Governor's Joint Task Force for Health Care Systems Response to COVID-19

Initial Report, March 23, 2020

Oregon Health Authority

V1.0

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Background

Oregon is in the initial phase of what is expected to be an unprecedented health care crisis related to the impacts of COVID-19 caused by a novel coronavirus. Current modeling projects that the number of individuals in Oregon requiring hospital level of care will greatly exceed Oregon's hospital bed and other health care system capacity starting within the next few weeks. The urgency to take swift action to strengthen Oregon's health care response to COVID-19 in order to save lives could not be greater.

For these reasons, the Joint COVID-19 Health Care Systems Response Task Force was established to guide the actions of Oregon's COVID-19 unified emergency response. To inform this guidance, three Task Force subgroups were convened focused on the following areas along the continuum of care:

- Emergency Medical Services (EMS)
- Hospitals and Acute Care Facilities (HACF)
- Long-Term Care and Vulnerable Populations (LTCVP)

Purpose and Process of the Task Force

The purpose of the Task Force is to provide guidance promoting a unified response to the outbreak throughout Oregon, including the actions of the Emergency Coordination Center (ECC) and the Oregon Health Authority (OHA) Incident Management Team, creating a framework that will best support health care system preparedness and response to the impending surge from COVID-19 cases.

The Emergency Medical Services, Hospitals Acute Care Facilities, and Long-Term Care and Vulnerable Populations subgroups of the Joint Task Force met separately, with the subgroups providing more specific input into the needs of their respective segments of the health care system. The subgroups met on March 18th and March 20th. The Joint Task Force reviewed and provided overall guidance to the state, considering input and recommendations from the subgroups. The Joint Task Force met on March 19th and March 23rd.

This report organizes input and guidance from each of the subgroups and Joint Task Force into a cross-sector "Action Plan" of critical steps that the State of Oregon must take to support and strengthen the health care system's response to COVID-19 across the continuum of care. The Action Plan summary is intended to combine input from all three subgroups, recognizing that the responses to COVID-19 are interconnected and must be coordinated across the entire health care system. A summary of each Task Force subgroup's discussion and input is provided in Appendices A-C.

Crisis Care Guidance

Input from the Joint Task Force and the resulting Action Plan go hand in hand with Oregon's Crisis Care Guidance in supporting the health care system's response to COVID-19. The Crisis Care Guidance, was developed by multiple partners in health care and public health from around the state over the past decade and is based on key ethical principles. The Guidance serves as a framework for expanding surge capacity, as well as for making difficult resource-allocation decisions in the setting of a health care crisis and scarce resources. Hospitals and health systems across the state are already utilizing the Guidance as part of their emergency planning and response. This Action Plan and continued application of the Crisis Care Guidance will ensure that our resource allocation, necessary changes in patterns of care and the overall health system response serve the greatest good for the greatest number of people in face of the expected COVID-19 surge.

Action Plan for COVID-19 Health Care Systems Response

The Task Force guidance obtained through these initial meetings has directly informed the following Action Plan for the COVID-19 Health Care Systems Response. This Action Plan is intended to address the following problems as identified by the Joint Task Force and its subgroups:

- In the face of the expected surge of COVID-19 cases, the health care system's resources could quickly be overwhelmed.
- Medical supplies and equipment, including personal protective equipment (PPE) and COVID-19 specimen collection kits and testing, are already constrained and affecting the health care systems' ability to respond safely and effectively to this health care crisis; further scarcity of critical medical supplies and equipment is expected soon.
- Oregon's hospital bed capacity is inadequate to accommodate the expected volume of COVID-19 patients who will need hospital level of care; furthermore, hospitals are facing unprecedented challenges in discharging patients due to a variety of system factors, which could further limit their capacity for treating COVID-19 patients if not addressed immediately.
- The current health care and non-health care workforces are inadequately mobilized to meet the needs of patient care during the upcoming COVID-19 surge.

