Let's Get Prepared for COVID-19!

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February 27, 2020

Region VII Disaster Health Response Ecosystem

Webinar Agenda

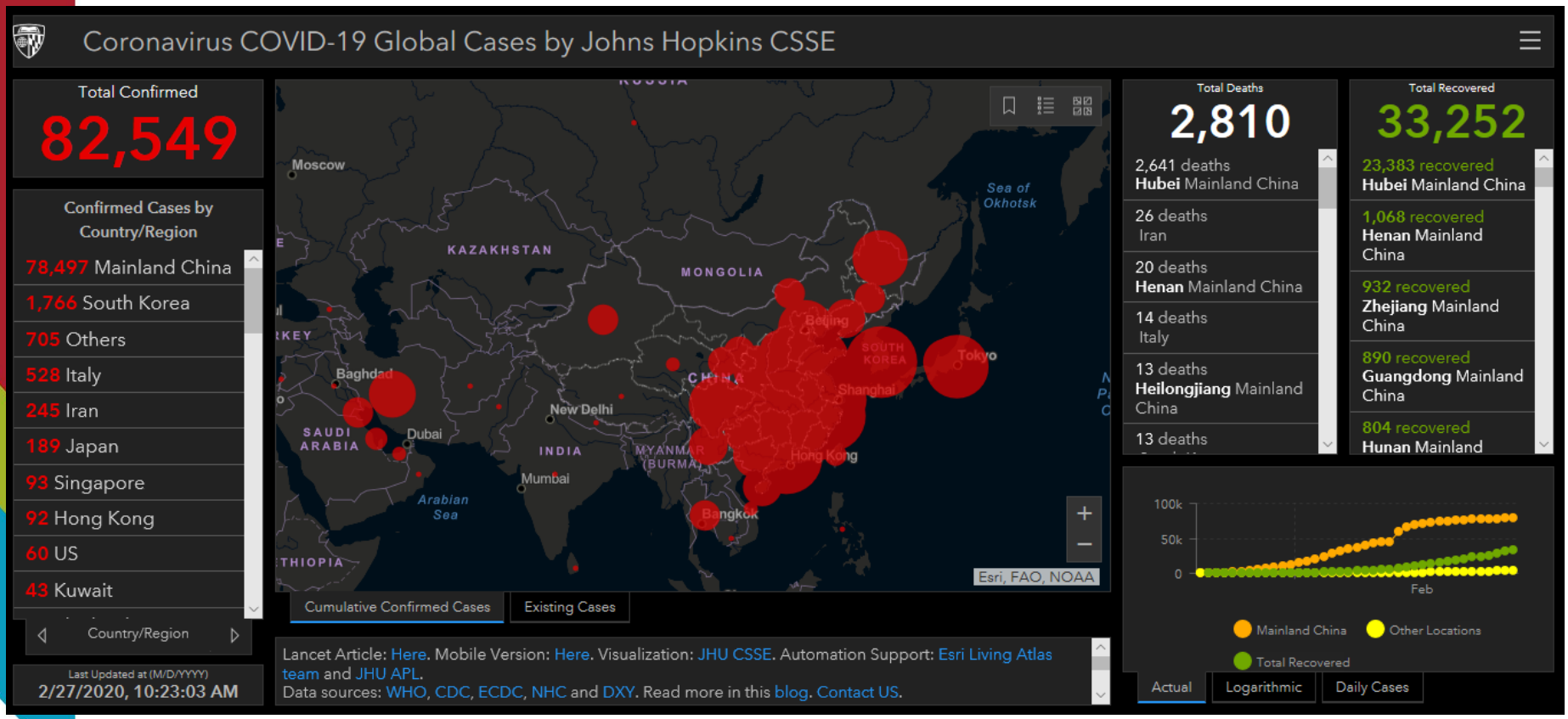
- **Overview of COVID-19**
- **Patient Symptom & Travel Screening Strategies**
- **Protecting Your Organization: Identify, Isolate, and Inform**
- **Triage and Level of Care Requirements (eg. Home Self-isolation vs Admission)**
- **Voluntary/Involuntary Legal Authorities for Quarantine and Isolation Scenarios**
- **Support Services Overview for Camp Ashland/Quarantine Unit**
- **Pandemic Planning Considerations**

