVANT RESOURCES

- **AHA Fact Sheet:** Financial Challenges Facing Hospitals and Health Systems as a Result of COVID-19

GOVERNANCE CONSIDERATIONS

THE ROLE OF THE BOARD DURING TIMES OF CRISIS

Board governance must be adaptable in times of unprecedented crisis. As health care boards navigate the extraordinary challenges presented by the COVID-19 pandemic, communication and oversight are more important than ever.

While decisions on reopening the hospital or health system are primarily the role of management, boards continue to have fiduciary responsibility (duty of care, loyalty) for oversight of operations, finances and other operational concerns — all of which have or will be affected by management's decision to reopen. These duties extend to enterprise risk management. Trustees should be kept informed about a variety of plans, protocols and issues in a timely manner.

An informed and engaged board is an important resource for management while confronting unprecedented challenges. Boards can add tremendous value to their hospitals and health systems by providing crucial advice, guidance and support to executives and their teams.

Boards should, as needed, examine their bylaws and consider necessary governance changes, even if these changes are temporary. Special task forces can be established to support efforts of sustainability during the months ahead. Management is responsible for developing and implementing an organization's overall strategy, taking into account business-related opportunities and risks. Management also is responsible for developing an appropriate crisis plan, and forming and preparing a crisis team. The board is responsible for overseeing management's work in these areas and monitoring its progress.

In a crisis, boards need information and a credible, candid communications policy that keeps them, the community, the media and other stakeholders aware of clinical, operational and strategic developments.

BOARD AND CEO COMMUNICATION

There is a strong need for collaboration and communication between the board and the CEO. The board will want to receive regular reports from management, but boards should be sensitive to how and when they engage with the management team.

Some boards may find they are having more communication with the CEO during this time of crisis. For example, some hospitals are engaging in weekly conference calls with key stakeholders to have an open dialogue on the status of cases, deaths and protocols; board members should be invited to participate on these calls. In whatever manner is appropriate for the circumstances, CEOs should keep the board informed as events unfold and should engage the board in evaluating alternative courses of action.

UNDERSTANDING ORGANIZATIONAL PLANNING AND SAFETY PROTOCOLS IN PLACE

The variables and risk factors of the decision to reopen a facility to non-COVID-19 care delivery after COVID-19 are quite complex. It becomes a decision that must be based upon the highest critical thinking, relevant information and government or other authorities' directives or recommendations. The board has responsibility to protect the mission and the health of the organization. As complex decisions are made, it is essential to communicate and engage the board in the reopening plans and include them in scenario analyses that lead to critical decisions affecting the organization. In addition, boards should be fully apprised of any shifts in patient decision-making, and changes in referral patterns, all of which have a significant financial impact on the hospital and health care system.

Boards also should be fully apprised of the safety protocols put in place for staff and patients. There should be updates on the status of all critical resources (staff, supplies, space, etc.). Special attention to the workforce wellness efforts should be communicated routinely to the board.

BOARDS AS COMMUNITY LEADERS

Boards oversee hospitals' and health systems' responses to community needs and the efforts to address those needs. This includes having a heightened awareness of the impact of social determinants of health and health disparities. Significant health disparities among people of color were exacerbated during the COVID-19 crisis.

Communicating with the local community also is extremely important. Boards should ensure there is a solid communications plan in place to assure their communities that the hospital is doing everything possible to keep them safe. One of the most challenging issues will be getting community residents to trust seeking care in the hospital and emergency department again. Boards should be briefed on the clinical risk/benefit analysis behind decisions to reopen non-COVID-19 care and the tools provided to patients to assist them in their care choices. It also is important for boards to know about contingency plans designed to shape actions should conditions change, e.g., infection rate prevalence, workforce or other resource shortage.

Having champions on the board to engage around focused strategic and operational considerations to address socioeconomic disparities, access to services and care, and the economic impact of the pandemic on the hospital and health system is critical. Designating one or more board members as spokesperson(s) for media and community events is recommended. Providing the spokesperson(s) with accurate and timely data and talking points will ensure the success of such community outreach.

COMPLIANCE WITH REGULATORY GUIDELINES FOR REOPENING

An important part of a board's responsibility is to ensure the hospital or health system is meeting the local, state and federal guidelines for reopening. Boards should be getting updates from management on their reopening plans for compliance with federal and state guidelines. Boards will need to provide oversight of management's plan to move forward as states release specific plans.

UNDERSTANDING FINANCIAL IMPLICATIONS

The extraordinary pandemic-based financial challenges affecting hospitals and health systems as a result of COVID-19 should prompt boards to continue to focus on the organization's financial condition. Keeping the board apprised of plans for reopening services and the financial implications of doing so will continue to be important.

CAPTURE LEARNINGS TO BETTER PREPARE FOR THE FUTURE

Boards should ensure that management is capturing the learnings from the pandemic and documenting actions taken. Boards also should observe the effectiveness of their own governance during the COVID-19 crisis by reviewing what worked well and what needs to be improved. Reviewing and improving governance processes will assist boards in planning for a second wave of COVID-19 or another public health crisis, and allow them to reflect consciously on learnings as they move forward.

Boards should consider:

- Which leaders are responsible for communication and to which stakeholders?

- What is the internal single source of information and which third party sources are necessary?

- Were board members proactive in their oversight of risk identification and mitigation?

- Has the board developed or reviewed its own crisis management plan which identifies roles it may play depending on management's role in crisis?

A NEW PATIENT EXPERIENCE

Patient experience, as defined by the Agency for Healthcare Research and Quality, "encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses and staff in hospitals, physician practices and other health care facilities. As an integral component of health care quality, patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care providers."[23]

As we begin to recover from the first wave of the COVID-19 pandemic, one critically important component to consider is a new patient experience. Patients' perceptions of teamwork, communication and cleanliness continue to be highly correlated with their perception of a positive interaction with a hospital visit.[24]

The "true north" for this new patient experience is: How can we make the patient feel safe? This is the aspect of care that is most important to a patient today.

Below are considerations for hospitals and health organizations.

ACCESS

- During the pandemic, many new modes of patient contact were put into place to avoid person-to-person contact.

- Maintain technology-enabled approaches for patient scheduling and registration.

- Introduce artificial and augmented intelligence-enabled communication protocols to patients for purposes of responding to patient calls in lieu of emergency room visits.

- Introduce digital triage protocols and practices.

- Increase use of technology for care management, communicating with patients to ensure they maintain care for chronic care conditions such as diabetes, heart failure, asthma, COPD, etc.

- The AHA is a partner with AVIA, a company specializing in the acceleration of digital transformation; consider connecting with AVIA for an assessment of opportunities.

CLEANLINESS AND INFECTION PREVENTION AND CONTROL

- Patient evaluations and comments indicated heightened fears regarding cleanliness and infection control even before the first reported U.S. COVID-19 cases.

- Use appropriate signage in languages spoken by the community to communicate social distancing practices and mask protocols for those in waiting rooms and public spaces in the health care facility.

- Make infection control practices visible (e.g., wiping down key pads between registrants, sanitizing touched surfaces).

- Augment communication regarding infection control (e.g., signage at entryways with protocols for entering the building and scripting during interactions: "We are not shaking hands during this time to keep everyone safe.").

- Communicate to COVID-19 patients about the use of PPE and reduced interactions with staff and how that will protect them; script this as much as possible for each touch point with patients, from scheduling/registration through care processes.

- Communicate to non-COVID-19 patients about protocols implemented to maintain their safety; script this as much as possible for each touch point with patients, from scheduling/registration through care processes.

- Announce the washing of hands/use of sanitizer before every interaction with non-COVID-19 patients to assure them this practice is occurring even if out of sight.

- Communicate about universal masking practices by staff.

- Prominently display hand sanitizer stations and use signage to encourage their use.

COMMUNICATION

(Also see the section on Communications: Internal and External)

- Develop a comprehensive communications plan about safety practices related to COVID-19 for patients, families, community members, staff and volunteers, as well as a process for updating the plan as information changes. Ensure the right communication goes to the right audience at the right time. Use multiple message formats (e.g., social media, signage, letters/written materials).

- In scripting an introduction, acknowledge the current situation, reinforce trust and safety, and create a connection.

- Consider: How do we make our communications as transparent as possible while maintaining privacy?

- Provide information to patients and families related to the mechanics of entering the hospital (which entrance, where to present to be tested, etc.). Emphasize how the hospital team is enlisting them as partners in safe interactions for greater compliance.

- Consider written materials and signage about compliance with CDC and state guidelines and what the organization is doing to keep patients safe. Examples: following evidence-based guidelines, ensuring cleanliness, screening/testing, separating COVID-19 and non-COVID-19 patients.

- Work with clinical family liaisons and patient and family advisory councils to help guide policy and practice in tandem with clinical leadership, with emphasis on literacy levels and multiple languages spoken in the community.

- Address patient fears of inability to connect with family (use of phones, iPads, etc.).

- **Narrate the care provided to ensure and strengthen connections between staff and patients/families:**

  – Explain what patients should expect, such as masked caregivers with gloves/gowns, etc.

  – Explain care as it is delivered to increase patient autonomy and perception of safety.

EDUCATION

- Use a multipronged approach with different methods to educate patients, families, community members, staff and volunteers. Partner with community providers so education is coordinated.

- Consider educational offerings to the community about COVID-19, infection prevention practices and how care/practices are being modified based on the latest science. Consider working with community and faith-based organizations and other trusted community groups to spread the message.

- Educate patients and families about the impact of COVID-19 on their condition or diagnosis (if COVID-19 positive). For vulnerable populations, what is the specific messaging?

- Educate patients and families about the safety aspects of new technologies and care models, such as telehealth, cohorting, team-based care, etc.

- Provide training opportunities for staff about the use and potential use of telemedicine.

- Provide training for staff on new protocols for communicating about COVID-19 processes, including special training for front desk/admission staff who will be the first staff members to encounter patients and families and will be the first to get questions.

TELEMEDICINE AND OTHER TECHNOLOGIES

Telehealth technologies offer new opportunities to support follow-up care and to communicate with all sites of care to support patients in their communities. See the list of waivers for telehealth below. While these waivers are still in place under the public health emergency declaration, consider:

- Are there opportunities to use technology to change current processes, e.g., pre-admission testing, intake admission information gathering, pre-operative teaching, screening, care delivery?

WAIVERS

- Waiver of originating and geographic site restrictions, allowing telehealth services to be performed in any area of the U.S. and allowing patients to receive telehealth services in their place of residence, including their homes.

- Waiver of penalties for HIPAA violations against health care providers that serve patients in good faith through non-public-facing everyday communications technologies, such as FaceTime or Skype, enabling providers to connect with patients through these readily available applications.

- Reactivation of CPT codes for delivering evaluation and management services through audio-only phone calls.

- Waiver to allow clinicians to provide remote patient monitoring for acute conditions, whether for COVID-19 or another condition.

- Waiver to allow direct supervision to be provided using real-time interactive audio and video technology, thus allowing billing practitioners to observe via telecommunication technology patient interaction with in-person clinical staff.

PATIENT AND VISITOR SCREENING/TESTING

(See Testing and Contact Tracing section, which provides additional information regarding the current guidance for staff, community and patient/visitor screening and testing.)

- Evaluate current guidance and standards from the CDC, The Joint Commission, state and other authorities; routinely monitor these sources for changes as the pandemic experience unfolds.

- Consider working with other providers in your community (and, potentially, across your state through your state hospital association) to provide consistency and avoid sending confusing messages to the public.

- Develop comprehensive screening/testing protocols that include specific procedures for patients in various settings, e.g., clinics, emergency rooms, before admission, etc.

- Develop screening/testing protocols for patients who exhibit symptoms while hospitalized, after being admitted as COVID-19 negative.

- Develop screening/testing protocols for defined special-need populations, e.g., maternity, dialysis (outpatients), behavioral health, etc.

- Establish protocols for screening visitors and for managing any visitors who display symptoms.

- Support your screening/testing protocols with a comprehensive communications plan.

COLLABORATION WITH ALL PROVIDERS

- Is there an opportunity to standardize processes/procedures across the care continuum with all providers and community services? For example, with local departments of health, social service agencies, pharmacies, etc.?

- Consider this an opportunity to establish innovative partnerships, with scripting for continuity and consistency of messages.

HUMAN CONNECTION

CLINICIAN AND STAFF WITH PATIENT

- Explain why there may appear to be fewer staff interacting with patients, why they may be more covered (masked and gowned) and how that promotes patient and staff safety.

- Reassure the community that staff are available and routine care is important to ensure optimum health of each individual.

- Provide outreach to patients (e.g., calls or iPad "visits" from chaplains, clinicians, volunteers and leaders) to supplement staff's reduced physical presence in the room.

