

November 2020 Hospital Preparedness Program Health Care Coalition Webinar

November 18, 2020
Event Transcript

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Jack Herrmann: Good afternoon, everyone. Thank you for joining us today. I'm Jack Herrmann, I'm the acting director of ASPR's National Healthcare Preparedness Program. We're excited to have our HPP Cooperative Agreement leads on the line, as well as our health care coalition coordinators.

The purpose of today's call is to connect on topics related to the current surge in COVID-19 cases throughout the country, including crisis standards of care and implementation of those crisis standards. Let me also say that, you know, I'm sure most of you are following the news and if not following the news, living in real life and on the front lines of this COVID pandemic, and you're intimately aware of the impacts that this virus is having on health care facilities and other public health and health care stakeholders being your communities. Obviously, the near term is very concerning as we project out and look at the impact that this virus is having on hospital surge especially as it relates to shortages of healthcare workers: compromising the health of healthcare workers, PPE shortages, and a variety of other challenges. We felt it extremely important to bring you together to talk through some of these issues and look at how other communities are addressing these challenges in the hopes that there may be some lessons learned here. Also, through our discussions, find out where you are having the most challenges and in hopes that we can help you meet some of those challenges. I want to thank all of you who provided an update on the status of your Crisis Standards of Care Plan when you registered for today's session. Most of you responded from the state perspective indicating that you've either begun or completed your Crisis Standards of Care Concept of Operations, or CONOPS, which is a requirement of the HPP Cooperative Agreement. For those of you who are still working on your plans, we also heard that legal and liability concerns, planning time constraints, staffing capacity issues, leadership buy in, and the ongoing COVID-19 response itself have posed significant challenges in allowing you the time to really focus on your CONOPS. We understand that those are our current and very real challenges that you're faced with. Several of you also mentioned that you think it would be helpful to see a template or an example of a Crisis Standards of Care CONOPS as well as have a source to provide legal guidance to assist you in addressing some of those liability and legal concerns. This feedback is tremendously helpful to ASPR. It allows us to understand not only the barriers that you may be experiencing in developing your CONOPS, but the resources that we may be able to bring to bear to help support you in this effort.

Before we dive into the call, I'd like to give a high-level overview of today's agenda. We'll start with a short presentation by Miss Shayne Brannman. Shayne's the director of ASPR TRACIE and she'll provide an overview of our Crisis Standards of Care resources available through the ASPR TRACIE Resource Center. Following Shayne, we will turn to Dr. Marc Napp, and Dr. Napp will share how Crisis Standards of Care principles were applied to address staffing adjustments during Mount Sinai Health System's response to the COVID-19 pandemic. Finally, we'll hear from Miss Amber Pitts from the Michigan Department of Health and Human Services and their work with state coalition during the COVID-19 response, including the success of their Medical Coordination Centers in facilitating patient transfers across the state. So, without further ado, I'll now hand it over to Shayne Brannman to talk more about the resources within ASPR TRACIE. Shayne?

00:04:31.620-00:06:32.100

Shayne Brannman: Thank you, Jack, and good afternoon everyone. ASPR TRACIE has numerous resources on Crisis Standards of Care, including several topic collections and resources specific to COVID-19 and Crisis Standards of Care. They are available on our website by following the COVID-19 resources page link. If you have any difficulty in finding our resources, please contact our assistance center and we can very quickly send links to you via email. We will also include links to this information in next week's NHPP weekly outreach. One definition to begin this discussion today: Crisis Care refers to the immediate healthcare-related decisions made when a health care entity is overwhelmed, and Crisis Standards of Care refers to the organizational support that health care institutions and government agencies implement systematically as part of an emergency management response plan. In addition to resources on our Crisis Standards of Care, we also have resources on patient surge management to support your planning for mitigating or addressing surge situations. We have resources on strategies individual facilities can take to increase their bed availability, resources on patient load balancing such as implementing Medical Operation Coordination Cells, and resources on establishing Alternate Care Sites. To reiterate, these resources are available on our COVID-19 ASPR TRACIE resources page, which is located at ASPRTRACIE.hhs.gov/COVID-19. As always, you can contact the ASPR TRACIE Assistance Center at AskASPRTRACI@hhs.gov if you need a more nuanced answer or have trouble locating any of these resources or for any kind of additional support. We thank you for what you do daily. It's now my privilege to introduce Dr. Marc Napp who serves as the senior vice president for Medical Affairs, Deputy Chief Medical Officer from Mount Sinai Health Systems Dr. Napp, over to you, sir.