Overview of COVID-19

Projections and Modeling

James Lawler

COVID-19 Cases



As of February 27,2020

https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6

Quarantine vs. Isolation

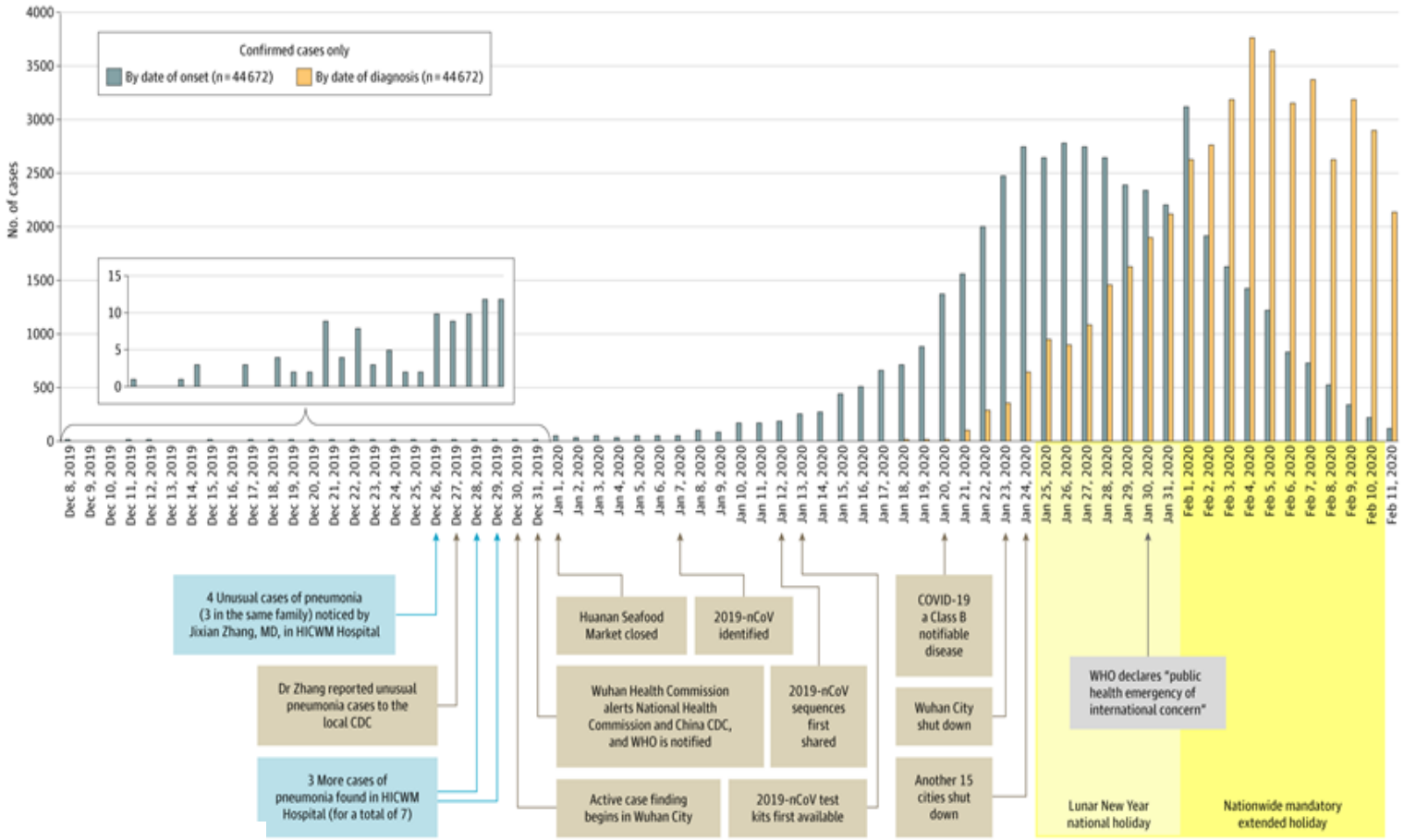
Quarantine

- To separate and restrict the movement of **well** persons who may have been exposed to a communicable disease
- Monitor to see if they become ill
- These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.
- Quarantine can also help limit the spread of communicable disease.

Isolation

- To separate **ill** persons who have a communicable disease from those who do not have that disease
- Restricts the movement of ill persons to help stop the spread of certain diseases
- Example: Isolation for patients with infectious tuberculosis

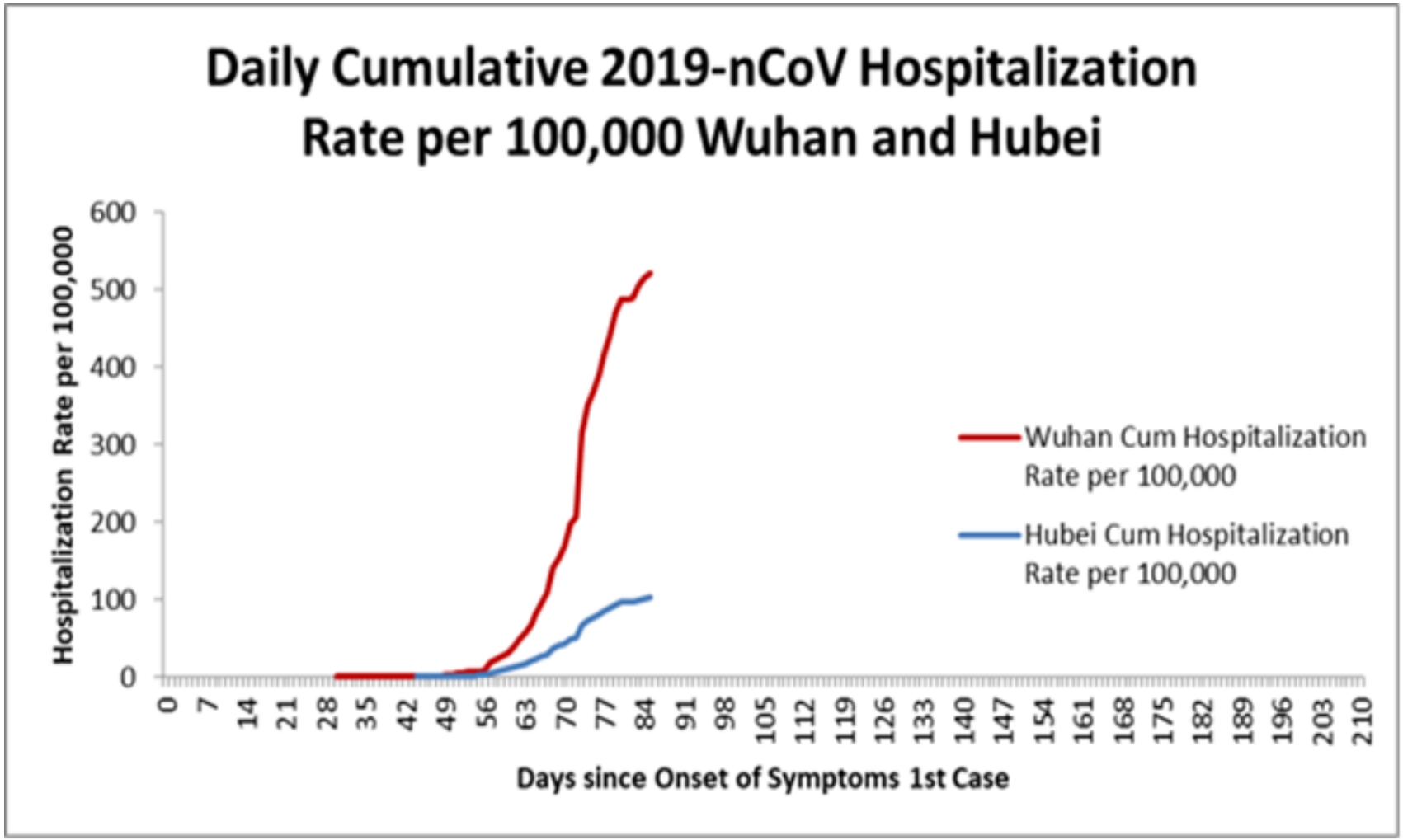
https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html



JAMA Network

From: **Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention**

JAMA. Published online February 24, 2020. doi:10.1001/jama.2020.2648


Daily Cumulative 2019-nCoV Hospitalization Rate per 100,000 Wuhan and Hubei
Hospitalization Rate per 100,000
600
500
400
300
200
100
0
0 7 14 21 28 35 42 49 56 63 70 77 84 91 98 105 112 119 126 133 140 147 154 161 168 175 182 189 196 203 210
Days since Onset of Symptoms 1st Case
Wuhan Cum Hospitalization Rate per 100,000
Hubei Cum Hospitalization Rate per 100,000