VISITATION/FAMILY SUPPORT

Social and family support is an important component of the care process.

- Revise policies and procedures for visitation and social distancing consistent with CDC and state guidance, and communicate these, along with underlying purposes. Assure that no medical jargon is included and that information shared is easy to understand. Ensure providers and their offices have the same information so that they can set expectations ahead of non-emergent procedures.

- Develop other methods of communication with families and allow patient/family choice, whenever possible (e.g., FaceTime, cell phone, scheduled conversations with clinicians, etc.).

CULTURAL SENSITIVITIES AND SOCIAL DETERMINANTS OF HEALTH (SDOH)

- What are our capabilities beyond our normal processes for translation?

- What are the impacts of SDOH on the admitting and discharge processes?

- Does the patient have access to new technology we may employ?

- How do patients in underserved areas access and comply with care needs?

ALTERNATIVE SITES OF CARE

- If considering or opening alternative sites of care, do we have adequate testing?

- How are we communicating this to patients/families?

- How do we reinforce the message that equivalent, safe care is delivered in these sites?

- How are we preparing the space to be compliant with all patient safety and infection prevention practices?

- How are we training staff to respond to questions from patients regarding the alternative sites of care?

DIFFERENT PROCESSES AND CARE MODELS (EMERGENT, NON-EMERGENT, COVID-19)

Due to the separation of COVID-19 patients and the introduction of different staffing/care models (team-based, for example), this encounter may appear very different from a previous hospital stay or clinic visit for both COVID-19 and non-COVID-19 patients.

- Have we inventoried what will be different, as perceived by the patient?

- How are we explaining this to the patient?

- Will the patient be seeing different providers than expected? If so, how will we orient the patient to these changes and the reasons behind these changes?

- Evaluate current guidance and standards from the CDC, The Joint Commission, state and other authorities relative to staffing, oversight, licensure, etc.; routinely monitor these sources for changes as the pandemic experience unfolds.

MEASUREMENT

Current measures of the patient experience include the CAHPS surveys, although reporting of required elements to CMS is suspended for Q1 and Q2 of 2020. By looking at various aspects of the patient experience, one can assess the extent to which patients are receiving care that is respectful of and responsive to individual patient preferences, needs and values. Evaluating the patient experience, along with clinical effectiveness and patient safety is essential.[25]

- Determine whether changes in who monitors patient experience or what is monitored are appropriate (e.g., suspending typical "report cards" to units and sharing the most useful comments).

- Examine trended views of data, based on discharge date or visit date, to monitor changes in experiences across the pre-surge, surge and post-surge timeframes.

- Assess themes in patient comments to understand how patients are experiencing new protocols and identify new concerns such as testing sites.

- Consider alternate methods in addition to phone or electronic surveys, especially for new and innovative programs and processes such as testing sites.

- Employ new methodology using artificial or augmented intelligence combined with natural language processing, which allows extracting insights from patient comments that can guide organizations in understanding issues and opportunities.

- Because care delivery, settings and processes are rapidly evolving, perform measurement with enough frequency to guide nimble leadership/management.

ADDITIONAL RESOURCES

"Person-Centered Guidelines for Preserving Family Presence in Challenging Times." Planetree. May 28, 2020. bit.ly/familypresence

TRANSITIONS OF CARE

The following lessons learned and related considerations pertain to managing transitions of care between various levels of care: clinic visits or emergency room to inpatient services, as well as discharge and cross-setting care management processes under evaluation as hospitals adapt to the new environment.

The relationships and partnerships between acute care and post-acute care providers are key to ensuring the successful transition of patients to their home communities, including skilled nursing facilities, rehabilitation hospitals, long-term care hospitals, home or hospice. Thoughtful care management will allow patients to be transitioned from each level of care and supported on their journey to recovery. Specifically, this section focuses on transitions of care along the full continuum of care and complements the earlier section of this document on Ancillary and Support Services.

As background, we note that during the COVID-19 emergency, the experience in effectively utilizing post-acute care settings has been mixed. Some settings have struggled to respond to the crisis, most notably nursing homes. In contrast, as an example, long-term care hospitals have played an important role in treating ventilator and other highly-acute patients — especially in pandemic hot spots. As such, when considering relationships with community partners and opportunities to collaborate during this and future public health emergencies, it is useful for each hospital or health system to communicate with partners across the local continuum of care to compare COVID-19 lessons learned thus far. By identifying relative strengths and deficits, such exchanges can provide a baseline for future collaboration to improve the discharge process for COVID-19 and other target populations.

Likewise, the pandemic has illuminated the advantages of having provider offices, community health clinics, home care services, prehospitalization services (ambulances), community services, public health offerings and other parts of the care continuum coordinated with hospitals and health systems. Consider partnerships and collaboratives established through memorandums of understanding to evaluate the best use of all licensed beds and other clinical resources within a community/region. Throughout the public emergency, regulations have been made more flexible through emergency use authorizations. State and local regulatory agencies should be engaged so they understand the advantages of such partnerships and collaboratives.

INITIAL LESSONS LEARNED RELATED TO TRANSITIONING PATIENTS DURING THE COVID-19 PANDEMIC

- Some settings of care – most notably, many nursing homes – lack the infection control, personnel and physical plant required to effectively prevent and mitigate the spread of infectious diseases such as COVID-19. Receiving entities must be adequately staffed and trained to provide the necessary care for recovering COVID-19 patients. Larger organizations could offer educational training and on-site support to potential partner/skilled nursing facilities to ensure vulnerable patients receive appropriate follow-up and thus are less likely to be readmitted to the referring hospital.

- Some nursing homes – especially those affiliated with or already in a partnership with a hospital or health system – have effectively contributed to their local pandemic response. Of note, hospitals participating in alternative payment models, such as ACOs or bundled payments, that involve direct partnership with area nursing homes appear to be best positioned to collaborate during this pandemic and may provide a model for other communities to emulate. Some key elements of these relationships include existing channels of communication and protocols for joint case management, as well as standardized discharge processes and forms.

- Likewise, provider practices and community health centers that are part of these alternative payment models with hospitals also are well equipped to coordinate and partner with hospitals and health systems for the same reason.

- Some nursing homes tested all residents for COVID-19, which resulted in a burst of patients transferred to a local hospital and created capacity and resource challenges for the hospital. Plans to avoid repeating this action should be undertaken now.

- Other nursing homes temporarily evacuated all patients to an area hospital. While a portion of these patients met hospital admission criteria, most generally did not and therefore required hospital custodial care that is not reimbursed by Medicare. Plans to avoid repeating this action should be undertaken now.

- Care managers can play an effective role in outreach to patients prior to their visit (clinic, outpatient and inpatient) to provide guidance and set expectations.

- Communication with families of patients being discharged home also is key to ensure that they understand the care plan and can assist with care coordination and ongoing protocols for recovery.

- Telehealth is playing a critical role in mitigating community spread by reducing contact across health personnel, patients and the community. During the COVID-19 pandemic, policymakers have significantly extended the use of telehealth across post-acute care settings; but in certain cases, requirements for some in-person care were maintained, such as in home health settings. The ability to follow up and evaluate remotely should be available and supported through the use of telehealth at post-acute facilities and for homebound patients.

- Protocols for hospital-to-nursing home transfers of COVID-19 patients varied from state to state, with some standards set at a level that greatly delayed – and in too many cases, prevented – discharges back to a nursing home. Most commonly, this issue was caused by the requirement that a patient must have multiple negative COVID-19 tests prior to being admitted by the originating or other nursing home. Testing delays and inconsistent nursing home and post-acute care admission criteria for prior-COVID-19 positive and COVID-19 suspected patients exacerbated this problem. Plans to establish and standardize patient flow protocols should be undertaken now.

- Many hospitals reported sharing their supply of PPE with key post-acute care partners to facilitate safe patient transitions to a new setting. However, PPE shortages were a chronic challenge for many post-acute care providers.

- Additional resources and flexibilities provided by policymakers were key to enabling hospitals and post-acute care providers to make timely adaptations to existing transfer processes, care delivery protocols and the physical plant. These adaptations facilitated additional and faster hospital discharges by expanding space for COVID-19 positive and suspected cases, including new isolation spaces, and also reduced patient contact with clinical personnel and their communities. The volume and ongoing issuance of these new authorizations presented challenges for providers. Certain patients transitioning from a hospital to a post-acute care setting are encountering access to care challenges due to a shortage of key personnel, such as respiratory therapists needed to treat ventilator patients and behavioral health providers needed during home health visits.

- The mental health status of patients must be monitored both before and after discharge, providing appropriate recommendations for support services as needed; new partnerships with behavioral health care providers are needed to ensure continuity of care and to work toward better care coordination and efficiency.

- Some safety protocols caused discharge delays and reduced efficiency, including those prohibiting clinical personnel from local hospital partners from entering the referring care location to assist with discharges and related case management.

- The lack of interoperable EMRs across the local continuum of care slowed some patient discharges from hospitals to external post-acute care providers.

- Special needs populations, such as the homeless, prisoners and shelter residents, have certain unique transitions of care challenges; address these specifically within any protocols and plans.

IMPORTANT ELEMENTS FOR HOSPITAL DISCHARGES AND CROSS-SETTING COLLABORATION

COMMUNITY PLANNING

- Work with state and local emergency planners to identify:

  - Alternative sources for custodial care provided by hospitals for nursing home and other non-hospital patients, to allow hospitals to focus on patients needing inpatient-level care.

  - Identify the particular personnel that were uniquely needed during a pandemic, yet were in short supply, and to the extent possible, create surge staffing models and personnel supply plans.

- Create an ongoing system for dialogue with local health departments, other acute care hospitals, post-acute care and other key partners in your area to:

  - Address COVID-19 lessons learned related to transitions of care to prepare for future waves of COVID-19 and other viruses.

  - Standardize communitywide communications and care protocols.

  - Incorporate best practices from existing partnerships to improve care through joint case management, communications and problem solving.

  - Identify strategies to minimize movement of patients and clinical personnel across settings, with a focus on treating vulnerable patients in their originating setting when feasible.

- Support efforts to maintain the effective telehealth tools that were newly implemented during this pandemic.

- When planning for future PPE needs, in addition to using state guidelines and practices, consider collaborating with providers across the continuum of care on inventory levels and materials management practices.

KEY COMPETENCIES

- Establish a reliable system for communicating with key community partners during and after a hospital discharge, such as:

  - Primary care doctors and practices;

  - Post-acute care providers;

  - Durable medical equipment (DME) providers;

- Social service agencies; and

- Other services needed by patients transitioning to home.

- Develop discharge protocols that facilitate timely and patient-centered transfers and that focus on conveying priority information in a streamlined format.

- Address capacity for remote patient follow-up and other care, when clinically feasible.

- Ensure adequate access to the DME needed to provide safe care at any site.

- Consider incorporating support tools and artificial intelligence to augment case management decisions related to selecting the post-hospital site of care and related factors.

- Provide access to reliable and timely guidance on emerging waivers and other relief from payers.

RISK MANAGEMENT

Risk management planning involves identifying risks, assessing the impact of risks and developing strategies to manage risks to your organization. COVID-19 can pose potential risks critical for business recovery and survival. But there also is an opportunity to manage the impact of COVID-19 proactively and meet your legal obligations to employees and the community you serve to ensure safety with risk mitigation strategies.

Managing the potential risks posed by COVID-19 will positively influence the preparedness of your organization for returning to non-emergent services. As recovery ensues, evaluating and addressing the considerations in this document will decrease your organization's risk exposure and assist in recovery.

Here are areas of consideration.

PLANNING

As your organization begins developing a path forward to reopen certain services, a number of risk management issues need to be considered and addressed to effectively mitigate any potential risk. This effort will require coordination with local public health officials, community groups, other health care providers and governmental agencies, as appropriate. Each of the eight risks, listed below, will have to be discussed with two sets of circumstances in mind: 1) immediate needs as your hospital continues to address the surge and 2) considerations as your organization transitions into the "recovery" phase of this process.

Effective planning can be accomplished using these eight domains of enterprise risk management:

1. Operational risk: Care that is safe, timely, effective, efficient and patient-centered within diverse populations. Operational risks relate to those resulting from inadequate or failed internal processes, people or systems.

2. Clinical/patient safety risk: Clinical risks relate to practices associated with the delivery of care to residents, patients and other health care consumers. In this environment, pay special attention to increased risks associated with changes made to the care process, e.g., cohorting, patient segregation, limited visitation, medication management, new laboratory testing protocols embedded in care pathways, etc.

3. Strategic risk: These risks are associated with brand, reputation, competition, failure to adapt to changes in the environment and consumer preferences.

4. Financial risk: Decisions that affect the financial sustainability of the organization, access to capital or external financial ratings have an impact on financial risk.