00:06:43.110-00:28:57.180

Dr. Marc Napp: Thank you. Good afternoon, everybody. I'm very honored to have been asked to present on the work that we did at Mount Sinai through the COVID surge back in the spring. You're a much more knowledgeable group of individuals, and I would say that we were, in general, as a health system when this all kicked off. I remember speaking with our Vice President for Emergency Management in the first few days of this and he was telling me about how we were going to have to start dealing with developing our Crisis Standards of Care because we had never discussed that in the past. The notion of having to do that was something we hadn't encountered but it was a rapid learning cycle and I'll share that with you. It started with a conversation with John Hick, who was very kind to walk us through exactly what we needed to think about. Let me tell you a little bit about Mount Sinai. Just quickly, an overview of who we are. We're young health system, only seven years old, right in the heart of New York City in the urban center of what was the center of the pandemic.

Here's a little bit of an overview of our facilities. You can get a sense of our size and our scope. We have the largest residency program in the country with over 20,00 trainees, 7,300 physicians, and almost 4,000 beds during peacetime. So, let me get into what we actually experienced. This is the timeline of events at the start of the outbreak. On March 1, I was in Atlanta in the airport getting ready to fly home from visiting my daughter when I got onto a conference call because the first patient diagnosed in New York City had been diagnosed in our emergency department. It turned out to have been one of our own residents who had just returned from traveling to Iran. She was not ill. She was able to live in her apartment, but it suddenly started creating a whole bunch of questions for us as to how we are going to deal with this and what was going to be the natural history of this event.

A few days later, there were no admissions yet in New York City, but there were cases that were being reported with positive tests. The Department of Health was ramping up its own testing, which was very tightly controlled. We opened up our Emergency Operations Center for the system. We opened at a HICS level two. Again, there were no inpatients anywhere, at least not on the east coast. On March 7, we admitted our first patient to one of our hospitals. The patient was quite ill, in

fact that patient remained hospitalized for close to two months and that started to give us a flavor for what we were going to encounter.

Fast forward two weeks by now, our Emergency Operations Center, which had been located in one space, had been dispersed into pods. About four days into operating as pods, one of the project managers actually developed high fevers and tested positive so we ended up dispersing. Two other people that have been working with her were positive as well. If you think back to early March, there were no recommendations about masking. We were vigilant about hand hygiene, but nobody was wearing masks and we were still thinking that this was just going to be like a bad flu.

Two weeks after that, we realized that we were not going to be able to function with our staffing as it is under normal operations. We were going to have to do something about stretching our staffing. In order to do that, because we're eight hospitals--seven acute care hospitals--we needed to start managing that centrally. We couldn't let each hospital figure out its own solutions. And so, I took over that responsibility.

Two days later, Governor Cuomo instituted what was called the "New York Pause" that basically shut down all non-essential businesses, encouraged masking although wasn't enforced, encourage social distancing, and also was a request to stop all elective surgeries and to only start doing urgent care.

On March 23, the day after he imposed the pause, this was our status: over 50% of our beds were already occupied with COVID patients and our ICUs were full. Our hospitalists were already exhausted, our emergency departments were overrun, we had large cohorts of patients that couldn't be admitted into the hospital but were being housed in the emergency departments to be managed by hospitalists. We brought in additional people to serve as hospitalists, who at the time were creating their own labor pool from their own resources. That worked out fine for the Mount Sinai Hospitals, which has 4,000 physicians on staff, but our smaller facilities were tapped out. They didn't have staff that they could spare, and they were starting to actually quarantine their staff because they were turning positive, or at least were exposed. So, we decided to develop our Alternate Care Models and started to actually contemplate developing our Crisis Standards of Care.

A week later, our epidemiologists got together and actually started working on the predictive modeling and you can see here what the graphs look like. At that time, which was the very end of March, we were anticipating having over 10,000 COVID-19 patients in our hospitals. We don't have 10,000 beds. We don't even have five 5,000 beds. This really started panicking us. The governor entreated us to develop space and staffing to increase our bed capacity by 50%. We figured out that we could probably get 3,700 beds stood up in time, but we didn't even have 3,700 physical beds.