This Action Plan defines the critical objectives, strategies and tasks to address these urgent problems. The plan builds on the Crisis Care Guidance to inform Oregon's unified emergency response (including the work of Oregon's Emergency Coordination Center (ECC) and OHA's Incident Management Team (IMT) in order to strengthen Oregon's health care system surge preparedness, and to reduce fatalities and other health-related impacts from COVID-19. The Action Plan will complement and support the work of the Regional Health Care Coalitions (HCC,) which implement the preparedness strategy across the five preparedness regions in Oregon. (See map in Appendix D.)

Action Plan Objectives

1. Procure and distribute critical medical supplies necessary for the health care system's response to the surge of COVID-19 cases, including personal protective equipment (PPE) and ventilators.
2. Optimize hospital capacity to prepare for the surge of COVID-19 patients requiring hospital level of care.
3. Mobilize the necessary health care workforce to respond to the surge of COVID-19 patients.
4. Maintain coordination and transparency to ensure a unified COVID-19 emergency response across Oregon.

The following recommended strategies and tasks will ensure that we achieve each of these critical objectives.

Objective 1: Procure and distribute critical medical supplies necessary for the health care system's response to the surge of COVID-19 cases, including personal protective equipment (PPE), COVID-19 collection and testing kits, and ventilators.

***Strategy: Optimize the use of the existing supply of PPE*.**

Tasks include:

- Create and disseminate guidance for the safe and extended use or re-use of PPE.
- Stop elective and non-urgent surgeries and procedures that require PPE.

➢ *Current Status:* Governor Brown's Executive Order No. 20-10 issued March 19, 2020 cancels all elective and non-urgent procedures across all care settings that utilize PPE effective March 23, 2020.

Strategy*: *Procure new sources of PPE and centralize PPE collection.

Tasks include:

- Establish an approach for centralized collection of PPE (including incoming federal stockpile supplies and donations), in coordination with Regional Health Care Coalitions (HCC).
- Procure additional resources from federal stockpile, local or national suppliers or manufacturers; identify and address any barriers to procuring new sources of PPE that do not jeopardize safety.
- Distribute guidance on required specifications for any new production of PPE informed by OR-OSHA and the Centers for Disease Control and Prevention (CDC).

➢ *Current Status: Coordination of collection and re-distribution of PPE is underway at the ECC; additional guidance for submitting donated materials can be found at:* https://oregon-coronavirus-geo.hub.arcgis.com/

Strategy: Align PPE forecasting metrics; centralize the management of PPE distribution.

Tasks include:

- Develop metrics to capture the forecasted need of PPE for hospitals and health care systems.
- Centrally collect data on the PPE supply and burn rates across the health care system.
- Develop criteria for PPE distribution or ensure that existing criteria meet the needs of hospitals and health systems.
- Prioritize distribution of PPE to the highest risk health care workers based on likelihood of exposure and volume of infected patients if possible.

➢ *Current Status:* PPE criteria for distribution have been created and approved by the Medical Advisory Group (MAG). The MAG is triggered by the High Impact Pathogen Plan of Operations. PPE supply management is being centralized through the Emergency Coordination Center.

Strategy: Assess the current number and distribution of ventilators in Oregon.

Tasks include:

- Incorporate ventilator availability as part of statewide bed capacity monitoring tools to inform transport decisions.

Strategy: Procure additional ventilators.

Tasks include:

- Implement a centralized collection process to collect unused ventilators (i.e., from EMS providers or ASCs).
- Procure additional ventilators from federal Strategic National Stockpile (SNS), existing ventilator manufacturers or distributers.
- Work with Oregon businesses to explore applicable regulatory barriers to possible new local production and innovation.

Strategy: Respond to medical equipment and supply needs among hospitals, health systems and providers.

Tasks include:

- Secure additional COVID-19 specimen collection and testing kits as soon as possible.
- Develop a centralized process for hospitals and health systems to request and access needed medical supplies and equipment; broadly disseminate this information.
- Procure and distribute needed equipment and supplies through centralized mechanisms.
- Broadly distribute information about the statewide Pharmacy-Public Health Memorandum of Understanding (MOU) available through local public health authorities to access needed pharmaceuticals.