5. Human capital: Risks in this domain include staffing models, infection control and prevention, appropriate training for new protocols, work schedules and fatigue, licensing and credentialing, workers' compensation and others.

6. Legal/regulatory: In the current environment that has experienced waivers, emergency use authorizations and other changes to regulatory requirements, the need to manage and monitor legal, regulatory and statutory mandates on a local, state and federal level is essential. Precise and timely documentation of any procedural changes made as a result of the legal and regulatory allowances, including start and stop dates, also is essential.

7. Technology: This domain covers machines, hardware, equipment, devices and tools, but can also include techniques, systems and methods of organization.

8. Hazard: Included here, along with natural disasters, are risks associated with business interruption and facility management.

INTERNAL AND EXTERNAL COMMUNICATION OF RISK MANAGEMENT ISSUES

- Is the board kept up to date? Whether communications are written, they can be discoverable.

- Communicate with supply chain vendors to mitigate potential disruption.

- Communicate through multiple modalities with staff directly affected.

OTHER ISSUES FOR CONSIDERATION

- Malpractice protection for providers via the CARES Act.

- Medical malpractice insurance of non-traditional care providers, e.g., nurses and providers reentering the workforce from retirement.

- Application for any business interruption coverage.

- Review of special insurance policies, e.g., directors and officers liability insurance, advanced practice care providers coverage/policies, etc.

- Audit of electronic health records with attention to any alterations in existing practice that may have taken place during the pandemic and a more harried work environment.

- Broader protection of liability through executive order or legislation.

ENDNOTES

1. AHA will work with federal agencies and others in an effort to extend the waivers to enable an efficient and effective workforce.

2. Additional resources are listed in the Appendix.

3. Issues regarding the work environment, e.g., work station design, social distancing, etc., are addressed in the section on plant operations/environment of care.

4. Testing Blueprint for Opening Up America Again: https://www.whitehouse.gov/wp-content/uploads/2020/04/Testing-Blueprint.pdf.

5. CDC – Comprehensive Hospital Preparedness Checklist for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/HCW_Checklist_508.pdf

6. Guidelines for Opening Up America Again: https://www.whitehouse.gov/openingamerica/

7. FDA Guidance document: https://www.fda.gov/media/136841/download;

   USP Response document: https://www.usp.org/sites/default/files/usp/document/about/public-policy/usp-covid19-garb-and-ppe.pdf

8. AHA – Checklist for Discharging Patients with COVID-19: https://www.aha.org/system/files/media/file/2020/04/COVID-19-Checklist-for-Discharging-Patients-Checklist.pdf;

   Advisory Board – 7 Lessons on Discharge Planning During COVID-19 from UW Medicine: https://www.advisory.com/daily-briefing/2020/04/03/uw-medicine;

   CMS – Hospitals: CMS Flexibilities to Fight COVID-19 (pp.4-5): https://www.cms.gov/files/document/covid-hospitals.pdf;

   National Association of Social Workers (NASW): https://www.socialworkers.org/;

   NASW – Teleheath: https://www.socialworkers.org/Practice/Infectious-Diseases/Coronavirus/Telehealth

9. CDC – Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

10. CMS – Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit: https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

11. Opening Up American Again, CMS Recommendations: https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf

12. CMS – Guidance for Infection Control and Prevention Concerning COVID-19 by Hospice Agencies: https://www.cms.gov/files/document/qso-20-16-hospice.pdf

13. National Hospital and Palliative Care Organization – Guide to Organizational Ethics in Hospice Care: https://www.nhpco.org/wp-content/uploads/2019/04/Ethics_Guidelines.pdf

14. AHA – COVID-19: Telehealth and Virtual Care: https://www.aha.org/issue-landing-page/2020-03-24-coronavirus-covid-19-telehealth-and-virtual-care

15. Center to Advance Palliative Care – COVID-19 Response Resources: https://www.capc.org/toolkits/covid-19-response-resources/

16. Home Care Alliance of MA – Guidance Related to COVID-19: https://discussion.nahc.org/wp-content/uploads/wpforo/default_attachments/1585861215-HCAM-Home-Health-Guidance-for-COVID-19-Admissions.pdf

17. Opening Up America Again, CMS Recommendations: https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf;

    American Enterprise Institute – National Coronavirus Response: A road map to reopening: https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/

    American Society for Health Care Engineering – Reopening Facilities to Provide Non-Emergent Non-COVID-19 Health Care Phase 1: https://www.ashe.org/system/files/media/file/2020/04/Re-openingFacilitiestoProvideNon-emergentNon-COVID-19Healthcare-Phase%201.pdf

18. Opening Up America Again, CMS Recommendations: https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf;

    American Enterprise Institute – National Coronavirus Response: A road map to reopening: https://www.aei.org/research-products/report/national-coronavirus-response-a-road-map-to-reopening/

    American Society for Health Care Engineering – Reopening Facilities to Provide Non-Emergent Non-COVID-19 Health Care Phase 1: https://www.ashe.org/system/files/media/file/2020/04/Re-openingFacilitiestoProvideNon-emergentNon-COVID-19Healthcare-Phase%201.pdf

19. National Kidney Foundation – Peritoneal Dialysis: What You Need to Know: https://www.kidney.org/atoz/content/peritoneal

CDC Interim Additional Guidance for Infection Prevention and Control Recommendations for Patients with COVID-19: www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/dialysis.html

CDC – Considerations for Providing Hemodialysis for Patients with COVID-10 in Acute Care Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis/dialysis-in-acute-care.html

20. AHA – Administration Requests Hospitals Report Daily on COVID-19 Testing Results, Bed and Ventilator Capacity: https://www.aha.org/system/files/media/file/2020/03/administration-requests-hospitals-report-daily-on-covid-19-testing-results-bed-and-ventilator-capacity-3-30-2020.pdf

21. AHA Coding Clinic – Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-19: https://www.codingclinicadvisor.com/faqs-icd-10-cm-coding-covid-19

22. COVID-19 Resources for the NAMSS Community: https://www.namss.org/COVID-19#COVID19%20Resources

23. Agency for Healthcare Quality and Research – What Is Patient Experience? https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html

24. Press Ganey Associates – Insights from National Patterns in Patient Experience During the COVID-19 Crisis: https://www.pressganey.com/docs/default-source/default-document-library/insight-from-national-patterns-in-patient-experience-during-the-covid-19-crisis.pdf

25. Agency for Healthcare Research and Quality – What Is Patient Experience? https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html

APPENDIX PREFACE

NON-EMERGENT PROCEDURE DECISION-MAKING DASHBOARD

COMMUNITY / REGIONAL ENVIRONMENT

New case growth rate

0	1	2	3	4	5	6	7	8	9	10

Increasing ⇧   Flat/ ⇧ 14 Days

TESTING AVAILABILITY

Pre-operative Testing

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Testing unavailable   100% Capacity

PPE AVAILABILITY

Days of Supply in Inventory

0	6	9	10	13	16	19	20	23	26	30

PPE Unavailable   30+ Days
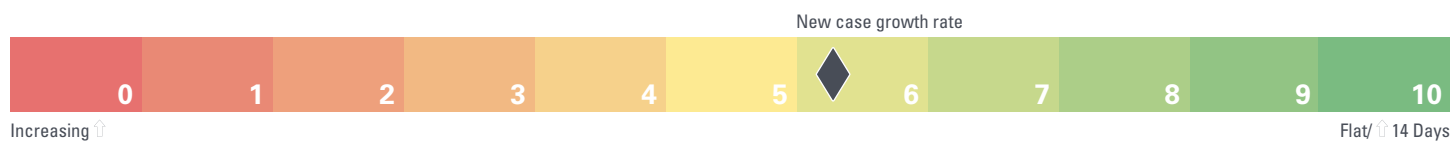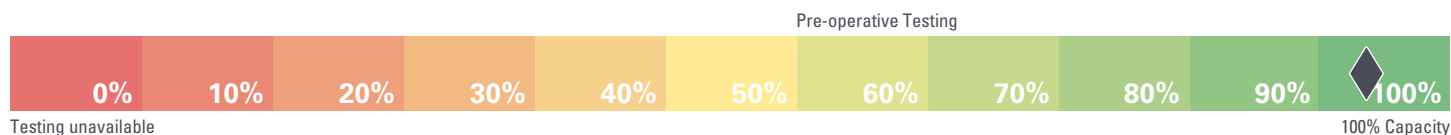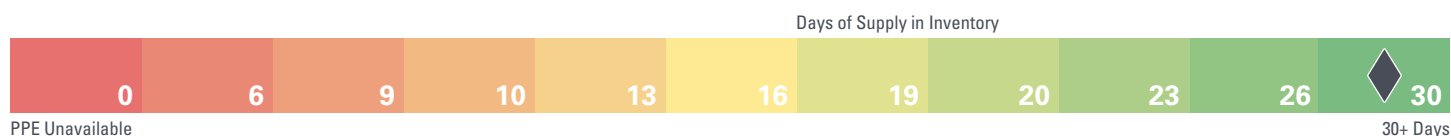
SURGICAL-RELATED MEDICATION SUPPLY

Days of Supply in Inventory

4	5	6	7	8	9	10	11	12	13	14

< 3 days   14+
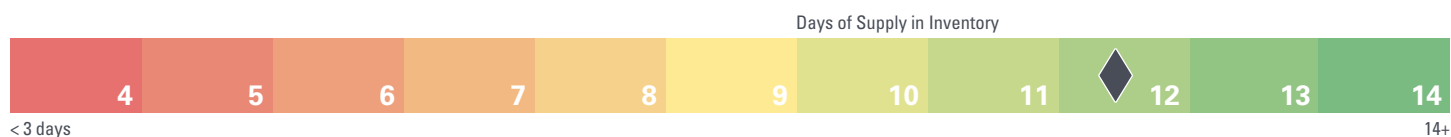
THERAPEUTICS AVAILABILITY

Days of Supply in Inventory

0	6	9	12	15	18	21	24	27	30

Unavailable   30+ Days

ACUTE HOSPITAL CAPACITY

Bed Availability

0	1	2	3	4	5	6	7	8	9	10
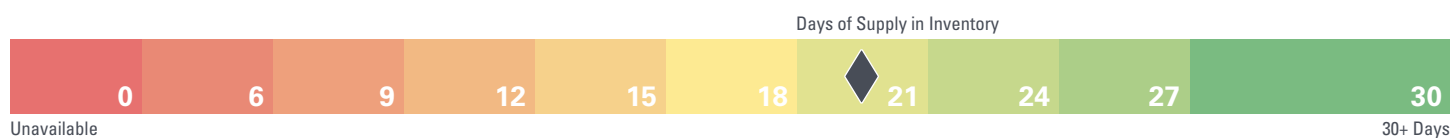
Limited Availability   Excess Availability
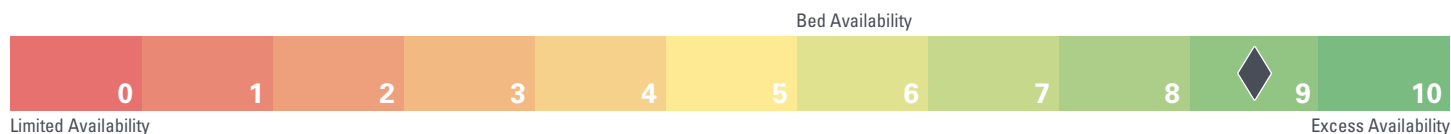
POST-ACUTE CARE CAPACITY

Bed Availability

0	1	2	3	4	5	6	7	8	9	10

Unsafe conditions/ difficult placement   Safe status/Easy placement

Cottage Health
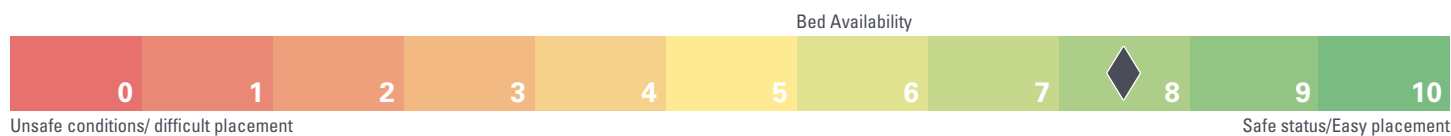
APPENDIX 1: WORKFORCE

BEHAVIORAL HEALTH RESOURCES

- COVID-19 Stress and Coping Resources

- APA Center for Workplace Mental Health

- Talkspace Donates Free Therapy to Medical Workers Fighting COVID-19

- AONL Resilience Expert Has Tips for Employees' Mental Health

- Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery: Behavioral Health

- Neurosequential Network: NN COVID-19 Stress, Distress & Trauma Series

- Resources to Support Mental Health and Coping With the Coronavirus (COVID-19)

APPENDIX 2: GUIDELINES FOR COVID-19 TESTING FOR PATIENTS

I. WHO GETS TESTED FOR COVID-19?

1. All symptomatic patients will be tested for COVID-19.

2. Testing of asymptomatic patients may be limited by our testing capacity.

3. Asymptomatic patients will be prioritized according to the table below.

ASYMPTOMATIC COVID-19 TESTING COHORTS AT VUMC		
COHORT	DESCRIPTION	PROPOSED START DATE
0	Transplant donors/recipients, selected post-acute care discharges, and heme-onc pts prior to admin of severely immunosuppressive anti-neoplastic chemotherapy	Ongoing
1	Procedures using N95 for all patients (Bronchoscopies, upper endoscopy and related procedures#, dental surgery, craniotomies via sinus access, ENT surgery, thoracic surgery in upper airways), L&D admissions, Trauma Unit admissions, pre-cardiopulmonary bypass patients	Ongoing
2	All patients who require general anesthesia for surgery or procedure.	4/29/20
3	Psychiatric currently hospitalized patients and new admissions	TBD
4	Adult and children's hospital new admissions not in Cohorts 0-2 above	TBD
5	All ambulatory procedures involving the head and neck, and any remaining procedures not noted in prior cohorts but that require anesthesia or deep sedation techniques that may require airway support	TBD

Cohorts 0 and 1 comprise scheduled and unscheduled patient encounters as described above and are currently being tested routinely.

