COVID-19 Response De-escalation: What Hospitals Need to Know

March 23, 2022

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Agenda

- Response De-escalation
  - State roadmap/transition planning
  - After Action processes
- Federal declarations and changes
- State Executive Orders, Public Health Orders, and regulations
- Recommended next steps

Colorado's Next Chapter

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Establishing Hospital Readiness Standards, Surge Planning, and Normalizing COVID Patient Care in Traditional Medical Setting:

Ensuring healthcare systems are prepared for future response efforts and normalizing COVID-19 treatment and prevention back into traditional health care settings.

Ensuring Public Health Readiness and Surge Capacity:

Building on lessons learned so the public health and emergency management fields can expand and contract for disease control and other emergency needs.

Investing in Health Care Workforce Stabilization and Expansion:

Stabilizing the current workforce and building and maintaining a sustainable health care workforce for the future.

Engaging Federal Government in National Endemic Response, Pandemic Readiness, and Needed Reforms:

Striving for a national plan for pandemic readiness and response, and investing in the public health system, including an updated and interoperable national surveillance system, and flexible, non-categorical funding to allow flexibility and increase the public health workforce.

Hospital Readiness:

» Ensuring critical supplies and PPE

» Maintaining and communicating appropriate use of ER services

» Maintaining hospital bed and staffing capacity and surge readiness activation plans

» Improving hospital throughput

» Cross-training of health care workers for emergency response

» All providers engage in delivering COVID-19 vaccinations

» All appropriate providers offer diagnostic testing and prescribe COVID-19 therapeutics

Workforce:

» Hospital reporting to CDPHE on staffing, staff ratios, and turnover

» Hospital reporting on worker safety protocols

» De-escalation training for patient-facing hospital staff

» Oversight process for reporting safety concerns

AAR/IP & Hotwash

Hotwash

A debrief process that reviews actions taken in response to an emergency event that identifies promising practices, so they may be duplicated in the future, while also identifying gaps for improvement before the next emergency event.

Upcoming AAR/IP Work

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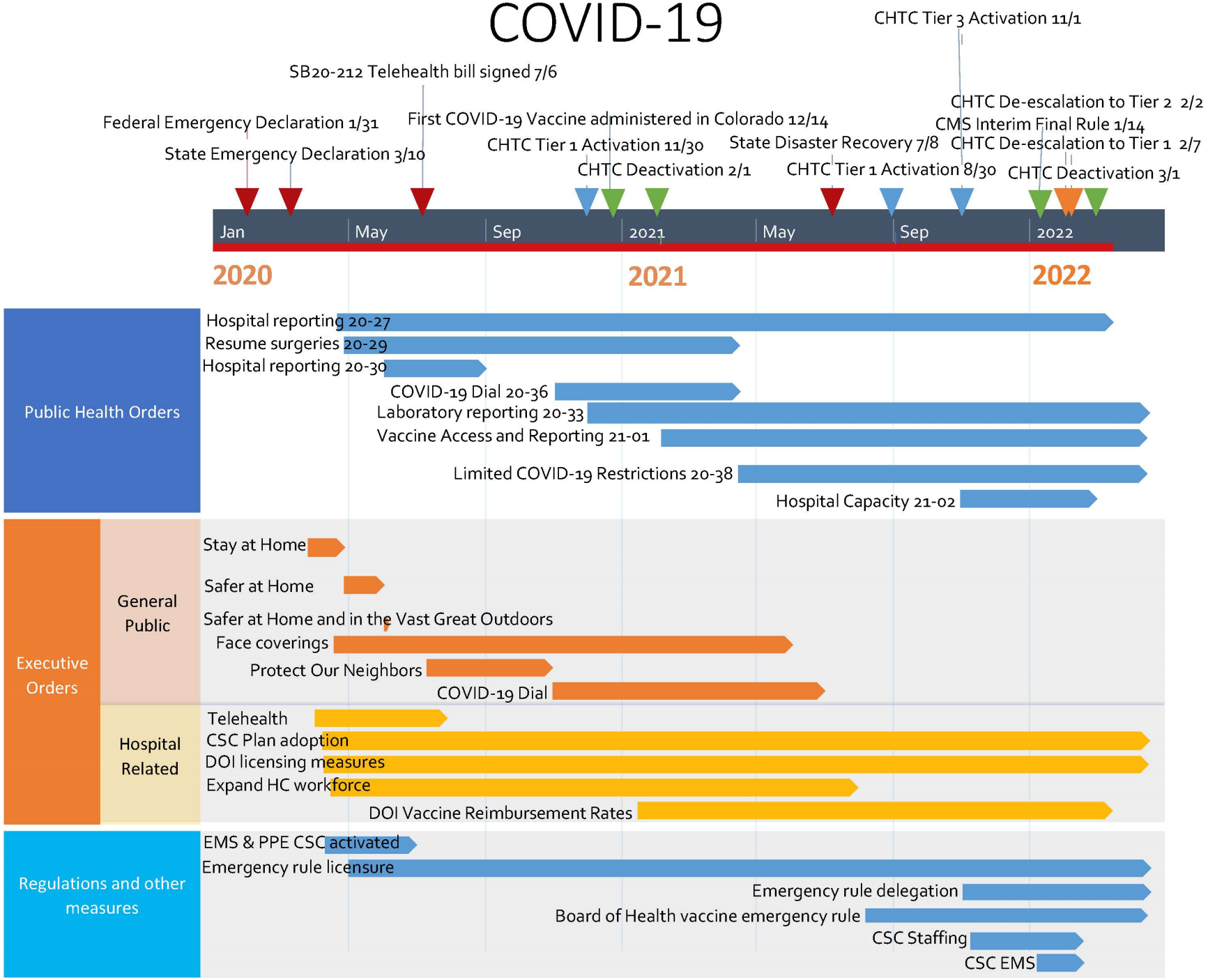
- Combined Hospital Transfer Center (CHTC)
  - Conducted hotwash with CHTC Leads
  - Developing survey to gain feedback from all stakeholders
- Health System Chief Medical Officer (CMO)
  - Conducting hotwash in April
- Rural Hospitals
- Colorado Hospital Association (CHA)
  - In-progress using command meetings
- State
  - Colorado Department of Public Health and Environment (CDPHE)
  - Colorado Department of Public Safety