➢ *Current Status:* Regional hospitals have established mutual aid agreements to share equipment, workforce and transfer of patients.

Objective 2: Optimize hospital capacity to prepare for the expected surge of COVID-19 patients requiring hospital level of care, including the management of admissions and discharges, and the development of alternative health care delivery sites.

Strategy: Reduce unnecessary dispatch of EMS providers.

Tasks include:

- Develop improved public messaging on calling 911 for respiratory symptoms to include social media, public service announcements (PSAs) to reach diverse audiences.
- Develop and implement additional COVID-19-specific screening protocol at Public Service Answering Points (PSAP)-911.
- Implement medical triage and non-response triggers at PSAP to prevent unnecessary response from EMS providers.

Strategy: Divert patients to lower levels of care during EMS response.

Tasks include:

- Identify alternate destinations for patients that are triaged as low acuity.
- Expand the ability of EMS providers to medically screen patients and transport patients to lower levels of care at alternate destinations.

Strategy: Reduce the use of unnecessary emergency department and hospital services by augmenting telehealth services and primary care.

Tasks include:

- Disseminate recommendations for the use of telehealth services and home care, when appropriate, to avoid Emergency Department (ED) over-utilization and to reduce transmission of the coronavirus.
- Encourage innovative approaches to engaging the primary care workforce to ensure access to non-ED and hospital care when appropriate.

Strategy: Free hospital capacity through discharge of patients not requiring acute care and provision of care, as appropriate, in alternate settings.

Tasks include:

- Establish alternate care facilities for non-COVID patients discharged from the hospital who are candidates for long-term care facilities (LTCF) admission, but who need to complete a quarantine prior to LTCF admission.
- Develop and disseminate clear guidance for admissions to long-term care (LTC) facilities or home health services that includes indications for testing, isolation and PPE.
- Use home health agencies to maintain and expand the provision of skilled medical services in homes.
- Address any necessary licensing and credentialing barriers to support this strategy.

Strategy: Establish expanded care sites to free hospital beds (i.e., for step down care).

Tasks include:

- Provide support to regional HCC liaisons to identify closed or unoccupied facilities for conversion to alternate health care sites; develop a supply and staffing plan, and timeline for activation; prioritize patients who are ready for discharge from the hospital but face discharge/placement challenges.
- Develop and implement a plan to convert existing care sites (i.e., ambulatory surgical settings) that can be equipped to provide a higher level of care and offset capacity challenges for hospitals.
- Develop clinical criteria (i.e., acuity level), guidance and protocol for transitioning both COVID-19 and non-COVID-19 patients to alternate care sites. Include the anticipated timing and expected duration of stay for both COVID-19 positive and non-COVID-19 patients.

➢ *Current Status:* Oregon has submitted an 1135 waiver to the Center for Medicare and Medicaid Services (CMS) that waives many requirements that could impede development of alternate care sites (ACS). This includes waiving the 24-hour maximum stay limits for ASCs and allowing ambulance services to transport patients to alternate care sites. The Oregon Ambulatory Surgery Center Association is currently conducting a needs assessment of all ambulatory care centers in Oregon to assess potential for alternative use.

The Department of Human Services (DHS) has established an inventory of recently closed and unoccupied LTC facilities that may be appropriate for this purpose. LTC agencies are coordinating to develop an inventory of current unused bed capacity at existing facilities.

Oregon has deployed the Oregon Medical Station (OMS). The OMS is a temporary mobile facility dedicated for emergency use. It will provide an alternate site for 250 patients. Planning is underway to determine how this facility will be used for the COVID-19 surge.

Strategy: Establish statewide system for monitoring hospital bed status and implement regionalized bed management system.

Tasks include:

- Implement a system for real-time or regular assessment of statewide hospital bed and ventilator capacity.
- Implement a regional system for bed management and decision-making, building on the Regional Health Care Coalitions.

