SETTING UP AND STARTING AN ALTERNATE CARE FACILITY

GALLUP ALTERNATE CARE FACILITY TEAM

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Alternate Care Site – Considerations

- **PARTNERSHIPS**
- **TEAMWORK**

Region II COVID-19 Response Quicklook Report 28 April 2020

Extracts

Planning Assumptions and Fallout

Three primary planning assumptions were made for the planning and allocation of resources.

1. Due to the uncertainty about the rate at which the virus would spread, States planned and requested support with the worst-case scenarios in mind.
2. FEMA would fulfill these State-led decisions for requested resources as best they could.
3. All initial requests for federal assistance to meet anticipated patient surge were predicated upon a State-identified goal of decompressing the non-COVID patients from hospital populations in order to free up hospital resources for the anticipated surge of COVID patients.

Identification, Build-Out and Equipping of Alternate Care Facilities

Federal support for State ACFs has been implemented in two conceptual categories:

Category 1) Renovation and equipping of remote Standalone facilities by USACE utilizing a military FMS model, hereinafter “Standalone ACF” (for example, convention centers, cruise terminals, sports stadiums); and

Category 2) Renovation or new construction within or adjacent to a State licensed hospital i.e.: reopening/repurposing closed wings or construction of tented facilities to create supplemental beds in parking lots etc., hereinafter “hospital Satellite ACF”.

It is incumbent upon States to identify identification of supervisory responsibility for patient administrative infrastructure and overall clinical supervision at each ACF prior to or in conjunction with any request for federally-source staff to support that facility.

Staffing of Alternate Care Facilities Assumptions

1. The ACFs would be non-COVID patient care sites

2. The State would take full operational control and ultimately staff the facilities either with State supplied personnel or State contracted support

Recommendations for Future ACF Planning

- ACFs built as expansions of or adjacent to existing hospitals are the most viable option for either COVID or non-COVID patient populations.

- States should identify in-state certified medical practitioners who either have specialties not actively engaged in COVID response or are geographically separated from the hardest-hit areas of the state. These personnel can then be administered by the State DOH and assigned to work within the ACFs. This will not only lessen the need to staff ACFs with personnel pulled from local hospitals, but will also ease the transition once DoD assets are redeployed or recalled.
  - *New Mexico Medical Reserve Corps*
  - *New Mexico Work Force Solutions*

Alternate Care Site Team Mission and Intent

30 March 2020

- **Mission**

Identify and synchronize Alternate Care Facilities (ACF) in order to expand local Health Care System (HCS) for anticipated surge of COVID-19 as a critical component of the Regional Surge Planning WG / Medical Advisory Team (MAT).

- **Intent**

All healthcare is local. The COVID-19 virus drives our timeline to be ready; we will proactively respond/adapt. Our ACS Team will proactively and quickly plan and synchronize the establishment of alternative care sites as a critical component of the local HCS to the COVID-19 pandemic. Anticipation; simple, focused planning; coordination within our Regional Surge Planning WG, within the MAT, and with state agencies and departments; and respectful coordination with local HCS are keys to mission success.

ACS Team Facts and Assumptions

30 March 2020

Fact- COVID-19 drives our timeline to be ready; we respond/adapt.

Assumptions

- In the short term—starting today, for the next 30-90 days—the overall well-being of all New Mexicans depends on our healthcare response to the COVID-19 pandemic. Thus, it also depends on our ACS Team response.
- COVID-19 cases will peak in late April- early May
- Demand (patient care required) will exceed Supply (Workforce; Equipment; Supply; Evacuation; etc).
- Workforce and/or PPE will be the rate-limiting asset in total number of ACF beds our State can make available
- The state will not receive assistance through Federal Medical Station (FMS)

ACS Team Guiding Principles

30 March 2020

Guiding Principles

1. Coordination/collaboration of local hospitals to achieve unity of effort as a single Health Care System is the most efficient and effective way to care for our patients

2. Current hospitals are best positioned to expand/surge Intensive Care Units and medical ward capacity as part of the single HCS

3. ACF will complement and integrate into the local HCS - Coordinate with local HCS to validate role and purpose of local ACF