COVID-19



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Federal Declarations

- Presidential emergency declaration (National Emergencies & Stafford Act) – March 13, 2020
  - Continuance issued Feb. 18, 2022
- Health and Human Services Public Health Emergency (319 Public Health Services Act) – Jan. 31, 2020
  - Expires April 16, 2022 – anticipated continuance
  - HHS will provide 60-days notice of termination
- Public Readiness and Emergency Preparedness Act (PREP)
- Defense Production Act (e.g., vaccine development, PPE, etc.)
- Flexibilities
  - Funding (e.g., Provider Relief Funds, loans, etc.)
  - Social Security Act 1135 – Centers for Medicare and Medicaid Services (CMS)
    - Blanket waivers – only apply to federal requirements
    - Allows applications for specific waivers
  - Protection from liability for COVID-19 countermeasures (PREP)

Federal Actions

- CDC guidance for COVID-19 mitigation and control
  - Guidance for health care facilities and workforce
  - Recommendations and information for the public
- FDA Emergency Use Auth.
  - Vaccination
  - Therapeutics
- CMS
  - CMS vaccine requirements are in effect as of Jan. 14, 2022
  - EMTALA waivers still in place
  - Other 1135 waivers (blanket and Colo.-specific) still in place
- OSHA
  - OSHA vaccine requirements were struck down and the administration withdrew the Standard after the Supreme Court ruling Jan. 13, 2022
  - Health care COVID-19 Prevention Rule hearing

Federal Data Reporting

- Jan. 6, 2022 – HHS issued updated guidance for the COVID-19 hospital data reporting:
  - Net reduction of approximately 30% of fields
  - Therapeutic D Required: Jan. 19, 2022
  - Pediatric and Influenza Fields Required: Feb. 2, 2022
  - Addition of pediatric capacity & age questions
- All data collected is driven by two core principles:
  1. The data must drive action and/or,
  2. The data must serve as a surveillance indicator for U.S. health care system stress, capacity, capability, and/or patient safety. Significant consideration was also given to align with state, tribal, local, and territorial (STLT) needs wherever possible, and to minimize system changes and/or disruptions.
- Hospitals need to report 7 days per week but can report weekend data on the following Monday.