➢ *Current Status:* Oregon's hospital capacity web system (HOSCAP) is a platform in use for monitoring hospital bed availability statewide although it is inconsistently updated. Additional research is underway to identify opportunities to capture timely (i.e., more frequent or real-time) information.

Strategy: Ensure a ready system for emergent and non-emergent medical transportation (NEMT) to support patient movement across locations of care.

Tasks include:

- Develop necessary contracts with emergency medical transportation and NEMT providers.

Objective 3: Mobilize the necessary health care workforce to respond to the expected surge of COVID-19 patients.

Strategy: Expand workforce capacity.

Tasks include:

- Recruit health care workers through the State Emergency Registry of Volunteers in Oregon (SERV-OR); ensure that SERV-OR is an efficient process for providers to sign-up.
- Explore options for the state to hire or contract with health care workers.
- Work with licensing boards to explore flexibilities in mobilizing trainees and recent retirees.
- By working with boards, develop lists of clinicians, with contact information, by county. Share these lists with regional and county planners to aid in engaging ambulatory care clinicians in response efforts
- Explore and mobilize medical personnel available via the federal government.
- Mobilize non-medical workforce needed to provide wrap-around services for individuals impacted by COVID-19

Strategy: Augment the level of care currently available within hospitals or health care settings.

Tasks include:

- Expand the scope of practice for licensed providers and loosen requirements to permit the issuance of emergency licenses.
- Expand telehealth services and training to support existing providers (i.e., in smaller hospitals) to provide care to higher acuity of patients (i.e., ventilator management).

Strategy: Support the needs of the existing health care workforce, including behavioral health.

Tasks include:

- Provide childcare support for the essential health care workforce needed for the COVID-19 response.
- Explore the need to provide isolation housing for exposed or symptomatic health care providers to reduce the risk of disease transmission.

➢ *Current Status: Emergency Support Function (ESF) 6 Mass Care is currently in the planning stage of a childcare support operation.*

Strategy: Increase the number of non-medical support staff.

Tasks include:

- Recruit and mobilize non-medical staff for support services such as facility maintenance, food preparation and wraparound services at step-down levels of care.

Strategy: Support targeted economic recovery using acquisition and procurement authorities.

Tasks include:

- Identify opportunities to recruit workforce to support the health care surge response from industries and populations disproportionately affected by school and business closures.

Objective 4: Maintain coordination and transparency to ensure a unified COVID-19 emergency response across Oregon.

Strategy: Coordinate the implementation of the Action Plan with Regional Health Care Coalitions and other health care partners across the five Oregon regions.

Tasks include:

- Establish regular and efficient processes to coordinate emergency response with Regional Coalitions and health system partners in the implementation of the tasks within this Action Plan.

Next Steps

The Task Force input and accompanying Action Plan strategies in this interim report will immediately inform Oregon's unified emergency response to COVID-19; many of the tasks are already underway. The Joint Task Force will continue to serve a critical role to inform health care system's preparedness and response to the impending surge of patients affected by COVID-19.

Joint Taskforce Members

Name	***Organization***
Tina Edlund	Governor's Office
Charlie Tveit	Lake Health District
Patrick Luedtke	Lane County
Ashley Cottingham	Long-Term Care Ombudsman
Kamala Taylor-Cline	Multnomah County: Behavioral Health
Mimi McDonald	North Central Public Health Department
Becky Hultberg	Oregon Association of Hospitals and Health Systems
Normund Auzins	Oregon Dental Association
Lillia Teninty	Oregon Department of Human Services
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Larlene Dunsmuir	Oregon Nurses Association
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Shawn Baird	Oregon State Ambulance Association
Ken Provencher	Pacific Source
Lindsey Hopper	Pacific Source
Lisa Vance	Providence Health & Services
William Olson	Providence Health & Services
Jenn Baker	Service Employees International Union (SEIU)
Jeff Absalon	St. Charles Health System
Jen Vines	Tri-County Health Officer

Taskforce Staff: Oregon Health Authority - Akiko Saito, Amelia Reynolds, Megan Auclair and Jeremy Vandehey

Appendix A: Emergency Medical Services (EMS) Subgroup Summary

The EMS subgroup was charged to advise the Joint Task Force on matters of triage, treatment and transportation of patients during the current COVID-19 outbreak.