Staffing was the challenge. When we broke it down by the facility, the Mount Sinai Hospital, which has about 1,000 beds, we anticipated due to its market share would be overrun with 4,000 patients. So, I put together a work group and this is what you can see as far as our plan. We were going to have five work streams. We would develop a labor pool plan, work on anticipating and figuring out how to deal with staffing demand, task reassignment, training up, and alternate staffing care models. One of the things that we did do was look critically at the various functions that our different staff members served to try to figure out who else could serve in those capacities and how we could optimize the functions for those various practitioners. I wasn't responsible for the nursing ranks, so I won't be covering that today, but nursing was a huge challenge. We really weren't able to augment our nursing staff with other individuals, except bringing people from the outside. One thing that I would say is that although we were hit very hard, we were fortunate to be hit early before the rest of the country. Because we were hit harder than the rest of the country at the time,

we were able to bring in traveling nurses as well as other staff, and I'll show you that in a minute. So we broke up the functions by physician types and by advanced practice practitioner types to try and figure out who could do what in a pinch. The ace in the hole were the CRNAs, and I'll show you how that played out. We did train-up for people so that they could basically take on responsibilities for care that they do not generally provide, and we came up with alternate staffing models, which I'll also share with you in a couple of minutes.

So, this is a schematic of how I looked at the system. And remember we have five Acute Care hospitals ranging in size from about 200 beds to 1,000 beds and they're spread out over New York City with one on Long Island. Within those hospitals, each one has a Department of Emergency Medicine, Department of Medicine, and Critical Care, and those are the three main disciplines that were hit by the pandemic in terms of the care needs. The first thing we did is we took our surgery staff and our anesthesia staff, and we redeployed them to support the Emergency Medicine, Medicine, and Critical Care staff. So, all our anesthesiologist started serving and a capacity of intensivists. The CRNAs from the ORs were even serving as respiratory therapists, as intubation teams, as rapid response teams, or as critical care nurses. We then realized that even with taking all our CRNAs from across the system, that still wasn't sufficient so we started to think about where else we could get them.

As far as what we did with our existing staff, this is how we handled it within the hospitals. Each hospital sort of taking care of its own, but we actually had some surplus in our Ambulatory Care Network, which was very rapidly converted and redeployed to one of the hospitals based upon geography and the remaining practitioners in the Ambulatory Care network were fed into a labor pool. Additionally, Mount Sinai Hospital, which has significant depth and resources, shared a lot of its staff and put them into a labor pool. We had to determine how to redeploy that pool. We set them up as either supporting Emergency Medicine, Medicine, Critical Care, or just generalists and we put them together. This was a little bit trial and error. Rather than sending them across the health system as individuals, we put them together as teams and typically was somewhere between four and six people per team and they were deployed for three day shifts with three days off. 12-hour shifts. This was all orchestrated through teamwork between our leadership and Emergency Medicine, Hospital Medicine, and Pulmonary Critical Care. Based upon where the site was where they were needed, what their individual skill sets were, what supplies we had available and what kind of scheduling they could encounter. We then figured out how to deploy them across the health system. We stood this up in a period of about five days, and it took a fair bit of effort. In total we redeployed of our own staff almost 1,300 practitioners and I would tell you that we probably had more than that at our disposal, but there was reticence to deploy people from Mount Sinai in particular to the rest of the health system. The department chairs were reluctant to send their people out for fear that they get sick and they wouldn't be able to then start taking care of patients when the wave surpassed So with even though we had 1,200 people, 1,300 people redeployed, we realized we needed to actually go outside the health system and look to bring in people from the outside.

You'll see in the table on the left are the types of practitioners we brought in from the outside. We reached out to volunteers, to per diem staff, locum tenens agencies, we worked with some of the contracted groups that are out there, relief agencies, and some total solutions firms. We ended up bringing in 264 physicians, and we actually only deployed 157 of them, and then you can see the Advanced Practice Practitioners, the largest single cohort with the CRNAs. Again, they really served a utility player kind of role in that they could do a lot of different things. So, we handled them by adding them to our pool, but we had to go through a vetting process. These were people from the outside who we didn't know. We had to evaluate who they were before they got there, figure out if we could we use them, what are their skill sets were, when they could be here, how long they could give us, etc. We then had to process them and credential them and orient them. Many of them did not know our medical record, didn't know our facilities at all. So we had to develop an

orientation process and then we fed them into the pool, figured out how to deploy them, and then split them across the health system as well. That's how we managed.