Daily Required

1a: Hospital Name

1b: Hospital CCN

1d: State

1e: County

1f: Hospital Zipcode

3a: All hospital inpatient beds

3b: All adult inpatient beds

3c: **[NEW]** All pediatric inpatient beds

4a: All hospital inpatient occupancy

4b: All adult inpatient occupancy

4c: **[NEW]** All pediatric inpatient occupancy

5a: All ICU beds

5b: Adult ICU beds

5c: **[NEW]** Pediatric ICU beds

6a: All ICU bed occupancy

6b: Adult ICU occupancy

6c: **[NEW]** Pediatric ICU occupancy

9a: Hospitalized adult suspected or lab-confirmed COVID-19

9b: Hospitalized Adult lab-Confirmed COVID-19

10a: Hospitalized pediatric suspected or lab-confirmed COVID-19

10b: Hospitalized Pediatric Lab-Confirmed COVID-19

11: Hospitalized and ventilated COVID-19 patients

12a: ICU suspected or confirmed COVID-19

12b: Hospital ICU Adult Lab-Confirmed COVID-19

12c: **[NEW]** Hospitalized ICU Pediatric Lab-Confirmed COVID-19

13: Hospital Onset

17a: Previous day's adult admissions lab-confirmed COVID-19 (+age breakdown)

17b: Adult suspected COVID-19 admissions by age group

18a: Previous day's pediatric admissions lab-confirmed COVID-19

18b: Pediatric suspected COVID-19 admissions

18c: **[NEW]** Age breakdowns of previous day's pediatric admissions lab-confirmed COVID-19

19: Previous day's total ED visits

20: Previous day's total COVID-19-related ED visits

33: **[CHANGE]** Total hospitalized patients with lab-confirmed influenza

34: **[CHANGE]** Previous day's lab-confirmed influenza admissions

35: **[CHANGE]** Total hospitalized ICU patients with lab-confirmed influenza

Weekly Required

27b-f: On Hand Supply: N95, Surgical & procedural mask, single use gowns, gloves, eye protection

30c,e-h: Ability to Maintain: N95, Surgical & procedural mask, single use gowns, gloves, eye protection

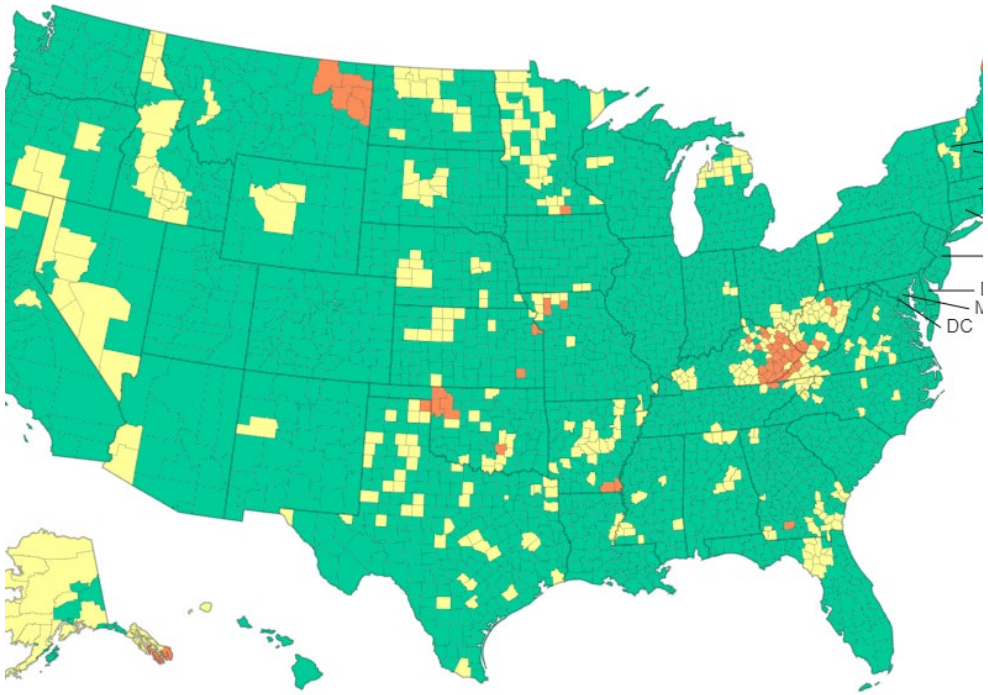
39a-b: Therapeutic A courses on hand & administered

40a-b: Therapeutic C courses on hand & administered

40c-d: **[NEW]** Therapeutic D courses on hand & administered

CDC Community Levels

U.S. COVID-19 Community Levels by County Map



- Risk level is calculated using the following 3 factors:
  1. New COVID-19 cases per 100,000 population (7-day total)
  2. New COVID-19 admissions per 100,000 population
  3. Percent of inpatient beds occupied by COVID-19 patients