Summary

During the expected surge in COVID-19 cases, a shortage in health care providers is expected. The EMS subgroup is charged with developing strategies to address immediate EMS staffing needs during this crisis. The EMS subgroup prioritized discussions in four key themes: health care/capacity management, workforce, and personal protective equipment (PPE). The EMS subgroup focused their guidance in the following areas:

Health Care Operation/Capacity (Bed/EMS) Management

For EMS to respond to anticipated surges in health care need, the subgroup suggested providing upstream and equitable public education on respiratory illness and the use of 911. The subgroup sought improved public messaging regarding calling 911 for respiratory symptoms that will better reach diverse communities. The subgroup suggested social media and public service announcements with influential personalities. An immediate action step in developing such content was to provide the Emergency Coordination Center (ECC) with subject matter expertise to develop content.

To relieve capacity issues for both hospitals and emergency medical services during a surge, the state can use Public Safety Answering Points (PSAP) and the 911 system to assist in triaging cases. The subgroup sought to develop and implement additional COVID-19 screening protocols for PSAP systems that direct patients to most effective and efficient points of care and maximize limited resources. In addition to screening protocols, the subgroup suggested partnerships between PSAPs and health care systems to establish clinician advice lines. Based on the results of a PSAP screening tool, dispatchers can utilize a health system's clinician advice line for medical triage.

Another strategy to relieve capacity issues at hospitals would be allowing EMS to provide appropriate low-acuity care that avoids transport to emergency department. EMS could transport lower acuity patients to identified alternate destinations or provide or refer to home-based care. EMS providers would need reimbursement for treatment on scene with no transport and for transporting patients to non-emergent destinations when appropriate. OHA is filing a request for a Federal waiver to allow such reimbursement.

Workforce

The subgroup discussed strategies for protecting, maximizing and expanding the EMS workforce. With respect to protections, the subgroup suggested revising guidance for response protocols to limit exposure to COVID-19 by EMS providers. One such guidance could be to develop triggers for non-response to certain calls in accordance with the Oregon Crisis Care Guidance (CCG). When responding to high-risk patients, EMS providers should implement modified triage strategies.

Another strategy discussed was maximizing the scope of practice and staffing models for EMS. Such expansion of practice could alleviate strain at hospitals and other acute care facilities. The subgroup suggested developing triggers, protocols, and training for emergency medical technicians (EMT) to perform testing and vaccinations in accordance with strategies in the CCG. Another strategy would be to develop models of care allowing EMS providers to be supervised by non-EMS physicians.

Finally, the subgroup discussed increasing the overall capacity of the workforce. One strategy would be to adopt emergency administrative rules allowing temporary practice authorization for out-of-state EMS providers. Another would be using EMS students as additional workforce in hospitals and in clinics.

Personal Protective Equipment (PPE)

The subgroup discussed the unique dangers EMS providers face with respect to answering emergency calls and transporting those with respiratory illness symptoms. To protect and maintain the workforce, the subgroup looked to address personal protective equipment (PPE) shortage in EMS. The subgroup suggested ensuring adequate supply of PPE among first responders but especially for EMS personnel. The subgroup discussed the modified use/reuse of PPE, including the development of triggers for implementing modified PPE measures using CCG.