One of the things we encountered, and I hope this doesn't happen to you folks if you have to bring in people from outside your systems, is that we had a terrible mismatch in terms of timing of the peak. I remember I had said that we anticipated the peak was going to be around the 20th of April, it actually peaked at around the 6-8 of April. So, it peaked earlier which meant that we never got up to the 10,000-patient level. We only got up to about 2,200 patients in the hospitals at one time. Because we were slowly bringing in the outside staff and because we had to enter into contracts with them to stay for certain periods of time, we were paying for them to be here long after we no longer really needed them. The financial hit between canceling elective surgeries and elective work and having the volume plummet for that kind of stuff, and then also paying premium prices for the staff was expensive. You can see some of the prices that we ended up paying. An intensivist could be up to \$450 an hour. Emergency Medicine, \$40 to \$60 an hour in some cases, and I just list the various firms, we got them from not to highlight, you know, who were the more expensive ones or not, that's not my purpose. In fact, we really needed these people. The problem was we couldn't plan for bringing them in soon enough and we couldn't plan for getting them out when we didn't need them which is something everyone should anticipate.

As far as the Crisis Standards of Care in addition to just working with people you don't know, there was a lot in the news about ventilator distribution and rationing. It never came to that, but that's what drove us to start really working on our Crisis Standards of Care. This was our ventilator monitoring table we kept track of. We looked at it twice a day. In the column on the right, if it's red, it means that you're over 80% utilization of your resources. You can see that at this point on March 30, this is a week before the peak. Mount Sinai Brooklyn, our smallest hospital, was already at 93% utilization. We were getting close to wondering what was going to happen. We did develop a model for rationing of ventilators that included a team that would evaluate medical prognoses, underlying disease states, the expected duration of the resource need or duration of benefit, and the quality of life after an intervention, and came up with a scoring methodology. It wasn't our scoring methodology; it came from the literature. We involved ethics, we involved legal, we involved Medicine, Critical Care, Emergency Medicine, etc. We trained a cohort of people to be at the ready if we needed to start making clinical decisions around the allocation of resources. Fortunately, it never came to that. The whole George Floyd incident occurred after this peak. We had not included anybody from a diversity and inclusion group. That was an eye opener for us. Now, we did have people from minorities in the group, but they were not representing that function. Now we will proactively include them.

In terms of bed capacity, even though our average daily census for critical care in peace times 190 patients, we got up to 535 critical care patients across the system. You can see how many resources that takes when you're 121% over our incremental surge capacity. That was drastic. We actually made double bedded ICU rooms, clearly not standard of care. We had remote management of drips, as well as remote management of patients. We gave patients iPads and we communicated with them from outside the room whenever we could so that staff wouldn't be unnecessarily exposed. Non-traditional care spaces, you may have read news that we actually opened up a tent hospital in Central Park. You can see it there at the bottom of the screen. Mount Sinai Hospital is that facility immediately across the street from cross Fifth Avenue. We took one of our atriums, one of the really large spaces we have in Mount Sinai Hospital, and we created patient rooms in there. You can see the overhead plumbing over those units. We took from the literature an extended staffing model for tiered staffing to stretch the reach, so about one intensivist to manage up to 24 patients.

I will tell you that we never achieved this level of stretch. It was theoretical. When we tried to do it, the patients just seem to be too sick and the people who are pitch-hitting for the intensive were

really having a hard time accommodating and managing them. We probably got to an intensivist caring for maybe 18 patients. We weren't able to really stretch the non-critical care physicians as much as we would have liked, and we certainly weren't able to stretch the non-critical care nurses. Although there are a lot of medical surge nurses who did learn some critical care through this.

In total we took care of 8,594 COVID patients during the surge. 6,400 were discharged, but over 2,000 died. This was an event that that nobody will forget. The takeaways really develop your Crisis Standards of Care during peacetime, so I know that the coalitions are developing the standards for a very high level, but each of the facilities has to understand what it's going to do about Crisis Standards of Care based on the fact that resources are not going to be coming to them from other places. There's only so much you can get from outside. Identifying space was critical. We were very rapidly doing it and again, we were using all sorts of unconventional spaces.