China Data

COVID-19
Mortality Stats

COVID-19 Fatality Rate by AGE:

AGE	DEATH RATE
80+ years old	14.8%
70-79 years old	8.0%
60-69 years old	3.6%
50-59 years old	1.3%
40-49 years old	0.4%
30-39 years old	0.2%
20-29 years old	0.2%
10-19 years old	0.2%
0-9 years old	no fatalities

COVID-19 Fatality Rate by COMORBIDITY:

PRE-EXISTING CONDITION	DEATH RATE
Cardiovascular disease	10.5%
Diabetes	7.3%
Chronic respiratory disease	6.3%
Hypertension	6.0%
Cancer	5.6%
no pre-existing conditions	0.9%

Best Guess Epidemiology

• Ro = 2.5; Doubling time 7-10 days	Community epi wave 2 months
• Community attack rate = 30-40%	US: 96 million cases
• Cases requiring hospitalization = 5%	US: 4.8 million admissions
• Cases requiring ICU care = 1-2%	US: 1.9 million ICU
• Cases requiring ventilatory support = 1%	US: 1 PPV
• CFR = 0.5%	US: 480,000 deaths

- **PREPARE FOR DISEASE BURDEN ROUGHLY 10X SEVERE FLU SEASON**

Draft

The conditions and environment here in Wuhan are more difficult and extreme than we could ever have imagined. There is a severe shortage of protective equipment, such as N95 respirators, face shields, goggles, gowns, and gloves. The goggles are made of plastic that must be repeatedly cleaned and sterilised in the ward, making them difficult to see through. Due to the need for frequent hand washing, several of our colleagues' hands are covered in painful rashes. As a result of wearing an N95 respirator for extended periods of time and layers of protective equipment, some nurses now have pressure ulcers on their ears and forehead

Yingchun Zeng, Yan Zhen Letter in *Lancet Global Health* 25Feb2020

Identify, Isolate, Inform
and
Personal Protective Equipment

Shelly Schwedhelm and Angie Vasa

Preparedness: Identify, Isolate, and Inform

1. Isolate

- Place facemask on patient
- Isolate the patient in a private room or a separate area
- Wear appropriate personal protective equipment (PPE)

2. Assess clinical status

EXAM	Is fever present?	Is respiratory illness present?
	☐ Subjective?	☐ Cough?
	☐ Measured? _____°C/F	☐ Shortness of breath?

3. Inform

- Contact health department to report at-risk patients and their clinical status
- Assess need to collect specimens to test for 2019-nCoV
- Decide disposition

If discharged to home

Instruct patient

As needed depending on severity of illness and health department consultation

- Home care guidance
- Home isolation guidance

Advise patient

If the patient develops new or worsening fever or respiratory illness

- Call clinic to determine if reevaluation is needed
- If reevaluation is needed call ahead and wear facemask

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

Identify

Patient Arrival

Know the points of entry at your facility

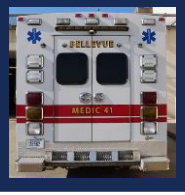
Potential Points of Entry

- Emergency department
- Clinics
- Ambulatory care centers

Walk-ins

- Arrive by themselves
- Brought in by another person(s)

By Ambulance



- Preidentified as a PUI
- Identified en route as a PUI
- May not be identified as a PUI until arrival

Patient Condition

- Non-Emergent
- Emergent
- Critical
- Expired

Identify - Self Screening

Screening: Signage

- Signage enables patients to self-identify
- Signage needs to be:
  - Positioned prominently so as to be easily seen
  - Easily understood, with simple to follow directions
  - Written in languages representative of the community
  - Created with pictograms that are easy to follow

Patient Symptom and Travel Screening Strategy

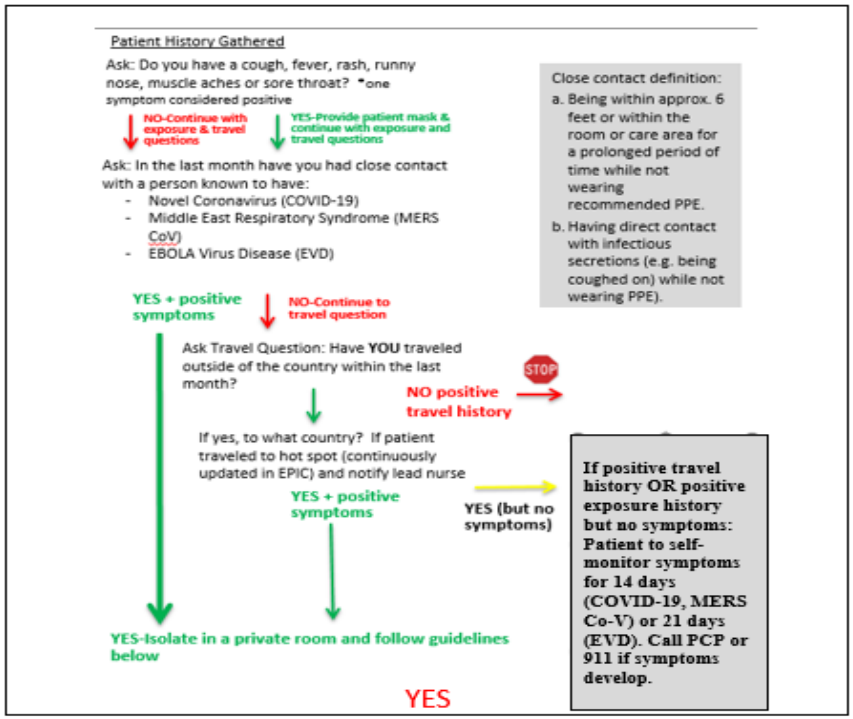
Shelly Schwedhelm

ED & Ambulatory Protocols

Nebraska Medicine

ED CORONAVIRUS (COVID-19) SCREENING PROTOCOL

GENERAL TRAVEL SCREENING



Isolate

Isolate

Place any patient with respiratory illness in procedural mask

- Identify patients with symptoms of respiratory illness as soon as possible and place in mask
- If patient has traveled to areas of interest or has been in contact with a confirmed case or another PUI
  - Isolate patient as safely possible without causing alarm or disruption to clinical areas
  - Maintain adherence to hand hygiene (both HCWs and patient)