EMS Subgroup Participants

Name	***Organization***
Dr. John Moorhead	American College of Emergency Physicians
Katy King	American College of Emergency Physicians
Michael Lepin	Jefferson County Emergency Medical Services
Dr. Ritu Sahni	National Association of EMS Physicians
Dr. Erin Burnham	National Association of EMS Physicians
Dan Brattain	North West Association of Aeromedical Responders
Laura Chaffey	Office of the State Fire Marshall
Erin Williams	Oregon Department of Justice
Joe Raade	Oregon Fire Chiefs Association
Joe Schnabel	Oregon Pharmacy Board
Fiona Karbowicz	Oregon Pharmacy Board
Brianne Efremoff	Oregon Pharmacy Board
Shawn Baird	Oregon State Ambulance Association

Taskforce Staff: Oregon Health Authority - Dana Selover, Dr. David Lehrfeld, Lisa Krois

Appendix B: Hospital and Acute Care Facilities Subgroup Summary

The Hospital and Acute Care Facilities subgroup was charged to advise the Joint Task Force on matters relating to increasing hospital capacity to serve the expected surge of COVID-19 patients.

Summary

The subgroup advised that the state prioritize efforts in three areas to support the COVID-19 surge: bed management, workforce and personal protective equipment (PPE). In addition, data needs to support the three areas were discussed.

Bed Management

To manage the expected surge of patients with COVID-19 requiring hospital care, a statewide real-time bed management approach with regional operationalization is needed. This will require regional hospital and health care systems to coordinate their approach. To support this function, Oregon should establish a tool that can collect statewide, regular or real-time hospital bed data. The state could serve in a role of collecting bed capacity data and supporting regional governance such as through the state's HCC Regional Coalitions. This information can also inform the state and regions where additional bed capacity may be needed (i.e., through the implementation of alternate care sites).

The subgroup identified the following levels of care that will be part of the continuum to help manage the appropriate flow of individuals during the surge: (1) critical care, (2) hospital, (3) step-down, (4) long-term care, (5) quarantine, (6) social (i.e., shelter), (7) behavioral health residential and (8) home health. Of these, the subgroup prioritized long-term care and step down as the areas that could have the biggest impact on helping hospitals and health systems open their existing beds to prepare for the surge. Ambulatory surgical centers were identified as potentially serving as a step-down or alternate care site. The subgroup encouraged a continued statewide role in mobilizing resources for the social and quarantine type of care sites.

The subgroup recommended that the state assist with removing barriers to placing individuals ready for discharge in a long-term care facility. Many long-term care facilities have reduced or stopped admissions due concerns about potential COVID-19 infection and concerns about adequate workforce. The state could help by providing guidance that created more standardized admission practices into long-term care that could free up hospital in-patient beds.

The state could also create additional bed capacity for individuals with lower acuity that still require medical care but do not have to be at a hospital. The state can also help identify additional space (e.g., hotel rooms) to place individuals that need to be quarantined following infection or for those individuals in the hospital that cannot be released due to an inability to address social complexities.

The subgroup discussed data needs to further gauge needed action and degree of the actions above for hospitals and the health care system. The conversation sparked action on assessing discharge lists and bed capacity of hospitals to better understand bed and patient flow. The group discussed inventorying ventilators.

Workforce

Through the identification of additional care sites, the hospitals and acute care facilities subgroup discussed various workforce issues and barriers that will need to be addressed to ensure that newly expanded bed capacity is adequately staffed.

The subgroup discussed repurposing existing workforce from outpatient or other care settings that have furloughed their workforce. In addition, the subgroup identified other possible opportunities for workforce expansion including volunteers, retirees, nursing students and medical staff not trained to provide acute care.

The state could play a role in identifying a pool of workforce that could be redeployed to operate some of the additional care sites.

Finally, the subgroup identified opportunities to further expand telehealth and consultation opportunities between rural and urban providers. The subgroup encouraged support of rural communities to limit the number of transfers to urban hospitals since capacity is expected to be limited. The subgroup identified training needs of the expanded workforce to ensure their ability to provide adequate care in their redeployed role in supporting surge needs. Overall, the state can provide support to hospitals and health systems by removing licensing, credentialing, and billing or reimbursement requirements.