Monitoring your community spread right now, we monitor it extremely closely and I imagine everybody across the country is doing that already. Back during the early part of this, nobody was monitoring this kind of spread that quickly and that tightly.

Solving for sufficient staffing is something that you need to be doing already. Again, now that this is spread all over the country, you may not be able to pull in resources from outside to the degree that we were able to. We did not have equipment stockpiles. We got very low on PPE at one point, and we were actually getting it from all over the world.

As far as tracking of supplies, it was fine to open up 1,000 extra beds, but you need to know what you've got the pumps, that you've got the monitors, that you've got the blood pressure cuffs, all the equipment that you need and where it is. We had no way of managing all that. With rapid transfer, since we're a health system, we were transferring patients from our smaller hospitals to our larger hospitals regularly. Every day we were moving patients around to try to match the patient demand to the staff, seeing if we had the staff available or the beds available. For standalone hospitals, there needs to be really robust transfer protocols in place.

I can open up to questions now. Thank you very much. Maria?

00:28:59.100-00:29:39.540

Maria Ramos: Thank you for the presentation, Dr. Napp, and we will be accepting questions right now. So just as a reminder, you can submit a written question via the chat function or if you'd prefer to ask your question verbally, please feel free to raise your hand. You can do so by clicking on the participants icon at the bottom of your screen and then the raise hand function on the right-hand side.

So, question from Chris, how were patient transfers managed outside the system in the coalition?

00:29:40.590-00:32:13.830

Dr. Marc Napp: So, the coalition in New York City is not really well built out. The majority of the hospitals in the New York City area, the tri-state area, are all part of systems, so each one of those systems really manages their own transfers. Health + Hospitals Corporation, which is our public or municipal system, managed them internally, New York Presbyterian managed them internally, NYU managed them internally, etc. The coalition didn't serve that function, which is why I really can't comment on the effectiveness of coalitions in other parts of the country.

00:30:31.380-00:30:55.620

Maria Ramos: Thanks Dr. Napp, and Chris, if you have any clarifying questions or anything feel free to submit them in the chat.

Okay, so the next one we have is: How many patients were in the tent site, and what types of patients were placed there? Did they present to your facility first, then be sent to the tent?

00:30:56.340-00:31:56.640

Dr. Marc Napp: An excellent question. We really had to work through the logistics of that. We worked with Samaritan's Purse, which is a relief organization that came in, they are entirely self-sufficient. They have been staffing Ebola across around the world during the Ebola crisis. They had a tent hospital set up in Italy that they were supporting as well when they came to us. So, they had a sense of the drill. Their facility was able to take 78 patients. I think it was roughly 12 critical care and the rest severe pulmonary. But again, they were self-sufficient nurses, critical care doctors, etc. That worked very well for us as far as how they were attached to us. We made them essentially an extension of the Mount Sinai Hospital, which was that facility right across the street that you saw in that picture. They do not have the ability to take patients in de novo off the street. A patient would have to come through one of our EDs or one of our hospitals and then be transferred to them. However, they were discharging patients directly from the facility.

00:32:20.820-00:32:42.420

Maria Ramos: It looks like we had a question come in from Eric. Eric, since your question is related to coalitions, I will get to that, but want to want to send another question to Dr. Napp. So, Dr. Napp: was PPE provided by the coalitions, state, federal or the system?

00:32:43.980-00:32:44.640

Dr. Marc Napp: We're on our own. The state did not provide any. We had to find our own PPE. We chartered our own planes to go around the country, we actually sent a plane to China. Nobody came to our aid, plain and simple.

00:33:06.360-00:33:11.670

Maria Ramos: Alrighty, next question we have is: did the triage team have specific criteria?