4. ACF will only be utilized for COVID-19 patients

5. ACF primary purpose is to create and expand minimal care bed capacity to serve:

    a. COVID-19 patients too sick to be at home and need minimal care

    b. COVID-19 patients transferred from hospital requiring additional care

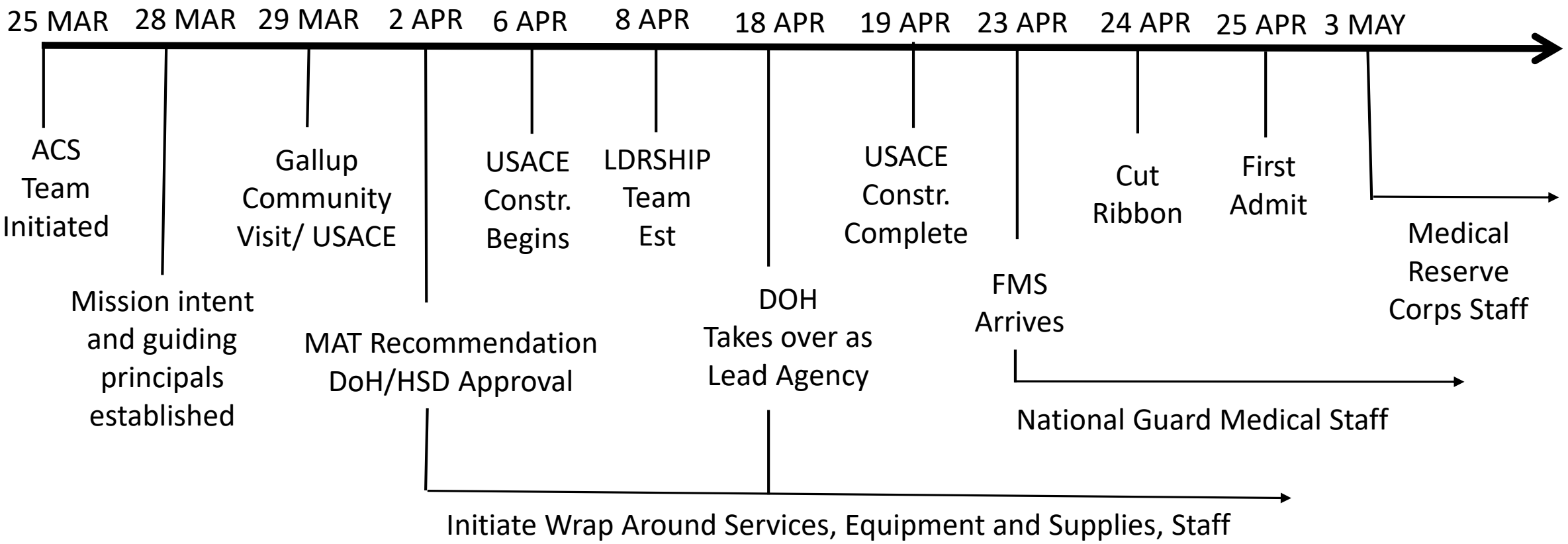
6. Available health care facilities with oxygen infrastructure, such as shuttered hospitals and nursing homes, are easier and faster to convert to ACF

7. Anticipate geography of COVID-19 spread

ACF Admission Criteria

- Patient requires O2 and home O2 not available or not appropriate.
- Patient requires admission to hospital setting AND can safely be cared for within the scope of its Local Health Care System ACF.
  - Comorbid conditions
  - Condition at presentation
- Patient no longer requires hospital ICU or Med Ward level of care AND can safely receive “step down” care within the scope of the LHCS ACF.
  - Comorbid conditions
  - Condition at time of transfer

Gallup Alternative Care Facility (ACF) Timeline



Wrap Around Services

- O2
- Laundry
- Food
- Housekeeping
- Security
- IT
- Medical Waste
- Non-Medical Waste
- Pharmacy
- Lab Services
- Transportation
- Mortuary Services

FROM HERE

TO HERE

LESSONS LEARNED 1

- Team Logistics & Procurement
  - Nurses and Doctors bring very different and very valuable perspectives, opinions and needs
  - Infection Control input is critical
- Setting up a hospital requires a team
  - A team needs food, space, communication technology (phones, internet, conference lines)
  - Having an incident command org structure is helpful

LESSONS LEARNED 2

- Scope of care feeds logistics, procurement, staffing, safety, etc.
- Scope of care determines drills and rehearsals
  - Seek to learn from the gaps
  - Be familiar with processes, space, guidelines
  - Learn donning and doffing
  - Be safe

LESSONS LEARNED 3

EVERYTHING IS FLUID & CHANGES EVERYDAY

You are working with a small group of people to do amazing things

REQUIREMENTS

- Patience
- Forgiveness
- Listening
- Celebrate small victories
- Have meetings

KISS

- Don't aim for perfection
- Accept that we will have to figure some things out as we go along
- Seek solutions
- Staff is your limiting factor
- Learn

LESSONS LEARNED 4

- Very few comprehend how fast you have to move
- Not everyone wants to help – move on
- People will be people
- Take care of your people
- You will upset at least some one
- there are ways around a bureaucracy in a crisis
- If you don't ask, you won't get
- Seek solutions
- Ask for and listen to advice
- Thank everyone

LESSONS LEARNED 5
HINDSIGHT IS … 2020

- Would you do it again (set up ACS)?
  - Maybe!
  - If we didn't have:
    - Hotels for homeless and people who do not meet admission criteria
    - Access to ICU beds in Albuquerque
    - Then NO
- If I had to do it again?
  - Extend capacity of both hospitals
  - Add ICU beds
  - Add Med/Surg beds
  - ADD nursing staff & providers (National guard, MRC, volunteers, local talent etc.)

CLINICAL LESSONS LEARNED

- 49 y/o male with no comorbidities admitted in the evening and decompensated at 2am and had to be transferred back to the sending facility on NRB.
  - Only spent one day at the sending hospital and had done well on 2lpm of O2
  - Initial labs revealed elevated acute phase reactants, but never repeated
  - Pt had symptoms for about one week prior to coming to ACF

CLINICAL LESSONS LEARNED

- 51 y/o female with several days of symptoms. Lived independently with her husband, independent with all ADL's. Was hospitalized for 2 days prior to transfer to ACF.
  - Pt did not have PT evaluation prior to transfer.
  - Pt also had diarrhea that was not reported to ACF
  - Once Pt arrived at ACF, she required a 2-3 person assist to get to the bathroom and back

UPDATED ADMISSION CRITERIA

- Must be ambulatory by P.T. evaluation
- Patient is independent in all ADL's
- Must have "clinical trajectory" of improvement
- Patient requires no labs or radiology studies
- Must be able to maintain sats on O2 of less than or equal to 4 lpm

LESSONS LEARNED COLLABORATION

- Different hospitals have very different systems
- Different systems create different problems
- Different problems require different solutions
- A common goal can overcome
- There is little that a determined group committed to a common goal can't accomplish!