Personal Protective Equipment (PPE)

The subgroup encouraged clear communication and transparency around the state and regional approach to coordinate PPE resources. It was suggested that the state could be useful in developing a distribution strategy and tracking the PPE shortfall at the local level to inform the requests for and distribution of PPE supplies. Finally, it will be necessary for the state to identify additional opportunities for PPE production, develop re-use guidance for PPE, and coordinate ongoing communications with hospitals and health systems regarding needs for PPE and other medical equipment (i.e., hospital beds and other medical supplies).

Hospital and Acute Care Facilities Subgroup Participants

Name	***Organization***
Joyce Newmyer	Adventist Health
Ryan Grimm	Alberty Surgery Center
James Grebosky	Asante
Holly Nickerson	Asante
Eric Hunter	CareOregon
Liz Heckathorn	Deputy Emergency Medical Services
Dennis Burke	Good Shepherd Health Care System
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Courtni Dresser	Oregon Medical Association
Carla McKelvey	Oregon Medical Association
Larlene Dunsmuir	Oregon Nursing Association
Joan Watson-Patko	Oregon Primary Care Association
Danielle Sobel	Oregon Primary Care Association
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Lisa Vance	Providence Health & Services
Leah Mitchell	Salem Hospital

Doug Boysen	Samaritan Health Services
Meg Niemi	Service Employees International Union (SEIU 49)
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Harry Geller	St. Anthony Hospital
Jeff Absalon	St. Charles Health System

Taskforce Staff: Oregon Health Authority - Lori Coyner, Dana Hargunani, Trilby de Jung, Lisa Bui, Veronica Guerra

Appendix C: Long-Term Care and Vulnerable Populations (LTCVP) Subgroup Summary

This subgroup was convened to advise the Governor's Joint COVID-19 Task Force on matters of development, and appropriate use of needed non-hospital level of care treatment and settings options for the purpose of supporting hospitals during the COVID-19 crisis, including health care outreach for homeless individuals and other especially vulnerable populations, as well as COVID-19 management within correction facilities during the current outbreak.

Summary

The LTCVP subgroup focused on populations in need of skilled nursing or residential care, but not a hospital level of care. After consultation with the Department of Corrections (DOC) and local jail facilities indicating prisons and jails did not need additional supports at this time, the subgroup did not focus on COVID-19 management within correctional facilities. The group primarily focused on facilities/bed management to support hospitals through diversions and discharges of patients who do not require a hospital level of care. It became clear during the subgroup conversation that Personal Protective Equipment and workforce (themes similar to Hospitals and Health Care Systems) were critical.

Bed Management

There are several categories of patients that could be diverted or discharged from a hospital level of care and served in other facilities or housing options with specialized staffing. For all of these, the subgroup discussed quantifying the expected need, including how quickly patients can transition from each stage of care.

The subgroup had a primary focus on COVID-19 positive or pending patients who need skilled nursing care or a step-down level of care. The group discussed that Oregon Department of Human Services (DHS) has identified five former secure nursing facilities (SNFs) that were closed in 2018 – they should be short-listed for re-opening and could offer approximately 220 beds. Like the Hospitals subgroup, the LTCVP subgroup considered Ambulatory Surgery Centers (ASCs) as the second choice for facilities and should be explored in parallel with the former SNFs above. Regulations and requirements will need to be waived or modified for these facilities, including exploring provider risk and liability issues.

For COVID-19 negative or asymptomatic patients who need skilled nursing care, existing facilities have been requesting or requiring a two-week window to confirm these patients are truly asymptomatic / COVID-19 negative before admitting to their facilities. However, as testing sensitivity increases and turnaround time for test results decreases, a two-week window is not necessary. The subgroup discussed the need for new protocols or state direction to clarify when this population is safe to admit into existing facilities without a two-week quarantine period; no new/separate facilities are needed for this population. While these protocols offer promise in decreasing hospital transition times, it became clear that "COVID-19 negative or asymptomatic" facility capacity also needs immediate development to support current hospital needs. In addition to reducing risk of virus spread, separating patients by COVID-19 status helps reduce the need for PPE for single individuals.

