Partners in Emergency Preparedness Conference

UW MEDICINE COVID-19 RESPONSE

April 3, 2024

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Agenda

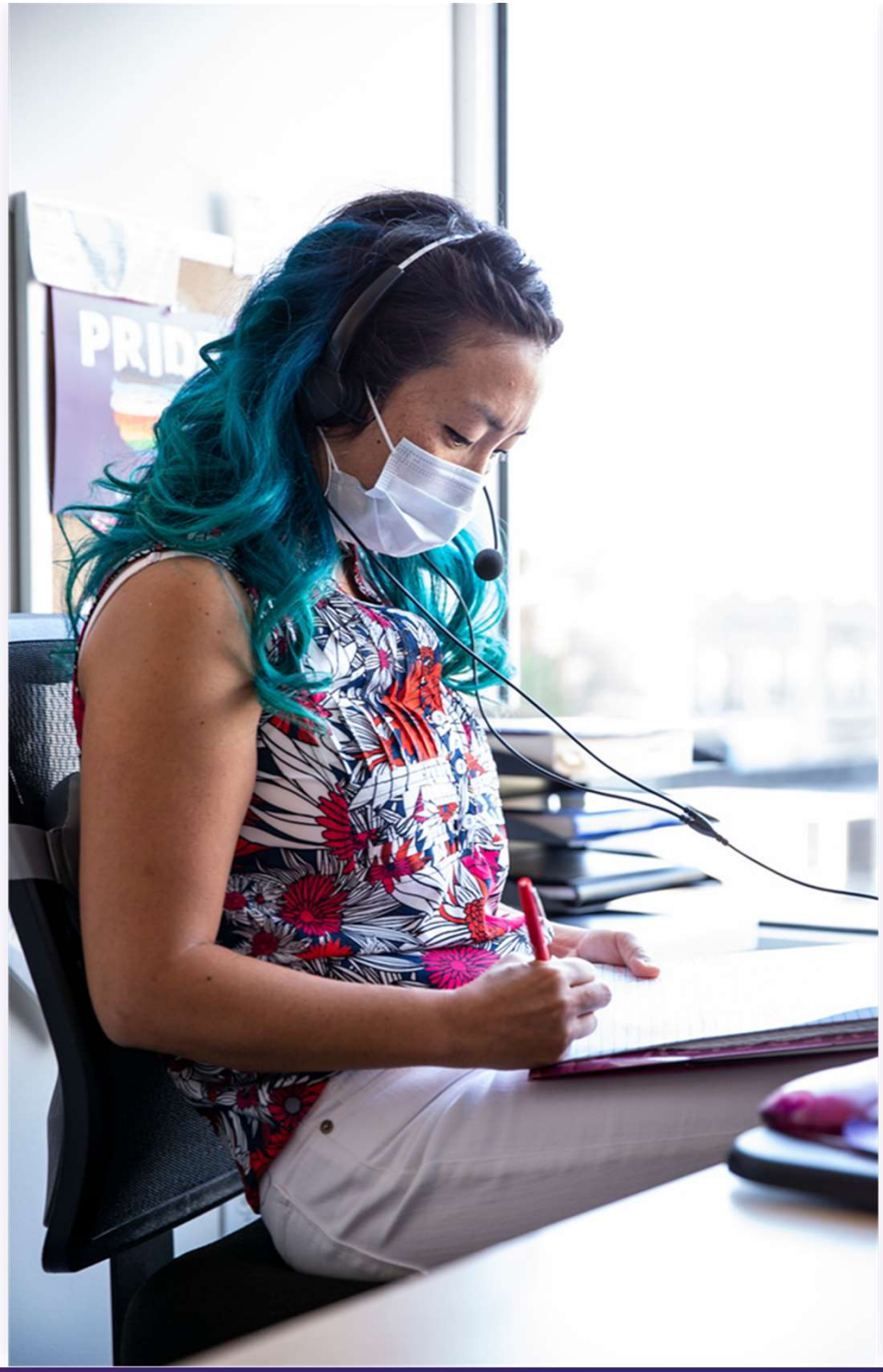
Things we **ARE NOT** covering today:

- Clinical Protocols
- Surge planning
- Mobile Teams
- Post Acute Care Support
- Crisis Standards of Care Planning
- Staff Exposure/ I&Q Management
- Fit Testing
- Contact Tracing
- Virology development and testing
- Testing site management
- Vaccination site development and management
- WMCC development
- Staff Wellness and Support Programming
- Cost tracking and FEMA reimbursement process

Agenda

Things we **ARE** covering today:

- ICS in healthcare
- Integrating IMT into a healthcare system
- Resource Requesting
- Collaboration with Community Partners
- Donation Management
- Innovations Team
- Reporting
- Policy Management
- Supply Chain Management
- Volunteer Management
- Lessons Learned
- Demobilization and Recovery Actions