Colorado Public Health Emergency

- Initially declared on March 10, 2020, through Executive Order
  - Amended and extended through additional Executive Orders
  - Directed and redirected funds to address the pandemic
  - Directed state departments and agencies to promulgate rules or take action to address the pandemic (**CDPHE public health orders**, CDLE unemployment insurance)
  - Adopted the state's Crisis Standards of Care Plan and authorized the activation by the CDPHE Medical Officer
  - **Rescinded July 8, 2021, placed with the Disaster Recovery Executive Order**

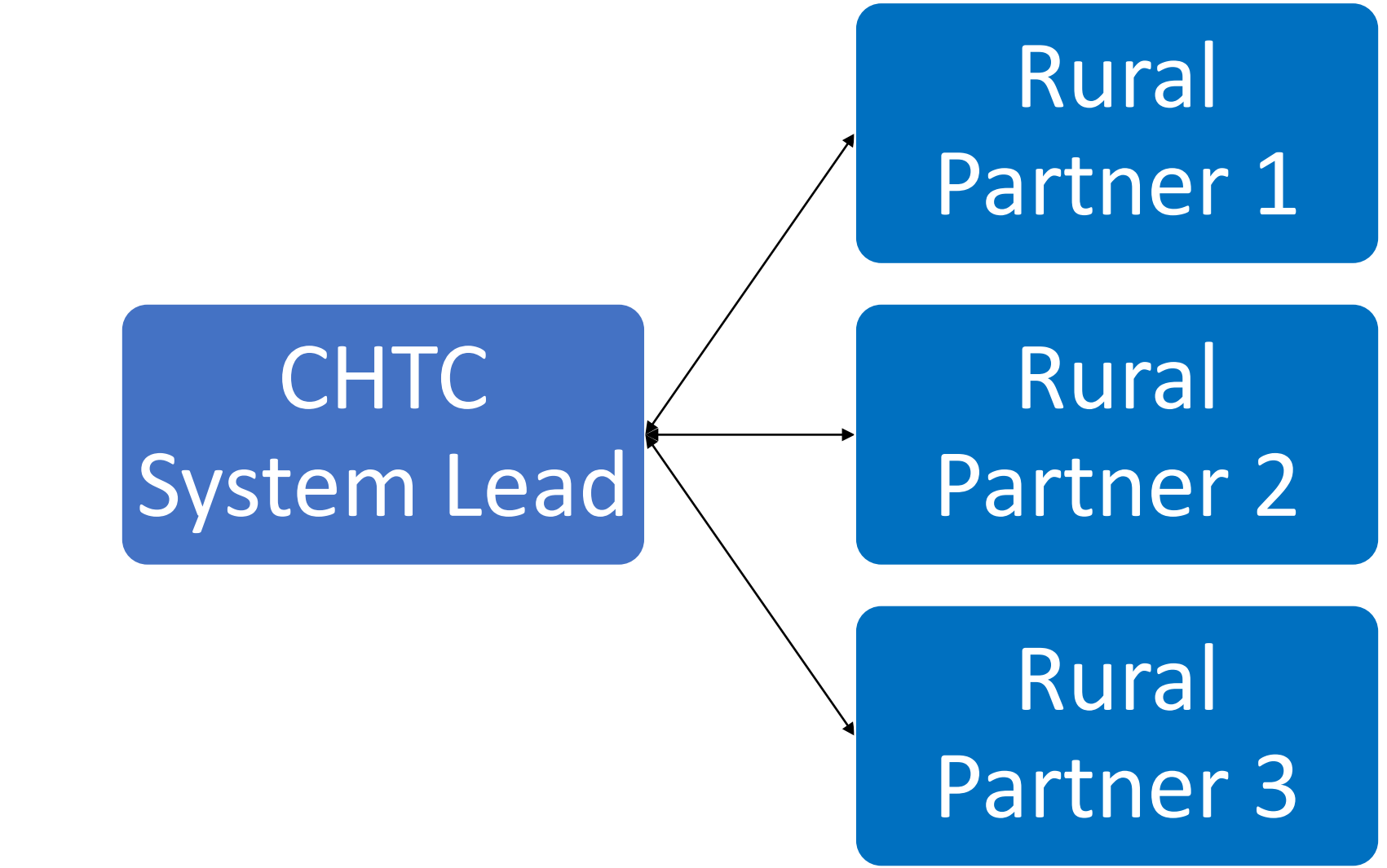
Colorado Executive Orders (EOs)