00:33:29.910-00:34:45.780

Dr. Marc Napp: If we are talking about triage for scarce resources like ventilators or dialysis, because the other thing that we run short of is dialysis nurses and respiratory therapists. Yes, we developed specific criteria. They were detailed so there was a lot of effort went into that. One of the things that was a challenge for us was political in that New York State did not come out with its own guidelines regarding rationing of resources. That would have been incredibly unpopular for our elected officials to do as well as creating panic because the message from the governor was, we have sufficient resources, that it's not going to be a problem. That's great, but at the hospital level, you've got to plan. We couldn't come out with any announcement about what our plan was, but we were getting called every day by every news outlet saying, "What are you going to do if you don't have sufficient resources?" So, we would never able to make them public, and we did create back channel communications with the other systems in the area so that we would at least be in sync with them if we had to do it. So I just would think about the political ramifications of doing this.

00:34:49.980-00:34:54.360

Maria Ramos: Thank you. About how long did it take to vet and orient outside providers?

00:34:55.410-00:37:12.990

Dr. Marc. Napp: The vetting, as you can imagine, was very thin. Now, I oversee medical staff services in one of my roles where we do a really rigorous job of vetting people before we bring them onto the system. We basically looked at their CVs, ran a data bank on them, and that's pretty much all we had. Whenever we could, we brought in people from an organization that we developed a contract with. So, for example, one of the organizations we brought a lot of practitioners from was Envision, which is a private group that staffs emergency departments ORs.

So each of their providers has already been vetted by them. That gave us some comfort as opposed to just taking people off the street. Whenever we could, we work with an agency that had already done some credentialing on their individuals. It was then a matter of figuring out: do they have the sufficient skills to meet our needs? The final thing I would say about that is early on, for the first CRNAs we brought in, they visited one of our hospitals and they left within eight hours and then refused to come back. People didn't understand what they were getting into. For those of you who have who have not yet been hit hard, talk to people who have been hit very hard. This was daunting in our smaller hospitals where the places were just literally overrun with incredibly sick patients. We realized we needed to start warning people before they came about what they might see. As far as orientation, it was done within a day, unless we had to train somebody on one of the EMRs that was very hard to use that nobody else uses called Prism and that took several days. We had to really fast track the orientation which is why we ended up putting people in teams as opposed to just going to a facility by themselves, not knowing anybody else. We gave him an anchor as to who to be attached.

00:37:15.990-00:38:01.590

Maria Ramos: Okay, thank you. Going to go back to Eric's question, which might be for Jack or Jennifer: It's fairly straightforward to understand how a health care provider, facility, or system can develop Crisis Standards of Care CONOP and you can also understand how a county or state can develop them, but unless the coalition owns or manages significant staffing inventory or supplies or significant and obligated financial resources, what is it specifically that a coalition has dominion over to assess and evaluate relative to establishing Crisis Standards of Care and CONOPs?

00:38:02.400-00:40:43.290

Jack Herrmann: That's a great question. It gets down to, primitively: what is the role and authority of coalitions? As many of you know on the call, there are roughly 360 health care coalitions across the country, and they do look different from jurisdiction to jurisdiction. Ranging from some that are just purely planning entities, they bring people together from various Acute Care Systems or other health sector partners and they work on planning and exercises. Others are much more robust, and they actually may have some authorities within the jurisdiction where they sit and have more prescribed roles in how to coordinate the variety of resources that the health care sector brings to bear during a disaster. From the Crisis Standards of Care perspective, yes, it really sits at the state level because it entertains state authorities, scope of practice laws, things like that, that are controlled at the state level. So, an HCC in theory, doesn't necessarily have a Crisis Standards of Care plan, unless they do have statutory authority within the jurisdiction that they sit in to take a more authoritative role on the coordination, distribution, and implementation of Crisis Standards of Care. So, while the big CSC is done at the state level, look at where all these other entities intersect and inform the Crisis Standards of Care plan and HCCs can have a role in helping integrate the various components of the health care sector within the jurisdiction that they sit in. They help inform, they bring subject-matter experts to the table, all in the development and hopes that the plan is executable to all jurisdictions within the community. I hope that helps a little bit, but there are some distinctions and we get that from questions like: what does a health care coalition have the authority to do? While recognizing that coalitions may not have their own hospital. They are a conglomeration of the resources that are in the jurisdictions in which they sit.

00:40:46.440-00:41:10.440

Maria Ramos: Thank you so much for that, Jack. In the interest of time, I think we have to move on to our next presentation. I see there's several other questions submitted via the chat and thank you so much for those questions. We will try to maybe get back to those if time allows at the end of the session. Without further ado, I will pass it over to Amber Pitts to begin her presentation.