Cohort 2 comprises scheduled elective procedures with obligate aerosol generating potential, and patients who cannot practically mask or effectively physically distance in the treatment environment.

Cohorts 3 and 4 are any remaining elective and unplanned hospital admissions in populations at no elevated risk of asymptomatic COVID carriage.

Cohort 5 comprises patients deemed to have lower risk of AGP & transmission from asymptomatic patients than Cohort 2.

II. COVID-19 TEST ORDERING PRIOR TO PROCEDURES

- **Inpatients:**

  – Emergent procedures- Proceed using PPE/precautions as defined in VUMC policies.

  – Procedures scheduled for >12 hours in the future- Proceduralist/surgeon or designee orders "SARS-CoV-2 PCR" in eStar. Reason for testing: "Screening of asymptomatic patient" and "Approved pre-procedure screening". Ideally, testing should occur no more than 48 hours prior to the planned procedure (unless the patient was screened for COVID-19 prior in the admission.)

VANDERBILT UNIVERSITY
MEDICAL CENTER

- **Outpatients:**

  – COVID-19 testing must be obtained within 48 hours of scheduled procedure for patients who are screened at VUMC and within 72 hours of scheduled procedure for patients who are screened outside VUMC due to distance.

  – Proceduralist/surgeon or designee orders "SARS-CoV-2 PCR" in eStar. Select "Future" status; Expected date 48 hours prior to the procedure; Expires "1 year"; "Clinic Collect"; Reason for testing: "Screening of asymptomatic patient" and "Approved pre-procedure screening". Consider diagnosis code: Z11.59 ("encounter for screening of other viral diseases"). Order must be placed prior to sending outpatients to test location.

    » Nursing staff working under the direction of the proceduralist/surgeon may enter this order using the "standing order" mode with co-signature by the provider.

  – Outpatients will also be asked to wear a mask and screened at time of procedure by symptom and temperature checks.

III. COVID-19 TESTING LOCATIONS FOR PRE-PROCEDURE OUTPATIENTS

- For VUMC testing locations, see table at end of document.

- For patients too far from VUMC to access our screening sites:

  – Scheduler reviews options for VUMC sites and counsels that VUMC testing is preferred as 3rd party testing can be less reliable. (See information about 3rd party testing options at end of document.)

  – Patients requesting 3rd party testing must provide documentation of negative PCR result time stamped within 72 hours of procedure. Verbal test results, SARS-CoV-2 serologies, or antibody results are NOT acceptable.

- All patients expected to self-isolate after sample collection and before the procedure.

- VUMC test results will be automatically placed into the EMR. Third party testing will need to be scanned into eStar.

IV. COVID-19 TEST RESULT REPORTING

- Clinical staff associated with the proceduralist/surgeon will follow up outpatient results as per other pre-op testing.

- Positive COVID-19 results will be alerted to the ordering provider via the lab FYI Alert Notification (mimics lab critical alert process).

  – COVID-19 negative: Results will be available to outpatients via MH@V.

  – COVID-19 positive: The proceduralist/surgeon will decide whether to proceed with the procedure based on the urgency of the procedure.

VANDERBILT UNIVERSITY
MEDICAL CENTER

V. CONSEQUENCES OF COVID-19 TEST RESULTS (PPE, CANCELLATION POLICY, LOCATION)

- COVID-19 negative: Providers should not wear N95 respirators (unless indicated for another infection)

- COVID-19 positive:

  – Cases should be cancelled unless medically necessary

  – If procedure is cancelled, proceduralist/surgeon or their designee will notify OR and patient and educate patient around self-isolation and to notify primary provider if they develop symptoms.

  – After 14 days, patient may be retested for COVID-19, and if repeat test is negative, patient may be scheduled for the procedure.

  – If procedure is to proceed immediately after a positive COVID-19 test, proceduralist/surgeon will communicate with procedure site and manage patient as COVID-19 positive.

  – Procedure can proceed only at a main campus location with COVID-19 PPE use guided by VUMC policies.

  – Patients will not be operated on at ASCs or free-standing facilities.

- COVID-19 pending or unavailable:

  – Procedure team will decide to postpone (most likely) or proceed based on medical criteria. If postponed, decision will be made when test results available.

  – A limited number of rapid COVID-19 tests are available on campus for testing of patients who arrive for their procedure without an available COVID-19 test result. Contact the holding room charge nurse and case anesthesiologist to discuss need for rapid testing.

- COVID-19 refused by patient:

  – Patients who decline testing will be considered a person under investigation and not operated upon at ASCs or other free-standing facilities. If medically necessary, procedure may proceed with proper PPE at a suitable main campus location.

VANDERBILT UNIVERSITY
MEDICAL CENTER

APPENDIX 3: COMMUNICATIONS: INTERNAL AND EXTERNAL

CONTENT FOR USE ON WEB AND SOCIAL PLATFORMS

Widespread use in printed materials, website content as well as social and digital media outreach.

ADS AND SOCIAL/CONTENT 1:
We're prepared to protect the healthy and care for the sick.s
We're here to take care of emergencies and other non-COVID-19 health needs you have.
We're ready, safe and open.

ADS AND SOCIAL/CONTENT 2:
We are ready, safe and open.
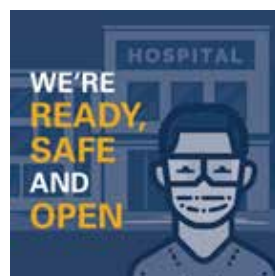
POSTER AND SOCIAL/CONTENT 3:
Thank You for Doing Your Part; We Are Here to Do Ours
Steps that hospitals are taking to keep patients and staff safe:

- Following national and local guidelines
- Monitoring local COVID-19 cases
- Enhancing cleaning and infection prevention protocols
- Providing curbside COVID-19 testing
- Creating dedicated entrance and waiting space for non-COVID-19 patients
- Restricting visitors
- Employing social distancing in common areas
- Keeping food safe with additional preparations

SOCIAL GIFS/CONTENT 4:
Emergencies don't stop. Neither do we.
Don't delay care for heart attacks, strokes, falls and other urgent needs.
We are ready, safe and open.

POSTER AND SOCIAL GIFS/CONTENT 5:
What you can expect when you come to the hospital:

- Curbside COVID-19 testing
- Limited entry and exit points
- Visitor restrictions
- Social distancing and mask use

POSTER AND SOCIAL GIFS/CONTENT 6:
Tips for Patients:

- Continue to follow public health guidelines
- Do NOT delay emergency or needed treatment
- Schedule appointments in advance when possible
- Limit the number of people you bring with you to the hospital
- Consider telehealth options if appropriate and available

DIGITAL OR PRINT ADS AND SOCIAL/CONTENT 7:
Hospitals will continue to fight COVID-19.
Hospitals will continue to provide lifesaving care.
Hospitals are open, clean and safe.

SAMPLE MATERIALS

SAMPLE OPED

More than COVID-19 Care

Let me first thank you. As the COVID-19 pandemic forced us all to change our daily routines, our community did the job they were asked to do – stay home and stay safe. I know how hard that can be, but I'm confident your efforts made a tremendous, positive difference in the health of our state. But I want to remind you that emergencies don't follow the same rules. Heart attacks, strokes and falls still demand urgent care. Important immunizations, cancer treatments and screenings can't be delayed. We are ready, safe and open for these non-COVID-19 health needs. In fact, [X] babies have been born in the last month, bringing some much-needed smiles to many.

COVID-19 hasn't changed the fact that [HOSPITAL OR HEALTH SYSTEM NAME] is here to help you and your family. You should know that COVID-19 has enhanced our already intensive patient safety efforts. We're doing everything in our power to keep our staff, patients and community as safe as possible. We're closely coordinating with the CDC, national public health experts, other hospitals, urgent care centers, physician offices and others both locally and statewide to prevent the spread of COVID-19 or a resurgence of the virus throughout the state. We are in this together and will get through this together.

If you come to the emergency department (ED) or hospital, you'll see additional precautions including intensive cleaning processes in all areas, particularly the ED and intensive care units as well as:

- Increased COVID-19 testing opportunity including curbside testing

- Social distancing in waiting rooms and mask use in common areas

- Dedicated non-COVID emergency department care areas

- Restrictions on visitors

- Limited entry and exit points

Over the past month, I've seen our doctors, nurses and entire health care workforce – cafeteria team, environmental services, administrative and support staff – bravely and skillfully do the jobs they are trained to do. It's inspiring, but it also serves as a reminder: We are here to care for you.

So, thank you again for doing your part. Know that we are here to do ours.

SAMPLE PRESS RELEASE

FOR IMMEDIATE RELEASE

[ORGANIZATION] Announces Recovery Plan and Return of Certain Non-Emergency Procedures

DATE – [ORGANIZATION] will begin taking steps to resume some scheduled surgeries by [DATE] in coordination with area health care providers and under the guidance and consultation of local public health experts. We have carefully implemented a plan that ensures the safety of our patients and caregivers is preserved, closely monitors personal protective equipment and other critical supplies and prevents the spread of COVID-19. This gradual return to pre-COVID-19 operations will include a phased plan to allow diagnostic procedures and other scheduled surgeries to resume. [can list specific examples]

"The health and safety of our community is always top priority," said [CEO NAME]. "COVID-19 has enhanced our already intensive patient safety efforts and ensured we're doing everything possible to keep staff safe as well. I want to assure everyone that we are here to care for you and it is safe for you to come to the hospital. If you have an emergency, don't delay. Call 911 or come to the emergency room."

IF RELEVANT On [DATE], [STATE] hospitals stopped performing so-called elective procedures in response to a request by Governor [NAME] to conserve critical resources such as personal protective equipment and assure hospitals were able to respond to COVID-19 emergencies. On [DATE], Governor [NAME] authorized the state's medical facilities to resume these so-called elective procedures.

[ORGANIZATION'S] plan to begin certain procedures is based on recommendations from the National Coronavirus Response and incorporates coordinated monitoring of new COVID-19 cases with local and state officials along with additional staff and patient safety protocols, including intensive cleaning processes in all areas of the hospital, particularly the emergency department and intensive care units. Individuals can expect:

- Increased COVID-19 testing opportunity including curbside testing

- Social distancing in waiting rooms and mask use in common areas

- Restrictions on visitors

- Limited entry and exit points

- [INCLUDE ADDITIONAL PROTOCOLS YOUR ORGANIZATION HAS INCORPORATED]

For more information, visit [ORGANIZATION COVID SITE].

###

SAMPLE PSAs

30-Second PSA 1: Hi, I'm [NAME/TITLE at ORGANIZATION]. Emergencies don't stop and neither do we. Don't delay care for heart attacks, strokes, falls and other urgent needs. We will continue fighting COVID-19. We'll provide our physicians, nurses, other team members and patients everything they need to stay safe. And we'll continue caring for you and your family. We are ready, safe and open for you.

30-Second PSA 2: Don't delay care for heart attacks, strokes, falls and other urgent needs. Hi, I'm [NAME/TITLE at ORGANIZATION]. We will continue fighting COVID-19. We'll provide our physicians, nurses, other team members and patients everything they need to stay safe. And we'll continue caring for you and your family. We are ready, safe and open for you.