- Stay at Home
- Temporary cessation of all elective and non-essential surgeries (expired April 2020)
- Suspending certain statutes to expand health care workforce (remains in disaster recovery EO)
- Face covering for critical businesses and settings defined in PHO 20-36 (expired June 2021)
- Operation of Alternate Care Sites by the state (expired March 2021)
- DOI to promulgate rules regarding reimbursement rates for COVID-19 vaccine (rescinded July 2021 by Recovery Declaration EO)

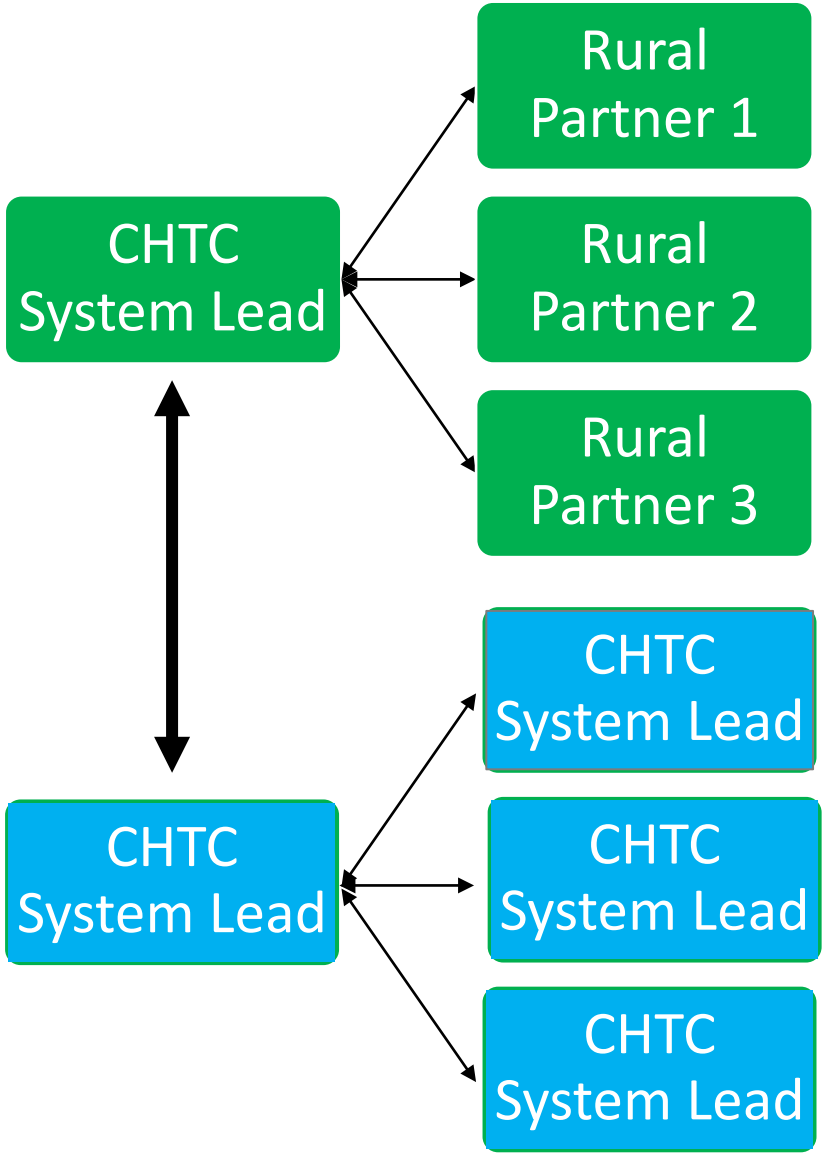
Colorado Executive Orders (EOs)

- Authorizing CDPHE to order hospitals and freestanding ED to transfer or cease admissions (expired Feb. 25, 2022)
  - Allowed for the transfer of patients without consent
  - Deemed transfers as “medically necessary” and that payers subject to Colo. insurance law were required to pay for transfers (and without balance billing)
  - State methodology for out-of-network rates
  - Provided immunity for civil or criminal liability for actions take to comply with the EO