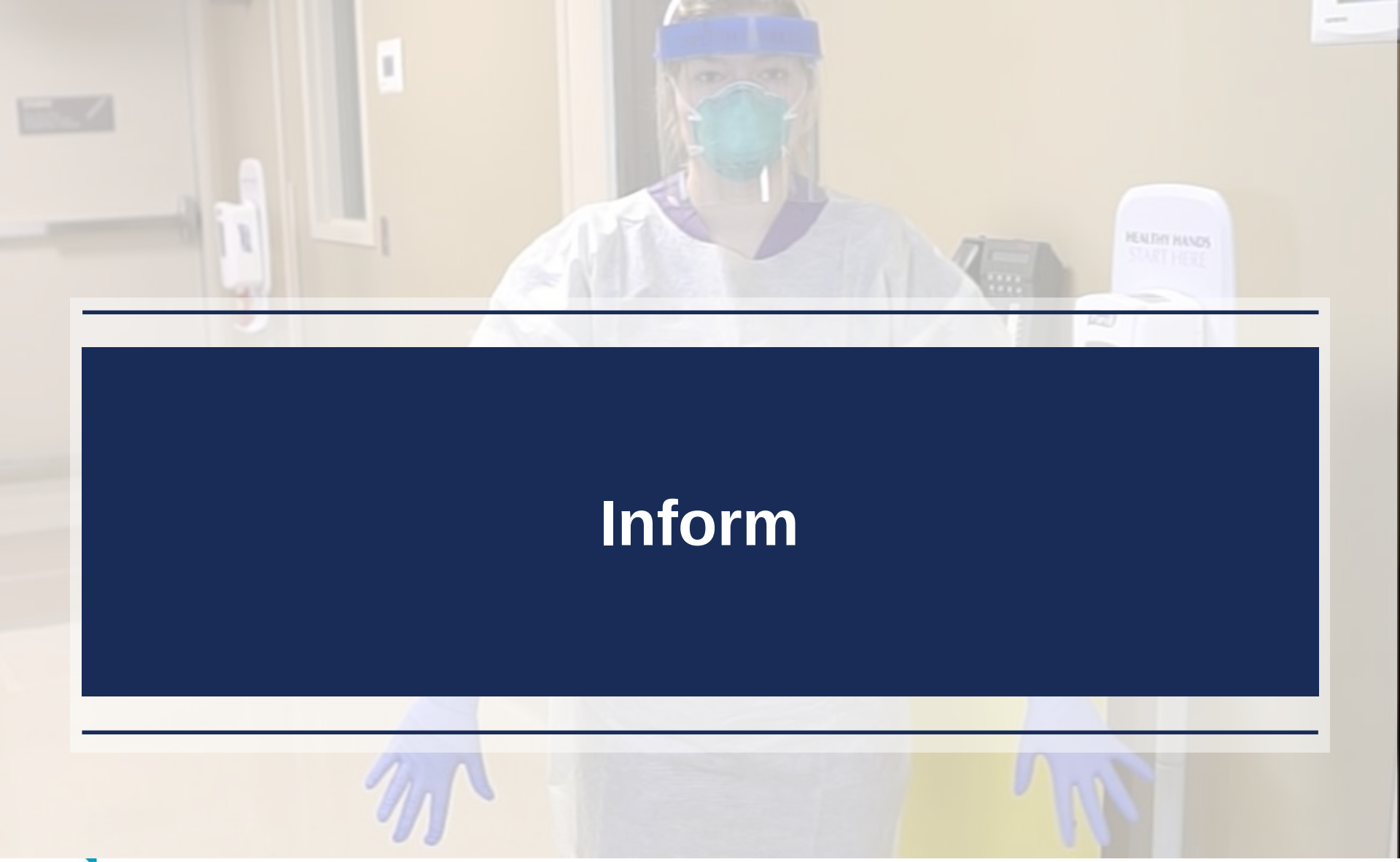
CDC Health Alert Network: Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)

Isolate

Infection Control and Prevention for 2019-nCoV

- Current CDC recommendations
  - Standard precautions
  - Airborne precautions if available
    - If AIIR not available, place in private room with door closed and keep patient in mask if tolerated
  - Contact Precautions
  - Eye protection for healthcare workers directly interacting or in room with patient

https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html



Inform

Inform

Internal Communication

- Do you have all these people/departments on this list?
- Who else is on your internal phone tree that isn't listed here?
- Who makes these phone calls at your facility? Who will be the lead so contacts know who to call back?
- Will any of these contacts change if it is a night, weekend or holiday?
- ** Will your internal incident command structure be activated? ** (Great thing to exercise!)

Important Contacts

- Charge RN
- ED MD
- Infectious Disease
- Infection Prevention/Epidemiology
- ED leadership
- Staffing
- Safety
- Security
- Environmental Services
- Supply chain
- Emergency Management
- Laboratory
- Public Relations Team
- Administration

Inform

External Communication

- Who else should you contact externally that is not listed here?
- Who makes those phone calls?
- Just like the internal phone tree, you need names and positions, multiple numbers and a plan if procedures differ depending on the time or day
- Communication is great to exercise. Try inviting contacts to your facility's exercises!

Important Contacts

- Public Health (Local/State)
- EMS/Transport
- Specialty services not available at your facility
  - Pediatrics
  - Labor & Delivery
- Other resources specific to your institution, region or CONOPS plan
- CDC

Personal Protective Equipment

PPE for Novel Coronavirus

1. Face Shield
2. N95 Respirator
3. Isolation Gown
4. One pair of gloves

Donning/Doffing video can be accessed at https://youtu.be/bG6zISnenPg

Triage and Level of Care Requirements

Home Self-Isolation vs. Admission

James Lawler, Shelly Schwedhelm & Angie Vasa

COVID-19 Placement Plan

Scenario	Plan for care	Team providing care
Asymptomatic, negative testing	Remain under quarantine in designated location	Monitoring per quarantine personnel at designated location
Asymptomatic, positive testing	Discuss with CDC/ASPR. If remaining in place under monitoring is not feasible, admit to NQU (11 bed side)	NQU/NBU team
Symptomatic, mild symptoms not requiring inpatient care	Discuss with CDC/ASPR. If remaining in place under monitoring is not feasible. admit to NQU (11 bed side)	NQU/NBU team
Symptomatic, severe disease/critically ill	Admit to NBU	NBU team
Emergency in NQU and transfer to NBU is planned	Notify NBU and ED of the emergency, then transfer the patient to the ED for stabilization. Admission to NBU when unit readiness is established.	NQU/NBU team, ED
NBU is full	Patients requiring hospital admission will be admitted to general medical floor (or ICU if appropriate), in negative air pressure rooms. Preference for 6N if available.	Hospitalist team for inpatients in floor beds, ICU team for patients in ICU
Special populations: Children/Infants/Pregnant women (especially last trimester)	Admit to appropriate area as above. Consider admission of family unit. Individual circumstances may vary. Consultation with Peds ID, Health Dept input	NQU or NBU team with Peds or OB involvement

COVID-19 Surge Planning

Ambulatory Clinic Operations Surge Plan

Patients in the community with travel history/risk factors for nCoV

Nebraska Medicine
SERIOUS MEDICINE. EXTRAORDINARY CARE.