COVID-19

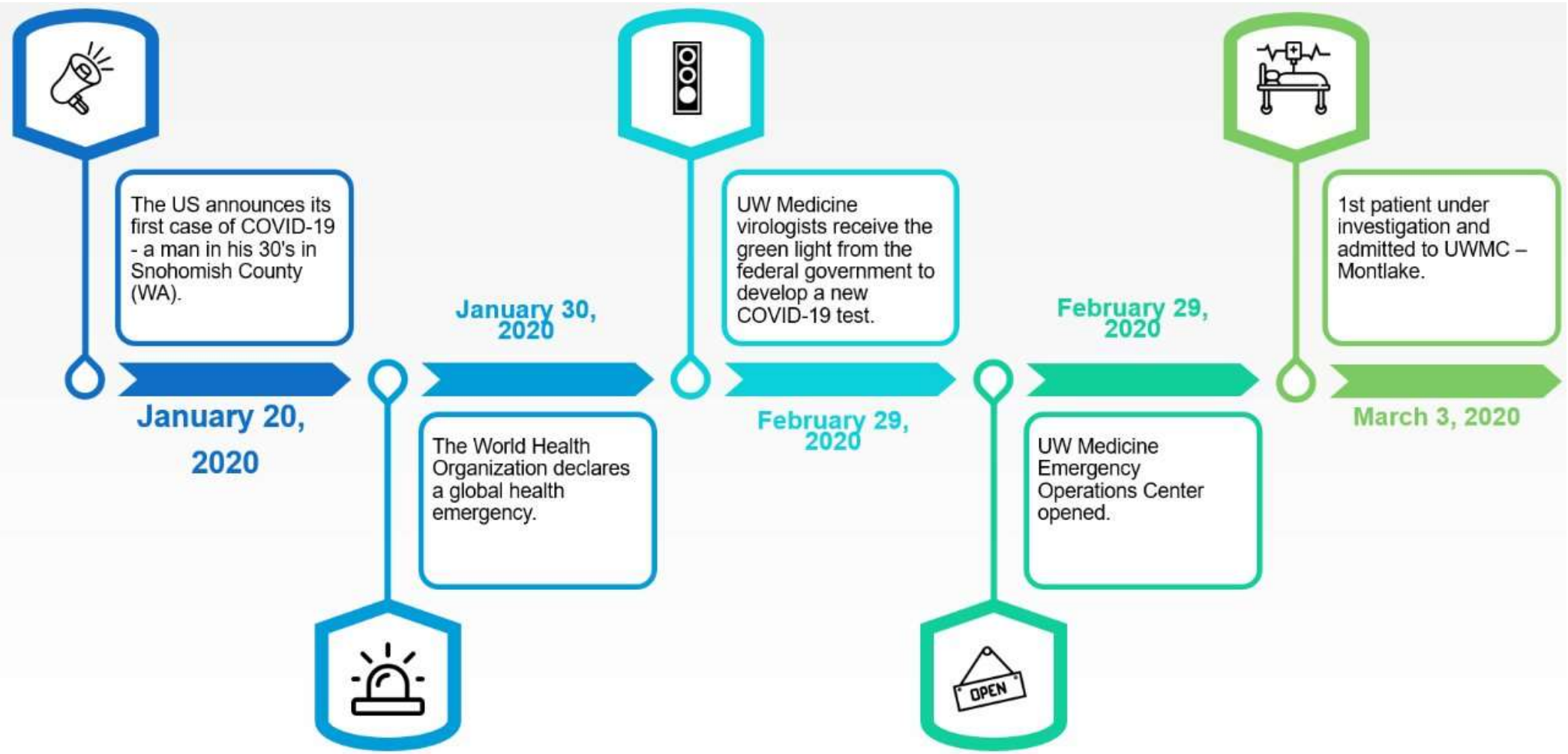
United Nations | UN News
Global perspective Human stories