45-Second PSA 3: Hi, I'm [NAME/TITLE at ORGANIZATION]. I want to assure you that we are doing everything possible to keep you safe and healthy in these unprecedented times. From additional intense cleaning of our hospital to limited entry points and visitor restrictions, our priority is your health. We're also making sure the doctors, nurses and other essential staff have the supplies and support they need to care for you and go home to their families. And if you have an emergency, don't delay. We're here for that too. We are ready, safe and open for you.

APPENDIX 4: SUPPLY CHAIN

MHA COVID-19 SITUATIONAL AWARENESS UPDATE

DATE: April 30, 2020

COVID-19 CASE SUMMARY

Positive COVID-19 Cases Identified (DHSS)

CATEGORY	COUNT	24-HOUR INCREASE
Total Statewide COVID-19 Cases	7,562	137
Total Statewide COVID-19 Deaths	329	11

Source: https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/
for county specific information please access the above source link.

Current COVID-19 Hospital Admissions

CATEGORY	COUNT	24-HOUR INCREASE
Hospitalized COVID Patients*	853	(34)
Hospitalized and Ventilated COVID Patients*	141	4

Hospitals Reporting 103 of 120

Source: CDC National Health Safety Network (hospitals with data > 3 days old is not included)
*COVID Patients include suspected or confirmed cases
Note: Hospitalized patient numbers may differ from MO DHSS due to several factors such as timing of admission or out-of-state residents.

NOTES:

1. EMResource sourced at 10 a.m and includes all inpatient, brick and mortar facilities to include psychiatric hospitals.

2. NHSN data is sourced daily at 1 p.m.

3. DHSS publishes daily COVID case counts around 2 p.m.

4. Every effort has been made to ensure the accuracy of this data. The number of available beds is based on hospital reports and will increase or decrease based on current utilization.

5. The 24-hour increase of hospitalized COVID patients, and hospitalized and ventilated COVID patients represents the difference published day-to-day, and is not normalized based on the number of reporting hospitals.

SUPPLY SUMMARY

PPE Shortages

CATEGORIES	# HOSPITALS REPORTING		
	4-14 DAYS ON HAND	1-3 DAYS ON HAND	0 DAYS ON HAND
N95 Particulate Respirators	21	3	0
Surgical Masks	31	5	0
Face Shields (Face Shields & Goggles)	32	1	0
Gloves	17	1	0
Single-use Gown	29	13	0
PAPRs	10	11	0

Hospitals Reporting 80 of 120

Source: CDC National Health Safety Network (hospitals with data > 3 days old is not included)

BED AVAILABILITY SUMMARY

Bed Availability by Type

BED TYPE	AVAILABLE	TOTAL***
Medical Surgical	2,933	10,795
Intensive Care Units	617	2,129
Emergency Department (ED)	1,308	*

Hospitals Reporting 113 of 154

Source: EMResource (hospitals with data > 3 days old is not included)
* ED beds are being collected for baseline. Additional statewide utilization data will be available as a baseline is established.
*** totals based on the annual licensing survey

VENTILATOR AVAILABILITY SUMMARY

Available Ventilators

CATEGORY	AVAILABLE	TOTAL
Mechanical Ventilators	1,720	2,329

Hospitals Reporting 87 of 120

Source: CDC National Health Safety Network (hospitals with data > 3 days old is not included)

REPORTED POSITIVE COVID-19 CASE TREND

APPENDIX 5: ANCILLARY AND SUPPORT SERVICES

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
Exception under Controlled Substances Act	Ability to prescribe controlled substances without a prior in-person exam; requires telemedicine & applies to providers with DEA-registration.	Providers must conduct a prior in-person exam before prescribing controlled substances.
HHS 1135 Waiver	To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during the emergency period.	HHS will resume audits and entities will be required to meet requirements of demonstrating a prior relationship existed prior to using telehealth (ex – virtual check-in services).

HHS 1135 Waiver (CMS Press Release)	Patients no longer required to be at eligible "originating site" (patient can access telehealth care from home). As a result, there has been an elimination of credentialing requirements (distant site practitioners previously would need to be credentialed by originated sites and undergo peer review as if they physically practiced at originating sites) (**this should be reviewed together with state law to ensure commercial and Medicaid will provide reimbursement).	In order to receive reimbursement from Medicare, the patient's location must meet the following requirements:
		• Geographic restrictions: Must be located in a Health Professional Shortage Area (HPSA) as defined by Health Resources and Services Administration (HRSA), or in a county that is outside of any Metropolitan Statistical Area (MSA) as defined by the US Census Bureau.
		• Eligible facility: Must be limited to the following facilities:
		  – Provider offices;
		  – Hospitals;
		  – Critical access hospitals;
		  – Rural health clinics;
		  – Federally qualified health centers;
		  – Skilled nursing facilities;
		  – Community mental health centers;
		  – Hospital-based or critical access hospital-based renal dialysis centers;
		  – Renal dialysis facilities;
		  – Homes of those with end stage renal disease getting home dialysis;
		  – Mobile stroke units
		*Exceptions apply for: end stage renal disease; acute stroke; or treatment for substance abuse or co-occurring mental health disorders.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
HHS 1135 Waiver (OCR Notification)	OCR will exercise enforcement discretion and will not impose penalties for noncompliance with HIPAA requirements to have compliant audit & visual communication platform (for the good faith use of telehealth during the COVID-19 emergency).	OCR will exercise enforcement as usual for purposes of requiring covered entities to comply with HIPAA (Saint Luke's would need to execute BAA's with all vendors providing video chat applications and those applications would need to be HIPAA compliant).
CARES Act (Broadens 1135 waiver authority)	Distant site practitioners who can bill for Medicare includes all health care professionals that are eligible to bill Medicare for their services (includes physical therapists, occupational therapists, speech language pathologists, in addition to others)	Distant site practitioners who can bill Medicare is limited to a restricted list of provider types including the following: • A physician as described in § 410.20. • A physician assistant as described § 410.74. • A nurse practitioner as described in § 410.75. • A clinical nurse specialist as described in § 410.76. • A nurse-midwife as described in § 410.77. • A clinical psychologist as described in § 410.71. • A clinical social worker as described in § 410.73. • A registered dietitian or nutrition professional as described in § 410.134. • A certified registered nurse anesthetist as described in § 410.69.
CARES Act (Broadens 1135 waiver authority)	Telehealth services can be billed for Medicare purposes using audio-only equipment (rather than requiring use of two-way audio-video technology) for services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.	In order to receive reimbursement from Medicare for telehealth, equipment must be used permitting two-way, real-time interactive communication.
HHS 1135 Waiver (OIG Policy Statement)	OIG acknowledged unique circumstances with emergency and stated the regulatory flexibility for telehealth extends to providers that offer reduced or waived cost-sharing.	OIG can issue administrative sanctions for waivers or reductions in cost sharing.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
MO Governor, Executive Order 20-04	Missouri suspended physical exam requirements prior to prescribing controlled substance; allowed providers to prescribe via telemedicine and allows pharmacy to dispense in those instances.	Providers must conduct physical exam before prescribing controlled substances.
Families First Coronavirus Response Act	Funding requirements related to telehealth established including all insurers must cover the costs of COVID-19 testing including telehealth visits without cost-sharing or prior authorization; funding to reimburse providers for testing uninsured patients; and clarification on 3-year from services (not billing).	Insurers may be permitted to cover COVID-19 testing costs including telehealth visits using cost-sharing or prior authorization.
KS Governor, Executive Order 20-08	Kansas expanded telehealth: temporarily suspend physical exam requirement for prescribing, incl. controlled substances (note: aligns with DEA & MO); also out-of-state physicians may use telemedicine when treating patients in Kansas, requiring written notice to the Board of Healing Arts. Quarantined physicians are permitted to practice telemedicine.	Providers required to perform physical exam prior to prescribing controlled substances. Providers would need to hold a Kansas medical license in order to provide services within the state.
Missouri Board of Healing Arts	Missouri waivers to include: no licensure application needed for physicians licensed elsewhere and assisting with COVID-19, and no geographic restriction for physicians & APPs under collaborative practice agreement.	Providers would need to hold a Missouri medical license in order to provide services within the state. Geographic restrictions (must practice within 75 miles of one another), review of charts, and practicing together at the same location before an APRN practices independently apply.
MO HealthNet Provider Tips re COVID-19 Telehealth	Quarantined providers may provide telehealth services from their homes. These services should be billed as distant site services using the clinic's provider number.	
CARES Act	Congress added to telehealth, including: providers no longer need a pre-existing relationship with a provider to utilize telehealth services; Rural Health Clinics (RHCs) are now distant sites of care for telehealth; and, temporarily waves End-Stage Renal Disease face-to-face requirements.	Absent the waiver, providers must have a pre-existing relationship prior to conducting telehealth, only eligible individual practitioners may bill as distant site providers (RHC may serve only as originating site, with a remote provider acting as the distant site) and telehealth cannot be used for evaluating patients with End-Stage Renal Disease.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
CMS approval of MO & KS Waiver Requests	MO may reimburse out-of-state providers for Medicaid claims without having to meet the 180 day period for provisioning of care. MO can enroll out-of-state providers who are enrolled in Medicare or with a state Medicaid program other than Missouri. State providing other relaxed enrollment requirements for providers. Relaxation of prior authorization requirements. Certain facilities such as intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities will be fully reimbursed for services rendered to an unlicensed facility during the emergency. Waivers of certain pre-admission screenings and annual resident review.	Original standards for Medicaid enrollment for providers will be enforced, pre-admission screenings and annual resident review re-instated.
CMS Interim Final Rule	CMS announced expansion promoting the use of telehealth to mitigate exposing patients and clinicians unnecessarily, adding specific services to its list of telehealth services such as emergency department visits, initial nursing facility and discharge visits, etc., flexibility in several post-acute settings and guidance related to supervision, as well as residents.	Medical residents will need to be supervised physically in-person.
CMS Interim Final Rule: Home Health Agencies (HHAs)	• Can provide more services to patients using telehealth as long as it is part of the patient's plan of care and necessary in-person visits continue. • Telehealth may not substitute for an in-person home visit ordered as part of the plan of care. • The use of technology must be related the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit or when there is a home visit. • The use of technology MUST be included on the home health plan of care along with a description of how the use of such technology will help achieve the goals of the plan of care without substituting for an in-person visit as ordered on the plan of care.	In-person face-to-face requirements would be reinstated, and there would be a reduction in the amount of services eligible to be provided via telehealth.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
CMS Interim Final Rule: Home Health Agencies (HHAs) **(Continued)**	• The plan of care must be signed before submitting a final claim to Medicare for payment. There is flexibility on the timing in which HHAs obtain physician signatures for changes to the plan of care when incorporating the use of technology into the plan of care. • The telehealth visit cannot be considered a home visit for the purposes of payment. Although HHAs have the flexibility, in addition to remote patient monitoring, to use various types of technology, payment for home health services remains contingent on the furnishing of a visit. • On an interim basis HHAs can report the costs of telecommunications technology as allowable administrative and general (A&G) costs by identifying the costs using a subscript between line 5.01 through line 5.19. • The CARES Act Section 3708 added a provision allowing physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives to certify that beneficiaries are eligible for home health care. • Prior to certifying the patient's eligibility for home health services, there must be a face-to-face encounter with the patient—this can be done via telehealth means. • Physician assistants, nurse practitioners, clinical nurse specialists and certified nurse-midwives may establish policies that govern the services it provides and may provide supervision for home health services.	
CMS Interim Final Rule: Hospice	• Can provide services to a patient receiving routine home came through telehealth if it is feasible and appropriate to ensure the patient can continue to receive reasonable and necessary services for the palliation and management of the patient's terminal illness without jeopardizing the patient's health.	In-person face-to-face requirements would be reinstated, and there would be a reduction in the amount of services eligible to be provided via telehealth.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
CMS Interim Final Rule: Hospice (Continued)	• The use of telehealth MUST be included in the plan of care and be tied to patient-specific needs as identified in the comprehensive assessment and measurable outcomes. • For the purposes of the hospice claim submission, only in-person visits (with the exception of social work telephone calls) should be reported on the claim. However, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as "other patient care services" using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as "PHE for COVID-19". • Face-to-face encounters by hospice physician or nurse practitioner to recertify patients for Medicare hospice benefit can be done via telehealth means.	
CMS Interim Final Rule: Inpatient Rehabilitation	• In order for a claim to be considered reasonable and necessary the rehabilitation physician was previously required to conduct face-to-face visits with the patient at least 3 days per week (post-admission evaluation may count as one of these face-to-face visits) • CMS is now allowing the face-to-face requirement to be satisfied via telehealth (although CMS is still encouraging in person visits to the extent providers can exercise precautions, such as use of PPE). • Removal of the post-admission physician evaluation requirement (provided this does not preclude an IRF patient from being evaluated by a physician within the first 24 hours of admission if the IRF believes the patient's condition warrants such an evaluation)	The in-person face-to-face visit requirement would be re-instated, and there would be a reduction in the amount of services eligible to be provided via telehealth.