Escalation	Timing	Description	Impact to Operations
Screening	Present day	**Reinforce** clinic nCoV travel screening protocol in primary care locations: ▪ Continue to identify, isolate and form a plan for care/transfer/self-isolation with support Infection Control team. ▪ Confirm fit testing compliance for clinical staff and direct medical receptionist staff complete fit testing. ▪ All staff to complete updated PPE donning/doffing module when live in Apollo. ▪ Specialty clinic locations to activate protocol as needed. ▪ Guidance from CDC related to risk and symptoms can be found here: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html#table-risk-management	Minimal

Wave 1	X number of cases confirmed in the community	Shift patients to **offsite clinics** for testing/screening needs:
		▪ Goal to move "walking worried" patients away from NMC/BMC/VP campuses that have multiple points of access.
		▪ Wave 1 – Clinic locations to include CFM, Chalco, Eagle Run, Elkhorn, Brentwood, Fontenelle and Plattsmouth.
		▪ Messaging needs:
		  ▪ Call center to support internal messaging and driving patients to Wave 1 locations.
		  ▪ Marketing to develop communication to community encouraging those with suspected symptoms to call for appointments.
			For established patients, maintain home PMCH location when possible.
			
			Begin cancelling annual well visits, routine follow-up and other non-acute visits. Shift to only seeing acute visit needs.

Wave 2	Wide-spread case confirmation in community and/or region	Offload ED surge at two dedicated clinic locations to focus solely on screening/treatment/testing: ▪ Wave 2 – Midtown clinic to support surge needs of NMC ED. ▪ Wave 2 – Twin Creek clinic location to support surge needs of BMC ED. ▪ Execute emergency credentialing of providers to support Wave 2 or any potential expansion of ICC support. ▪ Messaging needs: Marketing to develop communication to community encouraging patients with symptoms to walk-in to MT/TC locations.	Dedicated staff and providers to only see suspected nCOV cases. Business continuity at other PC clinic locations impacted due to likelihood of staff illness, float to surge locations, etc.

Updated: 02/07/2020 - 1330

Voluntary/Involuntary Legal Authorities

Quarantine and Isolation Scenarios

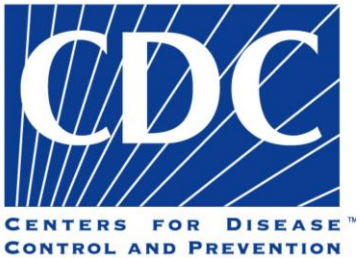
Rachel Lookado

Isolation vs. Quarantine

- **Isolation** –
  - Reasonable belief of ***infection*** with a quarantinable, communicable disease
- **Quarantine** –
  - Reasonable belief of ***exposure*** to a quarantinable, communicable disease

Federal Quarantine Authority

- Authority to “prevent the transmission, introduction, or spread of communicable diseases”
- Statutory authority for Health and Human Services to govern questions of isolation and quarantine
  - HHS created regulations which give operational oversight to CDC
- Covers interstate and foreign quarantine rules
- Federal quarantine last invoked in 1963



Quarantinable Diseases

- Determined by Executive Order
- List of diseases:
  - Cholera
  - Diphtheria
  - Infectious Tuberculosis
  - Plague
  - Smallpox
  - Yellow Fever
  - Viral Hemorrhagic Fevers
  - **Severe acute respiratory syndromes**
  - Influenza caused by novel or re-emergent influenza viruses that are causing, or have the potential to cause, a pandemic

CDC Regulatory Governance

- Most recently modified in 2017
- Regulations split between interstate and foreign quarantine
- Allow for protective measures such as limiting travel and conducting screenings at ports of entry

42 CFR Part 70 - INTERSTATE QUARANTINE

CFR

prev | next

§ 70.1 General definitions.
§ 70.2 Measures in the event of inadequate local control.
§ 70.3 All communicable diseases.
§ 70.4 Report of disease.
§ 70.5 Requirements relating to travelers under a Federal order of isolation, quarantine, or conditional release.

State Quarantine Authority

- Most frequently utilized
- Can be voluntary or involuntary
- Laws and processes differ across states
- Diseases that may qualify for quarantine/isolation differ across states

Legal Rights under Quarantine

- Right of Habeas
  - Determines whether there is sufficient cause to justify detention
  - Constitutional right, cannot be infringed by federal or state entities
- Right to Counsel
  - Federal – right to counsel at medical review
  - State – varies, only 23 states explicitly allow for the right to counsel in the state regulations

Legal Rights under Quarantine

- Right to Food, Medicine, and Other Necessities
  - Federal – Provides adequate food and water, appropriate accommodation, appropriate medical treatment, and means of necessary communication
  - State – Varies, some states require individuals to pay for their own needs
- Right to Lost Compensation
  - Federal – no provision
  - State – Varies, 20% of states provide employment protection for quarantined individuals

Support Services Overview

Camp Ashland and the Quarantine Unit

Dossy Felts & Angie Vasa

Camp Ashland

Key Players

- US Public Health Service Incident Management Team (IMT)
  - Provided Incident Command, logistical support, operations, reporting,
- Centers for Disease Control and Prevention (CDC)
  - Provided medical oversight of the incident
- Disaster Medical Assistance Team (DMAT)
  - Provided onsite medical care
- US Marshals
  - Security of the quarantine area
- Nebraska Medicine/University of Nebraska Medical Center
  - Coordinated food service, housekeeping, IT support lodging, facility maintenance, transportation from airport, EMS and terminal cleaning of all locations.
  - Provided office space allowing for unified incident command

Camp Ashland

Major Considerations

- Site Selection considerations
  - Single occupancy bathrooms vs shared bathrooms
  - Onsite laundry facilities to allow guests to do their own personal laundry
  - Security – fencing and limiting access to the guests
  - Ability to separate the guests from non-quarantined individuals
- Defining “Wrap around services”
  - Who does what, down to the details
    - Who takes the food from the plating area in the clean zone into the lodging area?
    - Who takes out the trash and from what location? To where?
    - How do the guests communicate with staff?
    - Who does facility maintenance?
    - And many more!