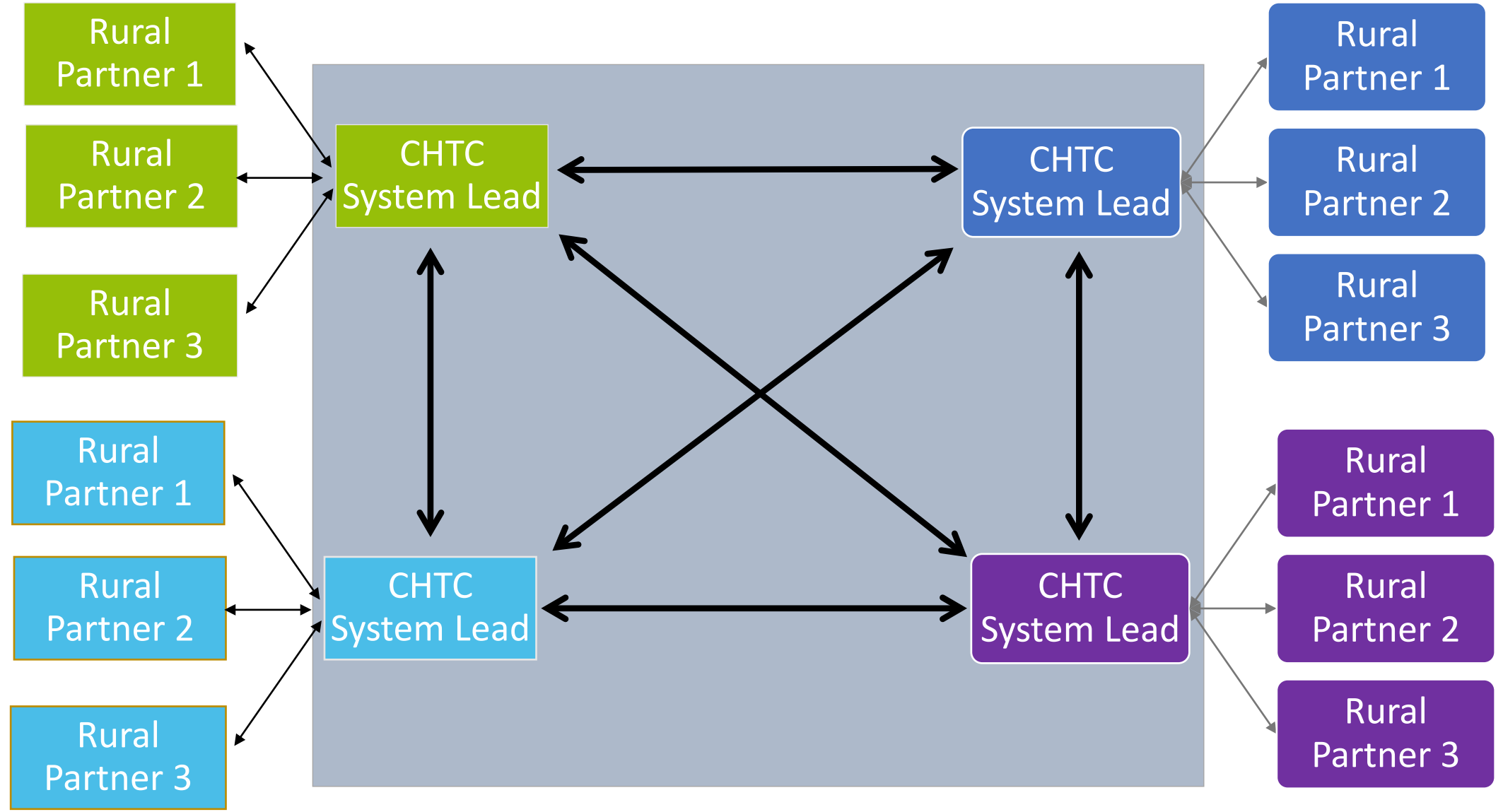
CHTC Tier 1


CHTC System Lead
Rural Partner 1
Rural Partner 2
Rural Partner 3

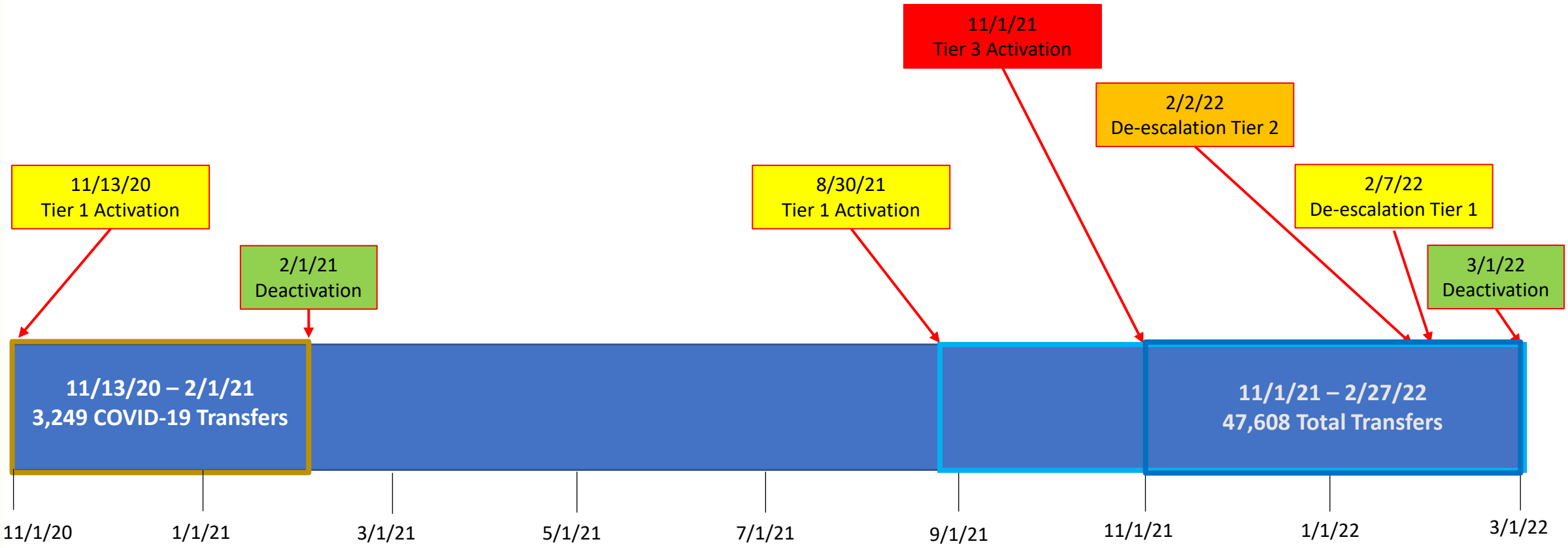
CHTC Tier 2 - Regional



CHTC Tier 3 - Statewide



Timeline


11/1/21
Tier 3 Activation
2/2/22
De-escalation Tier 2
11/13/20
Tier 1 Activation
8/30/21
Tier 1 Activation
2/7/22
De-escalation Tier 1
2/1/21
Deactivation
3/1/22
Deactivation
11/13/20 – 2/1/21
3,249 COVID-19 Transfers
11/1/21 – 2/27/22
47,608 Total Transfers
11/1/20
1/1/21
3/1/21
5/1/21
7/1/21
9/1/21
11/1/21
1/1/22
3/1/22

CHTC Tier 0

Actions	Pre-Requisites for Next Tier
1. Hospital transfer centers working under normal operations 2. CHTC Leads meet quarterly for ongoing communication and coordination 3. No EMResource CHTC tab requirements	1. Hospital(s) have enacted internal surge measures. 2. Affected hospital(s) or system transfer lead notifies CHTC Lead (if CHTC rotation still exists) and/or CHA, using activation process, providing information that supports CHTC activation. 3. CHTC Leads and CHA conduct meet to discuss affected hospital(s)' situation and determine need for CHTC activation or if systems are able to level load the patient need. 4. If CHTC activation is warranted, all stakeholders are notified of moving to Tier 1 activation. 5. The trigger for activation to Tier 1 is at least one facility requiring regional assistance to move 20% or more of patients requiring transfer out of their facility after all normal operation procedures have been exhausted.

Colorado Executive Orders (EOs)

- Temporary cessation of all elective and non-essential surgeries (expired April 2020)
- Recommencement of voluntary or elective surgeries (expired April 2021)
- Suspending certain statutes to expand health care workforce (remains in disaster recovery EO)
- Face covering for critical businesses and settings defined in PHO 20-36 (expired June 2021)
- Operation of Alternate Care Sites by the state (expired March 2021)