Prepared by: Saint Luke's Health System, May 6, 2020

AUTHORITY	EFFECT OF WAIVER	EFFECT OF WAIVER REVERSAL
CMS Interim Final Rule: Inpatient Rehabilitation (Continued)	• Clarification regarding the requirement for a beneficiary to participate in an intensive rehabilitation therapy program on admission to the IRF for 3 hours per day at least 5 days a week (i.e. the "3-hour Rule"). • When an IRF's intensive rehabilitation therapy program is impacted by COVID-19 (i.e. staffing disruptions due to isolation), the IRF is not required to meet the 3 hour standard but should note to this effect in the medical record.	

APPENDIX 6: STRATEGIES AND LESSONS LEARNED

Over the past months, the health care field has been through an unprecedented time of crisis management and recovery. We still have roads to travel as we move toward a potential resurgence of COVID-19 in the fall and winter, establish protocols for newly developed therapeutics, mainstream responsive clinical and operational practices developed and tested to date, and establish vaccination practices in – we hope – the not too distant future. New partnerships have emerged which require further nurturing and development. Technology has been used and adopted at an accelerated rate, demanding new staffing and patient practices.

We went to the field and asked if anyone would like to share strategies and lessons learned over these months. Below is a compendium of this input. We established category codes, defined at the bottom of each page, for easy searches. Please feel free to use these ideas from your colleagues across the field. We have provided at least one contact for each organization, should you wish to learn more details. Note that these comments are facility-reported strategies compiled by AHA regional executives during an informal survey.

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
1	Washington Regional – Fayetteville, AR	VP Pop Health spoke about their experience ramping up telehealth use for rural areas and tech-savvy patients, which is viewed as sustainable. Thinking differently about use of real estate to protect patients and looking to repurpose use of clinic space for more wellness-related activities. Created a testing center, call center and follow-up system to track patients who they have tested across multiple sites. ACO-type activities will be more vital going forward.	T,A	Larry Shackelford, CEO Mark Thomas, MD
2	Mercy Hospital Northwest Arkansas – Rogers, AR	CEO states that, from community messaging to adaptable workforces to managing inventory, his health system and others will run their businesses differently. For instance, looking at our stocks and really looking at how we address having enough protective equipment without having too much where it won't be used. It does have a shelf life, so a big lesson there.	M	Eric Pianalto, President
3	Wilson Medical Center Neodesha – Neodesha, KS	**Wilson Medical Center Implements Creative Care Alternatives to Address COVID-19: Wilson Medical Center, Neodesha, KS.** Rural communities' patients are typically older than those in metro communities, and with the onset of COVID-19, many seniors are reluctant to leave their homes. Access to providers is strained as people avoid hospitals and clinics yet are still in need of care. Wilson Medical Center (WMC) Dennis Shelby, CEO	A	Dennis Shelby, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		in Neodesha, KS, has found a solution to this challenge by instituting consumer conscious caring with its curbside lab and clinics.		
4	Marshall Medical Center – Placerville, CA	**Four Stages of Planning and Implementation During COVID-19: One Rural Hospital's Preparations, Marshall Medical Center, Placerville, CA.** Marshall Medical Center has been and continues to prepare for a potential patient surge related to the COVID-19 pandemic. At the same time, it continues its actions and education to help patients and communities "bend the curve down" and slow the progression of the disease. In this case study, we hear from Siri Nelson, CEO of Marshall Medical Center, about the four stages of planning and implementation her hospital has undertaken to prepare for COVID-19.	M	Siri Nelson, CEO
5	Riverwood Healthcare Center – Aitkin, MN	**Rapid Deployment of Telehealth Services for Rural Hospitals Fighting COVID-19 – Riverwood Healthcare Center, Aitkin, MN.** How Riverwood Healthcare Center (RHCC) CEO Todd Sandberg quickly deployed Zoom for Business to virtually treat patients amidst the coronavirus pandemic. Although the county has not seen any positive COVID-19 cases yet, RHCC, a 25-bed critical access hospital located about 130 miles north of Minneapolis, is actively preparing.	T	Todd Sandberg, CEO
6	Margaret Mary Health – Batesville, IN	**Rural COVID-19 Case Study: Surviving a COVID-19 Surge – Margaret Mary Health, Batesville, IN.** Margaret Mary Health (MMH), Tim Putnam CEO, located in Batesville, IN (population 7,500), is a not-for-profit, critical access hospital employing nearly 850 team members serving a population of more than 30,000 residents. MMH saw a surge of COVID-19 patients in early to mid-March and is proactively monitoring the coronavirus pandemic and taking aggressive precautions to stay ahead of the surge.	M	Tim Putnam, CEO
7	King's Daughters Medical Center – Brookhaven, MS	**Rural Hospital Shifts Operations in Anticipation of COVID-19 Surge – King's Daughters Medical Center, Brookhaven, MS.** King's Daughters Medical Center (KDMC), Alvin Hoover CEO, implemented a variety of strategic and operational shifts in anticipation of a surge of COVID-19 patients in April. Though the 99-bed hospital is	M	Alvin Hoover, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		in a rural community, it expects to be negatively affected by higher rates of the coronavirus from New Orleans, which is two hours south.		
8	SoHum Health – Humboldt County, CA	**Addressing Social Determinants of Health to Save the Lives of Seniors – SoHum Health, Humboldt County, CA.** The first case of COVID-19 in Humboldt County, CA, was confirmed on February 20, 2020. Through SDOH, SoHum Health Matt Rees CEO aims to get in front of the virus and save lives of its 3,400 seniors.	A	Matt Rees, CEO
9	Katherine Shaw Bethea Hospital – Dixon, IL	**KSB Hospital Response for Coronavirus (COVID-19) – Katherine Shaw Bethea Hospital, Dixon, IL.** At Katherine Shaw Bethea Hospital in Dixon, IL, Dave Schreiner CEO, health care leaders knew they had to act quickly to create a rapid response plan. Their solution: drive-through testing for COVID-19.	A	Dave Schreiner, CEO
10	Flowers Hospital – Dothan, AL	Limiting visitors to the hospital resulted in an increase in falls for hospital's inpatient population. Not having a caregiver or family member at the bedside has been a contributing factor.	A	Justin Bryant, Interim CEO
11	Methodist Jennie Edmundson – Council Bluffs, IA	Methodist Jennie Edmundson Hospital and Foundation started a Pictures for Patients. They've also started virtual visits using iPhones and iPads for patients to talk with family during their no-visitor period.	T	Steve Baumert, CEO
12	Murray – Calloway County Hospital – Murray, KY*	They are taking a "crawl, walk, run" approach as they slowly resume some procedures. They've rearranged waiting rooms for high-volume practices (e.g., orthopedics). They've found that telehealth has been valuable and is working. They built an elective procedure packet that went to the medical staff about what to expect going forward, including that surgeries might be canceled due to PPE availability. Every patient gets the same letter from his/her provider about testing and what to expect so that everyone gets the same info. The education piece for providers and patients is critical. They double-check steps and make sure that everyone's role is identified and they know the appropriate tier level to classify and assign medical procedures. The hospital has turned one floor of its 5-story hospital into a COVID-19 ward which has taken up most of the beds.	T,C	Nick O'Dell, MD, Internal Medicine

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
13	Methodist Jennie Edmundson Hospital; CHI Mercy Health – Council Bluffs, IA	Community partners in Pottawattamie County have stepped up to offer temporary housing for health care workers. One floor of an unoccupied Iowa Western Community College dormitory has been prepped to take on staff from Methodist Jennie Edmundson and CHI Mercy hospitals in Council Bluffs. More recently, Pork Belly Ventures has provided portable air-conditioned motel rooms and showers on the Mercy campus. The housing options are a partnership between the hospitals and their hospital foundations, Pottawattamie County Public Health, Pork Belly Ventures and Iowa Western. The Southwest Iowa Foundation is funding use of the trailers.	M	Katie Kyker, Director of Development, Methodist Jennie Edmundson Hospital and Foundation
14	San Ramon Regional Medical Center – San Ramon, CA	• Don't assume patient will be forthcoming with all history. Early on in this pandemic, we heard of an ED patient at another hospital who was under mandated quarantine for known exposure to COVID-19, and they didn't think to share that information with the ED staff. We learned we need to ask even the most basic of questions to make sure we get all the information. • Health care workers have varying degrees of comfort with infectious diseases. We need to support the entire spectrum, from staff who feel they need to self-quarantine after walking through our hallways, to staff who don't fully buy into the recommended infection control processes for their protection. • Be nimble and ready to change 180 degrees. We originally were told that nobody should wear masks so they all would be saved for the clinicians caring for COVID-19 patients. Even politicians were explicitly instructing the general public not to wear masks. Within a few weeks, the guidance changed completely to mandating that everyone wear masks. • Don't assume post-acute providers are as prepared and able to respond to infectious diseases as hospitals are. There were a number of COVID-19 outbreaks at nursing care facilities throughout the country. To be proactive, we sent our infection control director and CNO to several local facilities to assess their infection control practices and to provide guidance on how to prevent potential outbreaks.	C	Ann Lucena, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
15	Unity Point Health – St. Luke's Regional Medical Center – Sioux City, IA	1026 To-Go recently opened at UnityPoint Health – St. Luke's Hospital. It's a mini-grocery store located within the hospital's existing 1026 Café. It was added by hospital administration to help employees that may find it challenging to grocery shop during the pandemic. 1026 To-Go offers basic food items like bread, milk, eggs, fruit, vegetables and even toilet paper. Take-n-bake pizzas or made-to-order pizzas are also available to employees. St. Luke's Dining Services staff have received a lot of positive feedback from employees about the new addition.	M	Lynn Wold, CEO
16	CHI Health – Omaha, NE	CHI Health's transfer center typically handles patient placement for the system's 14 hospitals, but a recent move in conjunction with Nebraska Governor Ricketts and state health officials has CHI Health coordinating transfers for all facilities across the state.	A	Pete Festersen, VP Public Affairs & Advocacy
17	Children's National Hospital – Washington, DC	As a way to triage patients and expertise, area hospitals in DC transferred pediatric patients in their hospitals to Children's National Hospital in Washington DC to focus on adult care, while Children's focused on the younger population. With additional support from the Department of Health, Children's got their license revised to be able to care for young adults up to age 29, which also helped the area hospitals with their surge capacity. This could be a model for citywide triage in public emergencies of this scale. The hospital also had drive-in testing solely dedicated to children. This gave families in the community a sense of relief knowing there was a place to go specifically for this pediatric population. Having a pediatric lens was crucial in the early identification of the multi-system inflammatory syndrome in children (MISC). Children's has had 29 cases so far.	P	Kurt Newman, MD, CEO
18	Atrium Health – Charlotte, NC	Atrium Health incorporated mobile clinics throughout North Carolina to reach and test underserved communities, which may turn into a best practice for extending the reach of other services to these populations.	A	Ken Haynes, COO
19	NYC Health + Hospitals – New York, NY	Health & Hospitals is comprised of 11 public hospitals in the New York City market. They attributed some of their success in managing COVID-19 patients to their close collaboration with the NYC public health system. They		Dave Chokski, MD, Chief of Population Health

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		noted that while data and analytics are important, old-fashioned phone calls and intelligence about bed availability could save lives.		
20	M Health Fairview – Minneapolis, MN	• Innovated with University of Minnesota to create a booth (like old telephone booths) to use for testing and preserving PPE. • Recommissioned Bethesda Hospital (St. Paul) to treat COVID-19 patients only. • Remote patient monitoring has helped M Health Fairview keep in contact with their patients during the pandemic, ultimately assuaging patient fears. At M Health Fairview, patient care leaders implemented new patient engagement and remote patient monitoring tools to help manage case flow. The GetWell Loop technology allows the M Health Fairview team to send key patient education materials out to their panel, including public health messages from both the Centers for Disease Control & Prevention and the World Health Organization. Additionally, the platform facilitates secure texting, calling and virtual visits for patients and providers. The platform has played a big role in mitigating some of their COVID-19 cases, especially for patients with few or no comorbidities who were expected to recover with few complications.		Mary Edwards, VP Public Policy
21	Our Lady of the Lake Regional Medical Center – Baton Rouge, LA	For behavioral health intensive outpatient (IOP) and outpatient, we went virtual. We are currently looking at restarting IOP only for those patients that do not have internet/virtual capabilities. Those groups will be very small (5-6 at the most). My infection control team came to the IOP and gave us suggestions on setting up the physical space including the strategic placement of hand sanitizer. All patients will have to have a mask on when they enter the building. We will also take their temperature at the door. All staff are wearing masks and will continue to do so.	A	Denise S. Dugas, Senior Director, Mental and Behavioral Health