Camp Ashland

“Wrap around” Service Support

- Food Service Considerations
  - Snacks/drinks provided for guest rooms.
  - Transporting hot meals, plating on site, coordinating deliver to central location for guests to pick up.
  - Established a process for guests to contact food service for individual requests.
  - Provided meals for guest and staff since other food options were not readily accessible.

- Environmental Services
  - Daily cleaning of guest rooms and common areas.
  - EVS personnel wore PPE consistent with CDC recommendations.
  - Encouraged the guests to leave the room during cleaning, but lack of alternate locations made this difficult.
  - Terminal cleaning was conducted for buses, airport facilities, lodging, etc. as if the guests were positive.

Camp Ashland

- Linen
  - Linen exchanged every few days, as needed/requested
  - Onsite laundry for personal clothes, etc.
  - The plan was to red bag anything soiled with bodily fluids

- Key takeaways
  - Over communicating was key to ensure everyone understood the current situation, it changed hourly
    - Daily unified meetings, shared working space
  - Everyone willing to collaborate during problems solving
  - Diversional activities are key, these individuals will be contained in a small area for 14 days, minimum

IPC Posture: Isolation

IPC Practice for Quarantine Unit 2_ Isolation Ward (2.19.20)

General information. NQU2 is being used as an isolation area for individuals infected, or presumed, to be infected by SARS-CoV-2 and without inpatient medical needs. Consequently, infection prevention and control (IPC) practice on this unit will adopt a strategy commensurate with the geographic risk in containment units.

Flow of personnel through NQU2 will be unidirectional in terms of how staff don and enter the unit then subsequently decontaminate, doff, and exit the unit. All work in the unit will be conducted at the appropriate IPC posture, to include use of PPE and support functions such as cleaning, laundry, and food delivery.

If staff feel that they are contaminated from contact with an isolated individual or their material, or they experience fatigue or other concerns, the staff member will alert a colleague and proceed to the designated decontamination and doffing area, complete doffing, and exit.

Staff preparation. Staff will huddle, complete shift report and review activities for the upcoming shift upon arrival in the designated staff room (Conference 0061). This is located opposite the security booth and adjacent to the designated entry point for NQU2. Please note that this room has personally identifiable information and patient and staff privacy should be protected. Planned support and care tasks when on NQU2 should be prepared to the greatest extent possible prior to entry onto the unit.

Donning. Prior to entering NQU2 staff will don PPE in the staff room (Conference 0061). Recommended order: Foot covers, HH, Gown, N95, face shield, HH and 2 pairs of gloves. One pair of long cuff and one pair of standard exam gloves-both will be placed over the cuff of the gown. They will be observed for correct wear by a donning partner.

Entry. Entry into NQU2 is via key card. Either a colleague will release the door or the staff member will appropriately secure their credentials inside their PPE prior to entry. Staff will fully enter the unit immediately and observe door closure.

Activities on the unit. Staff will conduct their activities through-out the unit in their full PPE ensemble observing hand hygiene and glove changes in between room entries. While all persons in the hallway will be wearing the same PPE and practicing the same IPC posture, loose items, trash, and other material brought from rooms into the hallway should be consolidated and organized prior to their removal from rooms. When a breach of IPC practice occurs or there is concern for substantial contamination, the affected staff member shall alert colleagues and proceed to decontamination, doffing, exit, and reporting to the staff room.

Laundry and food handling. All support activities conducted on the unit will be undertaken at the same IPC posture as that performed by caregivers. Laundry, food, and other material even when washed on the unit will be considered contaminated.

Trash. All trash will be considered regulated medical waste (Category B). Trash containers will be used only to 2/3 full. Bags will be closed fully prior to removal from rooms, and placed immediately into a hard-sided trash container. This will then be stored in the dirty autoclave room in NQU2.

Prior to any hard-sided container being removed from NQU2 for waste disposal, it must be surface decontaminated with Oxivir or Sani Wipes through the decontamination and doffing lane.

Sharps containers must be utilized if using sharps containers.

Decontamination, doffing, and exit. The area immediately adjacent to the waste storage room is the start of the decontamination and doffing lane. Individuals and material may only be removed through this lane and fully prepped for exit before passing to and through the double doors. Use the doffing checklist.

IPC Posture: Quarantine

IPC Practice for Quarantine Unit 1_Quarantine Ward (2.19.20)

General information. NQU1 is being utilized as a quarantine area for individuals who have had exposure to, and are at particular risk, for developing an infection from SARS-CoV-2 and yet without inpatient medical needs. Consequently, infection prevention and control (IPC) practice on this unit will adopt a strategy for minimizing exposures between the individuals. Each room will be treated as a potentially infected space, and staff and material will be decontaminated and prepped for exit at departure from each room.

Staff preparation. Staff will organize, conduct turnovers, plan work on the unit, and maintain communications with the designated staff room (Conference Room 0061) located opposite the security booth and adjacent to the designated entry point for NQU1. That room has personally identifiable information and patient and staff privacy in it should be protected. Planned support and care tasks when on NQU2 should be prepared to the greatest extent possible prior to entry onto the unit. This includes mixing of any medications, laboratory supply and other required organization.

Entry. Entry into NQU1 is via key card. Staff will fully enter the unit immediately and observe door closure.

Donning. Prior to entering each room on NQU1, staff will don PPE. Recommended order: Foot covers, HH, Gown, N95, face shield, HH, and gloves. They will be observed for correct wear by a colleague.

Activities on the unit. Staff will conduct their activities in NQU1 and within each room as though the individual being assessed or assisted may be infected with SARS-CoV-2.

Doffing. HCW will doff their PPE (shoe covers, gowns and gloves) before exiting the room with the exception of N95 mask and eye protection which may be worn in between patient rooms. The N95 respirator and eye protection are removed immediately prior to departing NQU1. All persons will conduct hand hygiene before passing through the doors and exiting the NQU1.