00:41:27.600-00:51:33.510

Amber Pitts: I am Amber Pitts. I am the Health Care Preparedness Program Manager for the State of Michigan Department of Health and Human Services. I just wanted to give you guys a quick overview of what we have done in Michigan during wave one of COVID and specifically the role of the health care coalitions that we have here. That may answer some questions that we previously had. Our health care coalitions in Michigan definitely helped us get the personal protective equipment out to the hospitals, to the nursing homes, to the health care entities around the state, including EMS as well.

We've obviously we got the ventilators and they've definitely provided a lot of situational awareness, and definitely helped us to triage the messaging, getting that message out that needed to get out from the state level down to the health care entities throughout the state. Health care coalitions, when they are activated for a new event, are called the Medical Coordination Centers, or the MCCs. We have a lot of acronyms that we like to talk about in the world of emergency preparedness, so HCCs and MCCs are basically the same thing, but the MCC is when they are activated to support their local or regional jurisdictions.

This is an algorithm that we've had in place for quite a while now, since 2004, when the MCCs were designed and operational. As you can tell, the hospitals are activated, and the communication pathway is going up to the Regional Medical Coordination Center.

The check here off to the right is the Community Health Emergency Coordination Center and then we have a liaison and the State Emergency Operations Center. That messaging would go up to the governor and so that is a key component. Is it perfect? No, but during wave one, this was definitely instrumental in making sure that we had it. There were limited people that I had to communicate with that had the breakdown of the state, their jurisdictions. Working with our hospitals, with EMS agencies, with local emergency management, skilled nursing facilities. During the pandemic we had other entities that were going to them for PPE as well, like dental and AFC homes.

These are our health care coalitions we have eight in the state. Our coalitions were established in 2002. We have a full-time Regional Coordinator, a full-time assistant coordinator, and a part-time, 25% FTE for the Medical Director. Each of the health care coalitions have three staff members, which obviously can cause some issues when you're distributing PPE and medical supplies to all entities around the state. We were able to augment staffing with the National Guard. We actually also have trauma coordinators and each of the health care coalitions EMS coordinators were gracious enough to go into our health care coalitions and help assist in the warehouse, help with the phone calling, help with distribution of resources. As needed, they were able to help beef up our coalitions since we have three paid positions within the health care coalitions. This is just an example of our Region 1 Health Care Coalition. In the middle there by the forklift is our medical director. I'm definitely getting his hands dirty and getting into the distribution with our National Guard counterparts.

The role of the HCC is, like I said, varied and nothing was perfect during wave one nor going into wave two but we're definitely making it through. Our health care coalitions have been able to set up distribution centers that allow a drive-through system for pickup of supplies and equipment. Some of them have designated specific days for hospitals to come in, say, on a Monday, skilled nursing to come in on a Tuesday. And there's a rotation similar to that around the state. They've been distributing the PPE, the N95s, the gowns, gloves, etc. They were able to distribute over 200 SNS ventilators to hospitals and health care entities.

Our Region 2 North as an example, which is just north of Detroit was able to get out over 100 ventilators to hospitals and EMS agencies. The National Guard was able to work hand-in-hand with our regional staff and volunteers to receive packages and distribute PPE and they were at the

distribution nodes as well. The Regional Medical Coordination Center serves as the liaison between the state and health care entities, including a local public health and emergency management.

I've already touched on this, but we have had the Medical Coordination Centers established since 2004. Some of the health care coalitions were able to develop video education and outreach products for us as an EM resource which is our resource and bed availability system that we've implemented in the state. We did have to beef up our data team here in Michigan. As administrators, our health care coalitions coordinators were able to provide additional hands-on through Teams and Zoom meetings and many just-in-time trainings for our partners that needed the additional help with the changes to the data sets. They continue to provide daily updates to their health care coalition partners and technical assistance on the ever-changing data sets. They were an integral part in the Hospital Relief Strategy, which some of you have already been able to hear the presentation on an ASPR TRACIE webinar a couple weeks back, and I have a link to his slide later on in my presentation.