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

©2020 American Hospital Association | June 2020

www.aha.org | **Page 84**

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
22	Swedish Medical Center Providence St. Joseph Health – Seattle, WA	In all inpatient psychiatric rooms, we are ensuring that the beds are 6 feet apart, with other precautions including masking during the day and certain cleaning protocols for common use areas like the bathroom. We are also testing all patients prior to admit; but it is very important to recognize that some asymptomatic carriers might test negative initially, and we need to take all the appropriate set of precautions and not have a false sense of reassurance.	M	Arpan Waghray, Executive Medical Director, Behavioral Medicine
23	JPS Health Network	• As of 5/1/20 we have opened a 14-bed COVID-19-positive unit. We have a census of 12 right now. • We have closed semi-private rooms on another unit to make them private in order to accommodate 18 PUI's. 2 patients are still on the medical floor due to symptoms related to COVID-19. • Our length of stay has increased due to medical and psychiatric stability. • We are cohorting the positive patients. • We are discharging patients when they have medical and psychiatric clearance. If they are unable to quarantine for the 14 days, our city has a convention center to house patients like this. • We have a security guard on the COVID-19 unit in full PPE to respond to aggressive and/or combative patients.	A	Zelia Baugh, Executive Vice President
24	University of Nebraska Medical Center – Omaha, NE	Creating a COVID-19 unit in their hospital; 50-bed unit – looking toward permanent unit, given the expected long nature of the pandemic. Look to establish center of excellence.	A	James Linder, MD, CEO, Nebraska Medicine
25	MD Anderson Cancer Center – Houston, TX	San Antonio, Texas-based Xenex LightStrike robots disinfect spaces by using a high-energy UV light produced by pulsing xenon gas, a heavy, colorless gas used in specialized electric lamps. LightStrike's powerful UV light penetrates the cell walls of viruses, bacteria, bacterial spores and other microbes, damaging or destroying the harmful cells. "We can actually burst the cell wall with light," says Stibich, an infectious disease epidemiologist. In use in many facilities.	T	Peter Pisters, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
26	Bon Secours St. Francis Medical Center – Charleston, SC	COVID-19 impact: Having four hospitals has worked to their advantage. Average daily COVID-19 highest was 10 patients. Elective surgery has been opened for a few weeks and is slower than anyone wants it to be. Public is nervous to return to hospital. Incidence of violence has disappeared. May go back to "old school" visitation hours principle with one support person managing the care of the patient. St. Francis was set up to draw the public in with 7 entrances available to the public. Will look at improvements to limit access moving forward.	A	Gretchen Morin, Chief Administrative Officer
27	Baylor Scott & White Health – Dallas, TX	BSWH introduced COVID-19 safe care options and rolling out a "safe care plan." Combining enhanced safety measures inside facilities with innovative virtual offerings for care at home, the health system is poised and ready to re-engage with patients who may have postponed care. Virtual waiting rooms, virtual care and a COVID-19 home monitoring digital care journey for patients recovering at home in quarantine.	A	Alejandro Arroliga, MD, CMO
28	Calvary Hospital – The Bronx, NY	Calvary Hospital is redesigning its hospital to create COVID-19 sections and allow other areas of the hospital to operate and provide traditional procedural services. They are concerned about the increased use of PPEs but realize they must manage that utilization.	A	Andrew Greco, VP and CFO
29	Methodist Health System – Dallas, TX	We have moved light years toward virtual care/ telehealth. That is likely to stay (patients love it), and we will need to determine how to change our PCP delivery model as a result. Lots of conversation around the long-term use of PPE (N95's, etc.). There will always be patients presenting to the hospital that may have a communicable disease that you don't know about upon their admission. So is COVID-19-type PPE going to become more the norm? We think perhaps so.	T,M	Pamela Stoyanoff, President and COO
30	Monroe Hospital – Bloomington, IN	Brought in a Certified Critical Incident Stress Management professional who rounded and provided personal one-on-one meetings with staff members during the peak COVID-19 period. A hospital and staff blessing service was provided. A "quiet room" was also established with soothing music, coffee/tea, snacks, and a comfortable chair for staff to spend a few minutes away from the stress of the day. Leadership brought in food, needed	M	Nancy Bakewell, Administrator/ CNO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		items (toilet paper) and rounded frequently to ensure that staff, providers and patients were well taken care of. Also, we celebrated every "high point" – when patients were discharged, transferred to lower care facilities or taken successfully off the ventilator. Colorful cloth masks were distributed to staff members to wear outside the facility. We also took pictures of our teams and put these in the newspaper to tell our community what a great team we have here at Monroe.		
31	The War Memorial Hospital – Sault Ste. Marie, MI	Separated symptomatic patients from non-symptomatic patients. Developed a drive-through screening location and asked all physicians to instruct their patients to use the drive-through if they have any symptoms. This way, it keeps sick patients out of waiting rooms where they could infect well patients. Did this in the ED too, and separated inpatient floors into a hot zone on one floor and a not hot zone on another floor. By doing this, reduced the fear in community about coming to the hospital and picking up the virus. Maintaining this segregation provides a safer environment for healthy people to come for their routine checks.	A	David Jahn, President & CEO
32	Aspirus Health Care – Wausau, WI	The application of just-in-time concept is not good for the PPE situation. This system-wide practice exacerbated levels of critical supplies. Cannot count on the supply chain to quickly replace used quantities. No one anticipated that the entire supply chain would suffer a catastrophic setback. Coming out of this, will be re-evaluating how to maintain inventory levels of critical supplies so as not to get caught in this bind again.	M	Rick Nevers, SVP, Regional Operations & System Integration
33	IU Health – Indianapolis, IN	Need security 24/7 – even at rural facilities – due to new visitor restrictions, folks not wanting to wear a mask out of protest, etc. Also, the advent of virtual health, tele-meetings and utilizing technology for communication requires reliable internet access in rural areas, given the impact it has on health services for rural populations. Through forecasting work, hospitals developed models to predict staffing and bad capacity in the event of a COVID-19 surge, but will now expand the use of this same forecasting for reopening elective surgeries and general staffing.	T,M	David Hyatt, President, Critical Access Hospitals – IU Health East Central Region

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
34	Novant Health – Winston-Salem, NC	Novant Health created a HOPE Fund to support team members with food, rent, utilities and money for other needs. Team members and public donors raised over $2 million dollars, and the health system contributed $10 million dollars to the fund. Thus far, the fund has received over 7,000 applications for support. Novant Health found that many team members had spouses who were out of work during the pandemic, which created added pressure on their teams.	M	Carl Armato, President and CEO
35	Blessing Health System – Pittsfield, IL	Limited entry points to 2 and those are staffed. Do not plan to reopen other portals of entry. Limited the numbers of visitors and will continue this as well. Cross-trained many staff to cover in alternate areas. All visitors are escorted to their destination; and this practice will continue. Implemented drive-through lab collection services in rural health clinic and will continue this as weather permits.	A	Kathy Hull, Administrator
36	Spectrum Health – Grand Rapids, MI	• Relationships matter. Partnerships matter. People matter. Health care has always been a people-centered business. But the true value of these collaborations has never been more important or more apparent. It's the relationships we formed before that allowed us to call on people in our time of need to meet critical shortages in equipment and PPE – and they delivered with masks, gowns and more. It's these relationships that will continue to fortify our processes and investments in our community going forward. • More than ever, health has become a collective responsibility. At the start of the pandemic, we implemented a required daily symptom screening process to protect the health of our care teams and patients. We offered a free mobile "symptom checker" to businesses and the community, along with other tools that reflect best practices to help employers maintain a healthy workplace and minimize risk. Checking our health every day has become an important new normal to keep our communities healthy as we look ahead to a future with COVID-19. • The value of clear, transparent, continuous two-way communication is critical. One reason we were able to respond quickly and effectively as an organization is	P,C	Tina Freese Decker, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		that we established clear channels of communication early on and used frequent digital check-ins – virtual town halls, daily command center updates, regular emails and community conversations to keep our team members and communities informed about the evolving situation, the challenges and the unknowns. Listening is also key. Providing ongoing opportunity to solicit thoughts and questions – which we responded to either immediately or on our website – helped manage anxiety and uncertainty in the face of the unknowns. And engagement always supports the best decision-making.		
37	Memorial Health – Marysville, OH	Early deployment of the p100 half face mask respirators for at-risk hospital staff. By rolling them out early, substantially improved staff's morale and sense of safety at work.	M	Chip Hubbs, CEO
38	Baptist Memorial Hospital Crittenden – West Memphis, AR	The daily communication tools that we are using, including daily huddles, have been a very effective way of disseminating information that has changed daily. We have a white board that all of our leadership team and others come to each day, and we update on patients tested, PPE numbers and other communication changes related to processes and patient care. This tool, and further tweaks to this process, will likely be something that we continue with on a go-forward basis.	C	Brian Welton, CEO
39	Guadalupe Regional Medical Center – Seguin, TX	We have learned that the years of work , time, money, energy and effort of building an organization whose culture is genuine toward having a singular purpose – making a difference in the lives we are privileged to touch – are tested and proven, so we will adopt any necessary measures that continue to foster that culture in this new environment.	M	Robert Haynes, CEO
40	St. Tammany Health System – Covington, LA	We are especially proud of a simple innovation – UV mask disinfecting by repurposing tech we already owned for disinfecting patient handheld mobile devices. This drastically improved our PPE shortage crisis early on in the pandemic response, and it has continued to enable us to judiciously manage our supply, as we transition into balancing COVID-19 care with routine care throughout the health system.	T	Joan Coffman, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		Telehealth and teleconferencing have skyrocketed since we began to address the presence of COVID-19 in our community. Prior to the pandemic, we held some meetings via videoconference, but primarily, we relied on face-to-face communication in meeting rooms. Similarly, we offered the option of video visits in our primary care clinics, but neither our providers nor our established patients had much interest or enthusiasm for the technology. All of that changed when we suddenly still needed to conduct business, care for patients and seek professional advice while isolating at home, social distancing or just avoiding human contact to slow the spread of COVID-19. Our adoption of video visits in the clinics reached a high of 95% during the worst of our local outbreak, and even as we see a rise in in-person visits now that the outbreak is on the downslope, we continue to see adoption of and affinity for the technological connection, both in business and in clinical care.		
41	Memorial Hermann – Texas Medical Center – Houston, TX	We installed thermal cameras to streamline the screening of employees, physicians and visitors, allowing us to redeploy employees back to their units as patient volume has begun to increase. The value of meeting virtually every day with leadership across administration, clinical and physicians – that we are not too big or too busy to pull this collective team together each day for 30 minutes for relative updates and concerns.	T,C	Gregory Haralson, SVP & CEO
42	Baylor Scott & White Hill Country – Marble Falls, TX	Telehealth is likely the biggest pivot that will maintain some momentum. Remote meetings have been successful and the use of WebEx will continue. People will step up. There will be some reduction of middle management and systems will still meet their missions.	T,C	Timothy Ols, Regional President
43	Hendrick Health System – Abilene, TX	We have learned that a restrictive environment for hospitals is a better and safer place for our staff. We will continue to keep a daily restrictive hospital environment regarding guests and visitors. Ensuring locking down and restricting the vulnerable living in communal living conditions, like nursing homes, need to remain very restrictive. The issue is just as much as caregivers entering the facilities, and "cross pollinating" virus is probably the largest issue. Contact tracing for this	A	Brad Holland, CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

#	ORGANIZATION, CITY/STATE	LESSONS LEARNED / STORIES	CODE	CONTACT
		population or continuous oversight of restrictive policies is probably a need on a go-forward basis.		
44	Ascension St. Vincent – Evansville, IN	Provided a multi-page summary of lessons learned.		Emily Hurless, Senior Specialist Marketing & Communications
45	Hancock Regional Hospital – Greenfield, IN	Provided a multi-page summary of lessons learned.		Steve Long, CEO
46	CHRISTUS Health Louisiana – Alexandria, LA	Provided a multi-page summary of lessons learned.		Chris Karam, President and CEO

T = Technology
C = Communication and Education
P = Partnerships and Collaboration

A = Access
M = Miscellaneous: Supplies, Testing, Workforce

Insights and Lessons Learned (So Far) from Addressing This Pandemic

Ascension St. Vincent

Associate Recognition - BrightSpots and Kudoboard

To offer associates a quick and easy way to recognize their fellow healthcare heroes, Ascension St. Vincent created BrightSpots. Associates nominate their peers via an online form and a weekly communication is sent to shine a light on those associates who are serving patients and our Mission in extraordinary ways. In addition, Ascension has created the Ascension Kudoboard to offer associates across our national ministry a way to share their appreciation for each other. The Ascension Kudoboard has also been shared externally via social media to invite community members to post their own messages of thanks.