Colorado Disaster Recovery

- Issued July 8, 2021 – **still in effect**
- To focus only on those measures related to the state's recovery from the COVID-19 pandemic emergency
  - Maintain access to additional federal funding, and continue the state's disaster declaration and essential directives for response and recovery activities
  - Ensuring that health care facilities have sufficient resources to treat COVID-19 patients
    - Directs DORA – DPO to promulgate and issue temporary rules for health professionals related to delegation, supervision, and cross-training
  - Allows out-of-state emergency medical services personnel to request permission to "assist in preparing for, responding to, mitigating the effects of and recovering from COVID-19"
  - With regard to discharging, transferring, and caring for patients, authorizes DORA-DOI to temporarily suspend utilization reviews including prior-auth and pre-auth

Colorado Public Health Orders (PHOs)

- Authorized by Executive Order
- Varying expiration dates – tied to authorizing EO
  - 20-20 – SNF, ALR must follow state mitigation guidance (still in place)
  - 20-29 – Recommencement of voluntary or elective surgeries (rescinded April 15, 2021, with issuance of 20-38), *universal symptom screening for staff and patients (refer to CDC Interim Infection Prevention and Control Recommendations "Establish a process to identify and manage individuals with suspected or confirmed SARS-CoV-2")
  - 20-33 – Laboratory reporting for COVID-19 (still in place)
  - 20-38 – Limited COVID-19 Restrictions (extended/amended through April 14, 2022) requires face coverings for patients, visitors, staff based on community levels; continues hospital reporting in EMResource twice per week (Tuesdays & Fridays)
  - 21-01 – Vaccine access and reporting (still in place)
  - 21-02 – Concerning access to care (therapeutics) expired March 1, 2022

Other Agency Actions

- Emergency rules
  - CDPHE emergency rule for vaccination of staff in licensed facilities
    - Extended on March 16 – permanent rule making at a future date
  - HCPF emergency rules offering flexibilities – PAR, provider status, facility status, medically necessary transport
  - DOI rules on coverage for COVID-related services for plans governed by the state
  - DORA/DPO flexibilities on providers cross-training and supervising

14th Amended Public Health Order 20-38

COVID-19 Case Reporting Changes

Modified the hospital reporting requirements from Monday-Friday to Tuesday and Friday by 10 a.m.

Removed the following hospital reporting requirements:

- Laboratory test reporting requirement for suspected positive cases, **limited to just confirmed positive cases**
- Numbers of suspected and confirmed cases who are **discharged and in recovery**
- Ventilator availability and utilization, availability of N95 masks
- Clarified hospital bed capacity reporting to include acute care beds, med/surge beds, and ICU beds
- Added that hospitals shall continue reporting in the COVID Patient Hospital Surveillance System as directed by CDPHE

Hospital Bed Capacity Reporting

Modified the hospital reporting requirements from Monday- Friday to Tuesday and Friday by 10 a.m.

- Added reporting of the daily maximum number of adult and pediatric med/surge beds available for patients in need of non-ICU hospitalization

14th Amended Public Health Order 20-38

COVID-19 Case Reporting	Hospital Bed Capacity Reporting
• Race and ethnicity • Numbers of confirmed cases who are hospitalized, who are hospitalized and using a ventilator, or who are in the emergency department waiting for an inpatient bed • Deaths due to COVID-19 • Medical equipment and supply information, including but not limited to acute care bed, med/surgical bed, and intensive care unit (ICU) bed capacity and occupancy, • COVID-19 vaccination status, including primary, additional and booster doses, and age.	• The daily maximum number of adult and pediatric beds that are currently or can be made available within 24 hours for patients in need of ICU level care; • The daily maximum number of all staffed acute care beds, including ICU beds, available for patients in need of non-ICU hospitalization; • The daily maximum number of all adult and pediatric med/surgical beds, available for patients in need of non-ICU hospitalization.

CDPHE Public Facing Dashboards

- CDPHE does use hospital reported data in publicly available dashboards
  - Bed data from EMResource
  - Patient -level hospitalization data provided through COPHS (COVID Patient Hospitalization Surveillance)

Data Reporting Next Steps

- Advocate to the state to align federal and state reporting and hospitals to report to only one place
  - Using HHS protect to report admission data and removing fields that are no longer being reported as of March 16
- Do not see reporting requirements ending any time soon as the data is being used by state and federal agencies for assessing risk levels and understanding resource needs
- Work with hospitals to create a more efficient process to gather and send data where necessary

What's Next?

- Review your policies/procedures
- Ensure your patient-facing tools are up-to-date (e.g., website, patient materials, etc.)
- Update your HR materials and staff education
- Be flexible and ready for more changes!

Questions?

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