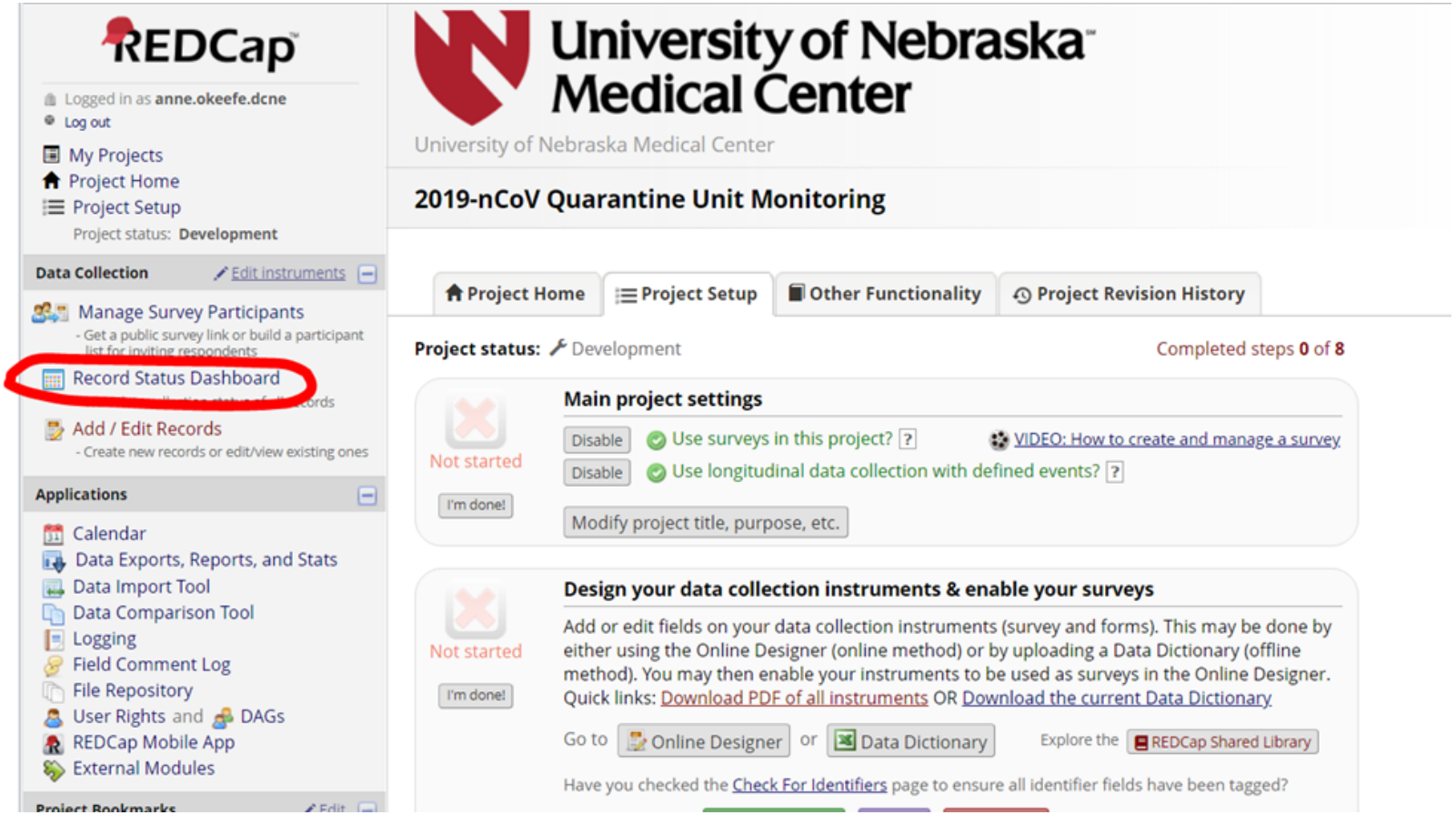
Laundry and food handling. Laundry, food, and other materials will be considered contaminated. These will all be appropriately packaged when moved and processed outside of quarantined persons' rooms.

Trash. All trash will be considered regulated medical waste (Category B). Trash containers will be used only to 2/3 full. Bags will be closed fully using a gooseneck knotting procedure prior to removal from rooms, and placed immediately into a hard-sided waste container lined with a biohazard bag in the hallway. Hard-sided waste containers will be kept in the hallway until full and will be surface decontaminated at shift changes.

Hard-sided containers must be surface decontaminated prior to being removed from NQU1 into NQU2 and stored following NQU2 procedures. Hard-sided waste containers will be moved from NQU1 to NQU2 through the lobby area outside of the security desk. Do Not Enter the Training Area.

Sharps containers must be utilized if using sharps.

Monitoring Approach



Pandemic Planning Considerations

Shelly Schwedhelm & Angie Vasa

HOSPITAL INCIDENT COMMAND SYSTEM

Communication

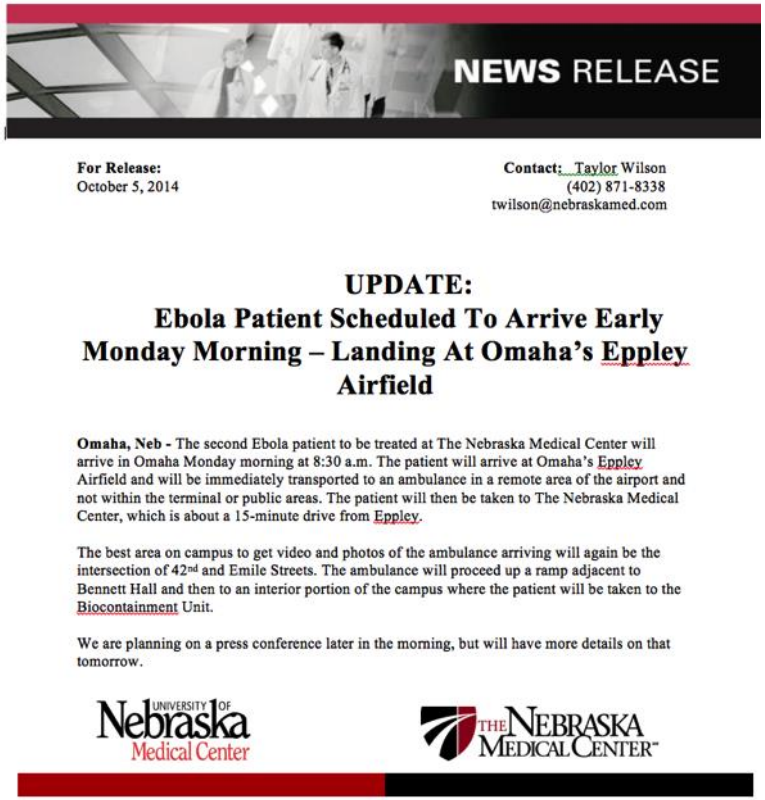
Coordination

Collaboration

Public Information Officer (PIO)

Conduit for information to internal and external stakeholders, including media as approved by Incident Command.