Associate Well-Being and Support

Ascension has taken a holistic approach to associate well-being during this pandemic, including enacting many programs for all associates in an effort to protect their health, financial stability, and spiritual well-being. Examples include:

- No cost virtual visits.

- Associates can access a single online repository of resources, tools, and contacts to help them remain mentally, emotionally, and spiritually strong. Resources include virtual peer support sessions, energy management and resilience guidance, grief support and more.

- Spiritual care support is available anytime, anywhere for associates via virtual one-on-one conversations with an experienced Ascension chaplain.

- Also available are virtual counseling sessions, stress-relieving podcasts and e-learning courses at no cost to associates through Ascension partnerships with reputable organizations.

- Ascension is committed to protect the pay of associates during this time of disruption due to COVID-19, including a commitment to no layoffs and a variety of pay protection programs, and will continue doing so as long as possible. Some of these pay protections efforts include:

  - **The Continuity of Pay** program protects associates whose schedule is impacted as a result of COVID-19.

- **The Associate COVID-19 Hardship Financial Assistance Program** provides financial support to associates and their immediate families experiencing financial hardship due to an unexpected or unavoidable circumstance as a result of the pandemic.

- **The dependent care support benefit** helps ease financial hardships from unexpected dependent care expenses due to COVID-19 for elderly and special needs family members and children under age 13.

- **The contribution deadline to the dependent care flexible spending account** has been extended so benefits-eligible associates can start, increase or reduce contributions at any time if their dependent care needs change.

- **The PTO Cash-Out program** allows associates with accrual Paid Time Off plans the option to cash out their PTO.

- Through the **Leave Sharing Program**, associates are also able to donate their PTO to other associates in need.

- **Internet Reimbursement** is provided to eligible associates who are required to work remotely due to the impact of COVID-19, but do not currently or did not previously have internet access.

- **The Hoteling Assistance Program** covers 100% of the hotel stay cost for COVID-19 asymptomatic associates in a high or medium work-related exposure category. Discount rates offered by various hotel chains are also available to all associates.

Protected Code Blue

Because Code Blue situations are likely to result in aerosol generating procedures (AGP) - (i.e. suctioning and intubation, etc.), the number of healthcare workers (HCWs) at the bedside should be limited to only those necessary to provide care. Across Ascension St. Vincent, all code blue situations for COVID-19 positive and persons under investigation (PUI) are announced as a "protected code blue" to limit the number of healthcare workers (HCW) at the bedside during a code situation and ensure all staff wear the appropriate personal protective equipment (PPE). Additional staff remain nearby to relieve staff and provide support.

Mobile Registration in Emergency Departments

As part of efforts to minimize contact between patients and registration staff, R1 and the Ascension Consumer Products team collaborated to create and implement a mobile registration process for Ascension Emergency Departments.The PX Mobile Registration platform allows registrars to remotely pre-register scheduled patients

and register walk in patients, reducing the need for direct patient and registrar contact. The solution utilizes the Phreesia Dashboard and R1 Dashboard and is compatible with all host systems.

Virtual Visitation

As a result of restricted visitation, associates have assisted patients with virtual visitation options with their loved ones via Facetime, Facebook Messenger, Google Hangouts, Skype, etc. iPads have been provided to nursing units in order to facilitate virtual visitation for those patients who may not have access to technology or who need assistance.

Universal Masking

In alignment with CDC and Joint Commission guidelines, Ascension St. Vincent has implemented universal masking. All associates are provided with and directed to wear an approved surgical or innovation face mask at all times while in the hospital facility unless a higher level of PPE is required and in-use. In addition, as visitation restrictions are safely relaxed, all visitors to Ascension St. Vincent hospitals will be provided with and required to wear an approved surgical or innovation face mask. Homemade masks are not permitted. Universal masking is a critical practice to protect staff, patients and visitors from being infected by asymptomatic and pre-symptomatic individuals.

PPE Conservation

While Ascension St. Vincent is blessed to be part of a national healthcare organization which continues to take proactive steps with our distributors and suppliers to ensure access to supplies, including PPE and ventilators, we also quickly enacted advanced conservation measures in case of any supply chain disruption over the coming months. Measures include the reuse and recycling/reprocessing of masks when safe.

Labor Pool

In order to redeploy sidelined associates or associates not scheduled to their full FTE or work commitment for PRN, local and statewide labor pools have been established. Leaders with direct reports complete the online Associate Availability Form each week which populates a statewide database used for reference in temporarily reassigning associates.

Virtual Town Halls

In order to communicate effectively and to give voice to associates and providers, senior leaders across Ascension St. Vincent have held virtual town hall meetings. Meeting times are used to provide regular updates to COVID-19 response and to address questions.

Back to Business Plan

In tandem with our pandemic crisis response, a multidisciplinary team of clinical and administrative leaders continues to develop a standardized process to return to the full complement of services that our community has come to trust and rely upon. This guidance provides the protocol for our back to business plan for patient screening, testing and scheduling services that can be immediately implemented based on a phased approach and status of the COVID-19 environmental conditions. These services have been developed with patient, caregiver and support staff safety in mind.

Insights and Lessons Learned (So Far) from Addressing This Pandemic Hancock Health

The efforts of the exceptional team at Hancock Health in responding to the COVID-19 crisis resulted in far too many stories to relate but following is a list of some of the more creative accomplishments. Many of these were chronicled by news organizations in central Indiana and links to those stories are provided as well.

- Hancock Health had invested heavily in developing new approaches to healthcare that apply public health thinking to chronic disease prevention and management and these were helpful as we moved into Covid-19. (www.behealthy365.org)

- Since the virus had not yet been identified in our county, we had time to implement protocols focused on visitors such as restricted visitation, education on hand hygiene and respiratory etiquette, as well as their own use of PPE. We also began distributing information to outpatient healthcare providers (long term care facilities, physician offices, etc.) in the area to ensure the best possible coordination and provided information to care takers and patients for effective home care practices. We also provided information for the "worried well" via our website, Facebook and Twitter. https://coronavirus.hancockregionalhospital.org/

- Quickly developed a community-focused web-based resource and toolkit and updated it frequently: https://coronavirus.hancockregionalhospital.org/

- The "Hancock Triage Covid Hotline" went live and was staffed by associates. Email set up for questions: nurse@hancockregional.org Staffed 24/7.

- We opened a "Hancock Triage Clinic" at an off-site location in town that has now been converted to a permanent "Respiratory Triage Clinic". https://www.wthr.com/article/new-triage-coronavirus-clinic-open-hancock-county and http://www.greenfieldreporter.com/2020/03/21/clinic_in_the_clutch_hospital_quickly_sets_up_triage_center_to_respond_to_covid19/ and https://www.ninestarconnect.com/wp-content/uploads/2020/04/DR-35040452-NineStar-April-2020-Newsletter-Final.pdf

- Our local power company, NineStar Connect, removed all data caps from our lines – we now had the fastest connection speed they offer – which helped with those staff working from home.

- Develop a local community leader forum and provided several video-based updates: https://www.youtube.com/watch?v=sSEto1B8lno

- Created intubation hoods in concert with a local manufacturing company and retired racecar fabricator: https://cbs4indy.com/news/intubation-hoods-combating-coronavirus-in-hancock-county/

- Generous members of our community contributed financially to our associates as well as contributing a variety of medical supplies that were helpful in meeting the needs of our local long term care partners, first responders, and for our use if things become critically low as they have in other parts of the country. https://www.facebook.com/hancockhealthfoundation/ Insights and Lessons Learned (So Far) from Addressing This Pandemic Hancock Health

- Local partners began 3D printing parts for ventilators, facemasks, and other equipment: https://www.ninestarconnect.com/wp-content/uploads/2020/04/DR-35040452-NineStar-April-2020-Newsletter-Final.pdf

Insights and Lessons Learned (So Far) from Addressing This Pandemic Hancock Health

- Developed "designated prayer spots" in the hospital parking lot: https://www.theindychannel.com/news/coronavirus/covid-19-healthcare/at-hancock-regional-hospital-a-place-to-pray-for-patients-and-staff

- By March 20th, we began the work to retrofit our Reflections Geropsychiatric Unit into a temporary Covid-19 treatment unit. This unit will stay in place until the public health emergency has passed.

- We developed a temporary transportation and food delivery team to help our patients make it to their health care appointments since other community transportation options closed.

- Our nutritional services director developed the Hancock Health Grocery Store in the cafeteria dining area. https://www.indystar.com/story/news/2020/04/02/hospital-mini-mart-blessing-workers-hancock-regional/5105799002/

- E-visitation was now available via iPad or iPhone. Reserved spots and iPads for visitors were identified to use in our parking lot if they did not have a device to use. https://www.hancockregionalhospital.org/2020/03/friends-or-family-in-the-hospital-e-visit/

- As we continued to prepare for the coming surge, we began the process of readying our associates for very different kinds of work than they were used to. The nursing education team started a Nursing Bootcamp for staff that work in specialty or outpatient environments so they could get used to the acute care environment. We also called on associates in our personnel pool to help in the inventory of our equipment so we would have a real-time count of the resources on hand and where it was located.

- We made arrangements with a local hotel, Fairfield Inn-Marriott, to house hospital associates and medical staff, as well as first-responders in the community, who needed temporary housing if they were concerned about carrying the virus home with them. Hancock Health covered the cost of these rooms.

- Our Hancock Physician Network offices remained open, but most of the visits became virtual (telephonic or video-based). https://fox59.com/news/hancock-health-providing-e-visits-technology-to-connect-patients-family/

- The second floor of our off-site the Gateway facility was converted for use as a 50-bed expansion unit in case we needed it. http://www.greenfieldreporter.com/2020/04/07/surge_protectors_county_state_prepare_for_peak_covid19_patients_in_coming_weeks/

- Developed a "return to work training and toolkit" available for all organizations in Hancock County, free of charge https://rise.articulate.com/share/yhOq0m4_JYZpBSF1hDHabLSK_DpjX2WZ#/

CHRISTUS Health Louisiana Best Practices During COVID-19 Pandemic

CHRISTUS Shreveport-Bossier Highland Hospital

- The use of technology in the patient care journey – both inpatient and clinic.
- Using "virtual waiting rooms" and texting the patient to come in when we are ready for them.
- For check in post discharge – zoom meetings for face to face rather than just by phone.
- Telehealth PCP visits.

CHRISTUS St. Frances Cabrini Hospital

- Daily Task Force Committee was critical for making real time decisions.
- Daily Communications update at same time every day with all information in one location was critical in communicating to the masses accurately and with one voice.
- Rapid deployment of telehealth in our clinics was absolutely critical in keeping our clinic volumes up and the masses out of the ER.
- The collaborative partnership for the Drive through absolutely reduced the number of patients coming to our facilities for testing.
- Limited access to entrances was key in controlling and monitoring symptoms.
- In the prolonged response, encouragement of staff was essential in their mental well-being (community praise in the parking lot, community donations of food, highlighting multiple associates each week regarding their perspective and the "good" things they are seeing.
- Establishing multiple communication chains to answer questions 24/7 like the online ChatBox was really important in calming fears.
- Rapid testing in multiple locations was key in helping spread the volume so it didn't bottle neck.
- Converting part of the cafeteria to an Associate grocery store went a long way in providing much-needed relief for associates working long hours who didn't have time or energy to shop after shifts.
- Providing Onsight showers and refreshed scrubs for associates allowed peace of mind for associates as they returned to and from work every day, alleviating personal fears.
- Handing out pre-made PPE bags that contained surgical masks, face shields, N95 and a thank you note for frontline staff. There was so much bad press about PPE shortages, this helped our associates feel like we were taking care of them.
- Universal masking.
- Regular updates by the CMO and C-Suite on to the medical staff on testing, policy, surge planning, etc.—This was via Zoom, in person and regular CMO email updates.
- Cohorting COVID patients onto one floor.
- Testing algorithms for patients, associates and medical staff.

CHRISTUS Ochsner St. Patrick Hospital

- Communication, communication, communication – we can't communicate enough during regular times, but in times like this it becomes even more important.
- Making sure our leaders are sharing information they receive is vital to our associates feeling safe and confident.
- Making sure we are transparent in all of our efforts.
- Community collaboration is CRITICAL-Our community wants to be a part of the solution and it really helped us to have those additional resources for supplies.

American Hospital Association™

Advancing Health in America

Chicago Office:
155 N. Wacker Drive, Suite 400
Chicago, IL 60606
312.422.3000

Washington Office:
800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001
202.638.1100

www.aha.org

@AHAhospitals; @AHAadvocacy

facebook.com/AHAhospitals

@AHAhospitals

linkedin.com/company/american-hospital-association