For COVID-19 negative or asymptomatic patients who are "difficult to place" (e.g., behavioral health conditions, unhoused, justice involved) and for COVID-19 positive or pending patients who are "difficult to place" (e.g., behavioral health conditions, unhoused, justice involved), the group suggested a secondary phase of planning in order to properly place those individuals. However, the group did have some

conversations for this population who may require a lower level of care through wraparound services or visiting providers.

Workforce

One question raised was who will run new COVID-dedicated facilities? Current facility administrators do not have capacity to stand up and run the new facilities. Certified Nursing Assistants (CNAs) are another component of the workforce the subgroup anticipated would be difficult to fill. Subgroup participants suggested attracting workers to work in COVID-19 facilities may require "hazard pay" in the range of 1.5x standard pay. The subgroup acknowledged that PPE will be essential for all facilities but particularly important for the COVID-19-positive facilities. The group also considered the use of telehealth to expand reach of the workforce – the State's 1135 waiver should include flexibilities for telemedicine, reimbursement guidelines and other regulatory requirements for facilities. The subgroup discussed the transitions for patients between levels of care: the length of stay at each level of care will inform overall capacity and staffing needs.

Personal Protective Equipment (PPE)

The subgroup discussed the idea of a directive for all facilities to begin extended use of Personal Protective Equipment (PPE). Facilities currently calculate a burn rate of up to 50 masks/gowns per patient per day, although this could be modified to 30-35 per patient per day under extended-use guidelines.

Long-Term Care & Vulnerable Populations Subgroup Participants

Name	***Organization***
Allison Sandall	Salem Health
Brad Litle	Avamere
Carl Tabor	Avamere
Roxy Stennett	Avamere
Eric Hunter	CareOregon
Ev Armitage	Central City Concern
Rachel Solotaroff	Central City Concern
Captain Lee Eby	Clackamas County Jail
David Allm	Department of Human Services
Jeanne Bristol	Department of Human Services
Sarah Odell	Governor's Office
Cheryl Miller	Home Care Commission
Marc Jolin	Joint Office of Homeless Services
Ruth Gulyas	LeadingAge Oregon
Ashley Cottingham	Long-Term Care Ombuds Office
Fred Steele	Long-Term Care Ombuds Office
Ebony Clarke	Multnomah County
Mike McCormick	Oregon Department of Human Services
Nancy Karatzas	Oregon Department of Human Services
Sarah Odell	Oregon Department of Human Services
Whitney Hill	Oregon Department of Justice
Judy Guzman	Oregon Health & Science University
Maya Lopez	Oregon Health & Science University
Nicole Cirino	Oregon Health & Science University
Lori Kelley	Oregon Health Authority
Rebecca Pierce	Oregon Health Authority

Gwen Dayton	Oregon Health Care Association
Linda Kirschbaum	Oregon Health Care Association
Phil Bentley	Oregon Health Care Association
Andrea Bell	Oregon Housing and Community Services
Kenny LaPoint	Oregon Housing and Community Services
Dan Bristow	Oregon Psychiatric Physicians Association
Patrick Sieng	Oregon Psychiatric Physicians Association
Sheriff Jason Myers	Oregon State Sheriff's Association
Rex Emery	Oregon Youth Authority
Ken Provencher	PacificSource
Deborah Adams	Partners in Care
Clara Ruiz	Providence
Allison Woitall	Salem Health
Melissa Unger	Service Employees International Union (SEIU 503)

Taskforce Staff: Steve Allen, Dana Hittle, Chris Pascual, Sarah Bartelmann, Sarah Wetherson, Berk Nelsen, Jordan Wiley, Marc Overbeck

Appendix D: Oregon's Regional Health Security Preparedness and Response Program Map

Note: Regions 3,5 and 6,9 work collaboratively. Due to historical factors there are no 4 and 8 regions.