This is an example of our Alternate Care Sites. We stood up in Detroit and in Novi with FMS resources. In the center here is our Medical Director, Dr. Attis for our Region 2 South, which encompasses the Detroit area. We had two medical directors that helped oversee the medical aspects of the Alternate Care Sites in Detroit and in Novi. During wave one, we had daily calls between our state office and regional health care coalition staff. It was not just the coalition staff, but also we had representatives from the Michigan Hospital Association, Michigan Pharmacists Association, Michigan State Police, and currently we have meetings twice a week with them to make sure that we have a pulse on what is going on throughout the state, where there are needs. The newest addition to our meetings this go-around has been obviously immunizations at the state level. This is just a picture of a screenshot of our resource. As you can see at the top there are multiple boards, we have the hospitals, the EMS agencies, we have psych beds, long-term care facilities, and then the regional health care coalitions are also putting in their regional caches of supplies into this so we can monitor that.

Coalitions have really done an amazing job of providing just-in-time training for their providers, for the hospitals, and nursing homes that are calling all day, all night, asking them questions. We actually implemented weekly office hours to give them technical assistance from the state level to the coalitions and to the facilities to call in and do any kind of triaging of questions or rolling out of new information. The coalitions definitely took on many of those phone calls that the state was not receiving and answered questions of why changes are happening and how to identify the definitions of the fields that were being requested. We have Hospital Boards, Skilled Nursing Boards, Pediatric, Psychiatric, and we were doing daily reporting for the health care coalitions. At this point, they're reporting to us on a weekly basis what the PPE caches are.

Like I said, there was a presentation a couple of weeks back, and if you're interested in his slide deck, you can go to the ASPR TRACIE website or you can wait a couple more weeks for the presentation on Hospital Relief Strategy that we used during the spring, and how it's been modified for the current wave. That is what I have. If there any questions, I would definitely entertain those.

00:51:36.390-00:52:16.740

Maria Ramos: Thank you so much. Amber. We're waiting for a couple questions in the chat. I'm going to check to see if anyone has raised their hand. Looks like there's no questions that have been submitted just yet. Just a quick reminder: feel free to submit questions through the chat, or if you wish to ask a question verbally, feel free to click the participants button and then the raise hand button.

00:52:30.420-00:53:26.400

Shayne Brannman: This is Shayne Brannman from ASPR TRACIE. On the previous question on what the role of the health care coalition is when they don't have direct oversight of resources. One thing that we would just highly recommend is that health care coalitions are certainly in varying degrees of sophistication and maturity. Almost all of them are involved in information sharing and situational awareness to help indicate that. A big part of Crisis Standards of Care is to mitigate, to take action, so you don't go into Crisis Standards of Care and to also maintain situational awareness and begin to plot the actions you are taking to move you back to either contingency or to conventional care. Health care coalitions have a vital role, regardless of whether they have direct authority over specific resources. Are the actions you're taking moving you back end to either contingency or conventional care, so health care coalitions have a vital role, regardless of whether they have direct authority over specific resources.

00:53:37.890-00:53:45.690

Jack Herrmann: I do see one question in the box: Did your health care coalitions assist with offloading and hospital load balancing?

00:53:48.060-00:54:21.810

Amber Pitts: Ours did, but it was very limited. Many of the COVID-positive patients stayed with the health care systems. There was very limited movement because there are very few facilities that wanted to take them in. We have been looking at the best strategy and modifying that to see where we can try to work with skilled nursing facilities and other existing facilities to expand their bed capabilities. Thank you.

00:54:22.830-00:56:21.030

Jack Herrmann: I know we are nearing the top of the hour here, and folks probably need to leave the call. I want to thank both of our presenters for highly engaging presentations on two very important topics and we will work with the presenters on hopefully releasing slides and try to do our best to address some questions that were left in the chat box.

Let me just close by saying a couple things in that based on projections and models and information and data coming to us and certainly to you, the next two weeks and months ahead are going to be very challenging and we ask that you reach out to us if there are potential resources we can share with you to help address the burdens and challenges that you're experiencing in your communities. Feel free to contact us at our HPP email box which is hpp@hhs.gov.

Please remember to utilize ASPR TRACIE as a resource, because as Shayne said, there are a number of tools and resources on that website that many are using to address some of the challenges that they're facing in their communities. We hope to get back with you soon and provide opportunities to talk more about what's going on in your community as the pandemic unfolds.

Thank you all for your cooperation and collaboration in today's webinar, and we look forward to chatting with you soon. Take care and have a great day.