- Risk communication strategies
- Determine internal and external messages
- Collaborate with medical staff and family on messaging
- Establish information lines/hotlines
- Monitor and manage social media
- Who, what, where, when, how, why?



NEWS RELEASE

For Release:
October 5, 2014

Contact: Taylor Wilson
(402) 871-8338
twilson@nebraskamed.com

UPDATE:
Ebola Patient Scheduled To Arrive Early Monday Morning – Landing At Omaha's Eppley Airfield

Omaha, Neb - The second Ebola patient to be treated at The Nebraska Medical Center will arrive in Omaha Monday morning at 8:30 a.m. The patient will arrive at Omaha's Eppley Airfield and will be immediately transported to an ambulance in a remote area of the airport and not within the terminal or public areas. The patient will then be taken to The Nebraska Medical Center, which is about a 15-minute drive from Eppley.

The best area on campus to get video and photos of the ambulance arriving will again be the intersection of 42nd and Emile Streets. The ambulance will proceed up a ramp adjacent to Bennett Hall and then to an interior portion of the campus where the patient will be taken to the Biocontainment Unit.

We are planning on a press conference later in the morning, but will have more details on that tomorrow.

University of Nebraska Medical Center

The Nebraska Medical Center

8 Week Pandemic Planning

Alert Phase (WHO classification) "Normal Flu Season"	Week I	Week II	Week III	Week IV	Week V	Week VI & VII
Monitor International and National Cases of Influenza through Infection Control	Meet w/PIPC: Activate HICS for notification and planning.	HICS: Monitor inpatient bed capacity & hospital status twice daily. (Coordinate with Surge Manager, NRC and PPU)	Transfer unaffected patients to long-term care if possible.	Convert ICU rooms to doubles where possible (Consider 7 & 8 Clarkson)	Identify available beds & resources w/Public Health daily.	Monitor influenza-like illness outpatient visits, admissions & ventilator needs.
Review the Pandemic Plan	DCHD & PIO: Set up information lines to highlight Flu Clinics & send to Central & Medical Call Centers, NM staff, patients, & public. Align community response w/OMMRs.	Hospital Lock Down to control patient & visitor flow.	Collaborate w/OMMRS to obtain supplies from the strategic national stockpile.	Secure additional beds for patients & staff (UNMC colleges).	Collaborate w/OMMRS to use arenas, school gyms for low acuity patients & those triaged to hospice care.	Scale back previous steps: Deactivate alternative inpatient locations & volunteer staffing.
Review and begin organization of student and volunteer response/support plans	Collaborate with OMMRs to ensure alignment with community response	HICS Coordination: Prepare alternate NM areas for patient care and determine staffing for alternate locations.	Cancel elective procedures, routine admissions, & health maintenance visits. Delay non-life-saving treatments for existing patients.	Not all ICU patients will receive ventilators. *Use Altered Standards of Care.	Convert all rooms to doubles as appropriate.	
Begin discussion to adjust staffing ratios/plans and floating policy adjusted to meet patient demands if pandemic declared	Monitor school & business closings.	Consider vaccination strategy for essential personnel.	Expand ICU capacity: Convert CPCU, BCU Reopen BURN as ICU, 4th Clarkson ICU.	Convert OB beds to regular beds in Clarkson Tower.	Consider using stretchers & carts as beds.	
Review and prepare the activation plans for walk in Flu Clinics	Discourage visitation.	Consider areas to accommodate staff.	Use HLC and Werner PreOp & PACU for inpatient beds & possibly Pediatric Unit.	Consider use of CON or Storz for staff sleeping areas.		
Place primary care staff and providers on standby to be able to set up walk-in "flu clinics"	Activate JITT plan for staff & volunteers.	Activate Phase 2 clinics w/extended hours to triage & care. Brentwood Clarkson Family Medicine Fontanelle Eagle Run Midtown	Convert OR anesthesia machines to ventilators.	Implement palliative care model & alternative location for palliative care.		
Monitor NEDOCS trends and total daily volume – sustained overcrowding measure to initiate ER Flu Split Flow and Walk-in Flu Clinics	Evaluate the capacity for double occupancy rooms on NM & Bellevue campuses where able.	ED activates alternate location for triage & care.	Centralize non-pandemic ICU patients in one ICU.	Triage patients off vents. See Altered Standards of Care.		
Begin community communication regarding social distancing and other preventative measures.	Consider utilizing licensed beds that are not currently operational on NM & Bellevue campuses.	Triage patients & implement Altered Standards of Care—identify & activate Triage Team members.	Triage patients off vents & implement additional Altered Standards of Care.	Implement Mass Fatality Surge Plan (Morgue Disaster Plan).		
If vaccine available – initiate plans for vaccination of high risk population, staff, and then community	Discourage routine admissions, elective procedures, preventive care, especially for pediatric patients.	Shift elective & other procedures to DOC or Village Pointe.	Possible use of body sealer system for remains—provide JITT to non-NBU staff.	Mobilize refrigerator trucks for bodies.		
Begin ER planning for split flow for low acuity influenza like illness complaints (Likely an area in the waiting room/tent or trailer)	Limit incoming patient transfers; encourage dismissal of immune-compromised patients.	Lab: Monitor influenza panel & routine blood test supplies; communicate limits to Triage Team.	All ICU-competent staff become essential ICU (PACU, OR, Clinical educators, CNS, faculty.)	Pandemic Staffing Plan: Use students, staff & family members. Continually monitor staffing needs.		
Monitor the number of times the Hospital Surge Management Protocol is triggered	Consider home care/other options when possible.		Students, volunteers, & staff will support clinical care providers and serve as nurse extenders.	JITT for family members in patient care.		
Consult with Lab Leadership for recommendations for novel influenza testing – communication to be sent to all providers via the Lab Alert Process	Separate flu patients from non-flu patients who do not meet discharge criteria.					
	Consider alternate ED locations: Empty DOC clinics; former PreOp/PACU.					
	Consider a back-up unit for PICU – (recommend converting 7Univ Peds Unit to PICU)					
	Encourage admission of children over 14 to adult ICU.					

Resources

Resources for COVID-19

Additional Resources

- NETEC COVID-19 Information
  - https://repository.netecweb.org/exhibits/show/ncov/ncov
- CDC
  - https://www.cdc.gov/novelcoronavirus
- WHO
  - https://www.who.int/westernpacific/emergencies/novel-coronavirus