EN SEARCH

AUDIO HUB SUBSCRIBE

The virus that shut down the world: 2020, a year like no other

Event Timeline



EOC Actions

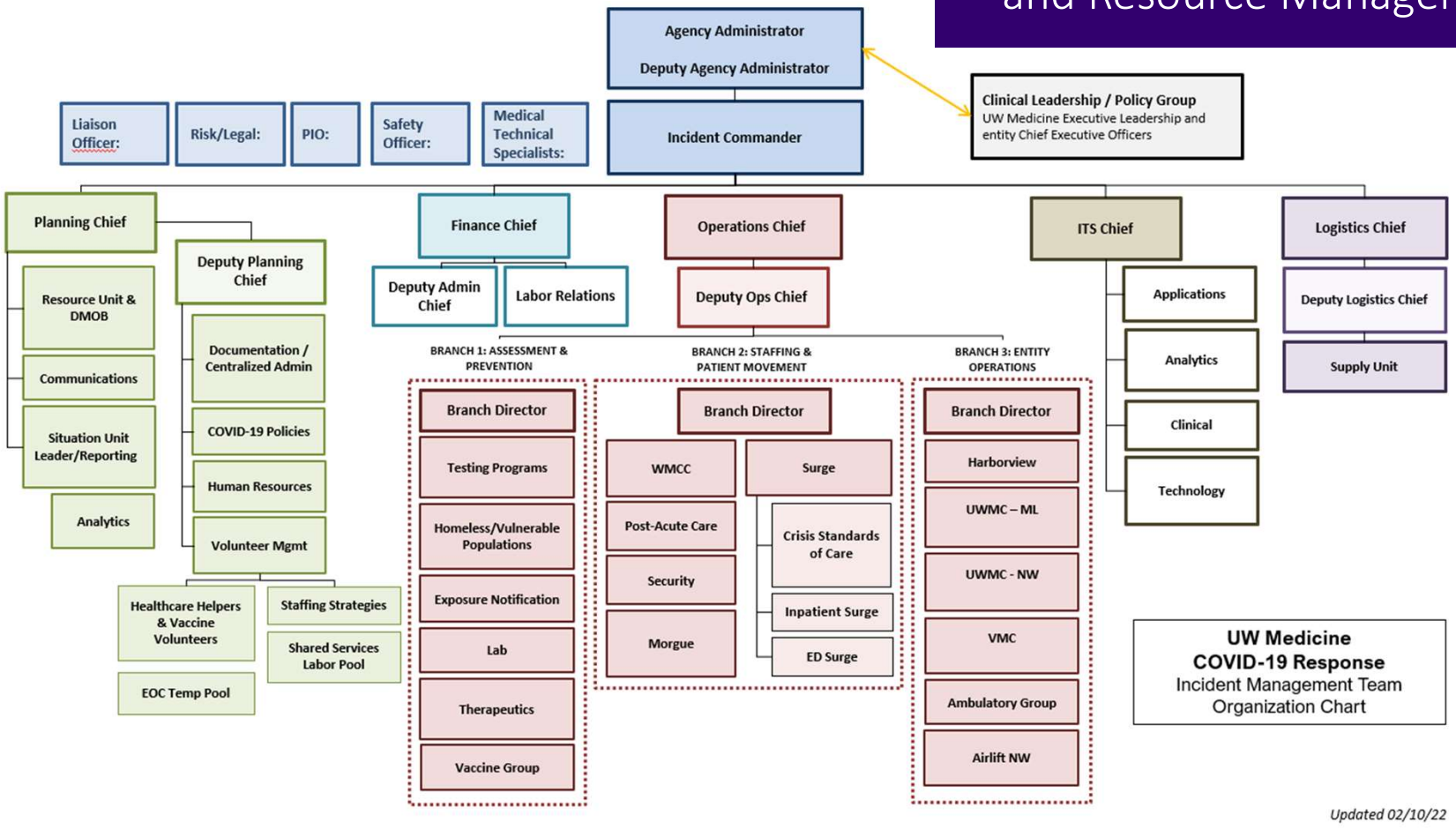
UW Medicine Activated February 29, 2020

- Established planning cycle and staffed 3-deep in Command and General staff roles
- Started in a hospital based EOC
  - Within one week, expanded the EOC into existing large space owned by UW Academics
- Drafted Goals and Objectives and Situation Status Report templates
- Created generic EOC emails to support continuity in shift changes
- Implemented cost tracking processes
- Provided ICS training to all shifts March 8, 2020
- Launched public facing website to publish/share all clinical protocols and policies, to help other healthcare organizations

The Incident Command System in Healthcare

- NOT emergency managers
- Organized similarly to General Staff
- Operations run 24/7
- Focused on Patient Care, Staff Safety and Resource Management

Healthcare Leaders are:



IMT Deployment

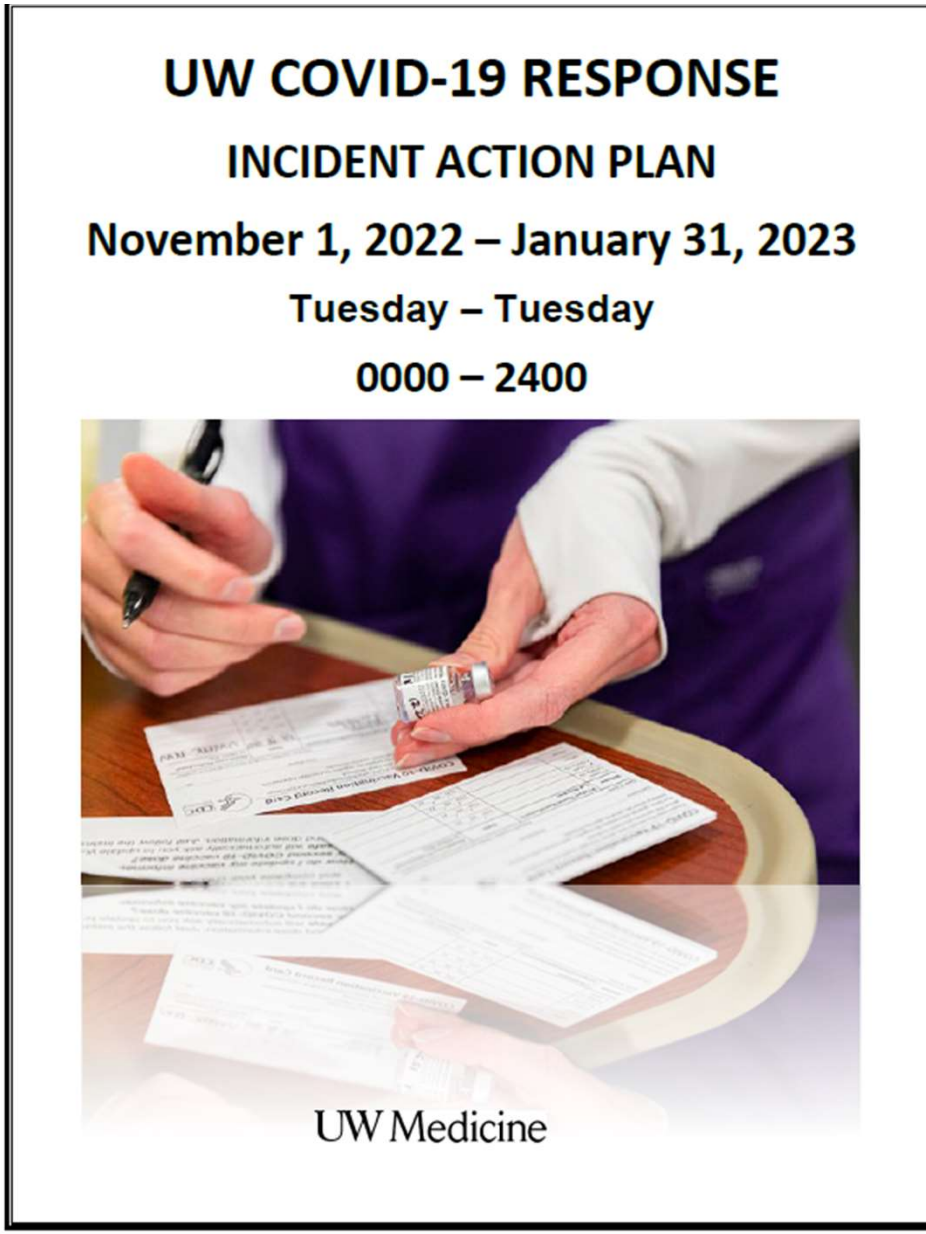
Engaged assistance from an Incident Management Team early in response

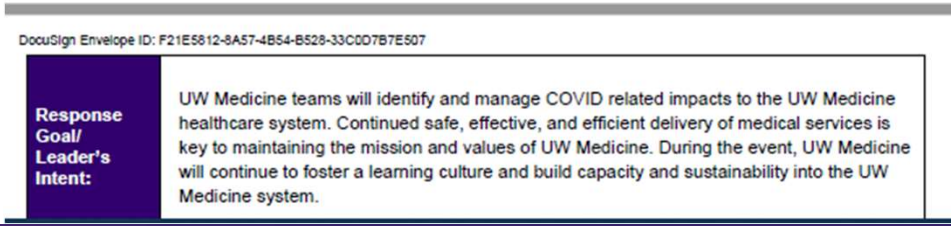
- Invaluable in assisting with building a flexible structure that interfaced well with existing healthcare operations
- Provided expertise in organizing our response processes and documentation
- Filled roles in Emergency Operations Center to improve situational awareness

Value of an IMT

Expertise to adjust the structure to the needs of the incident

- Developed robust IAP template and trained UW Medicine team to planning section roles
- Brought continuity to Safety Officer's roles, visibility and participation
- Improved situational awareness by becoming liaison officers for UW Medicine and integrating into the larger response structure
- Assisted with development of linking activation levels to operational periods and actions
- Drove the development of the demobilization and reactivation plan

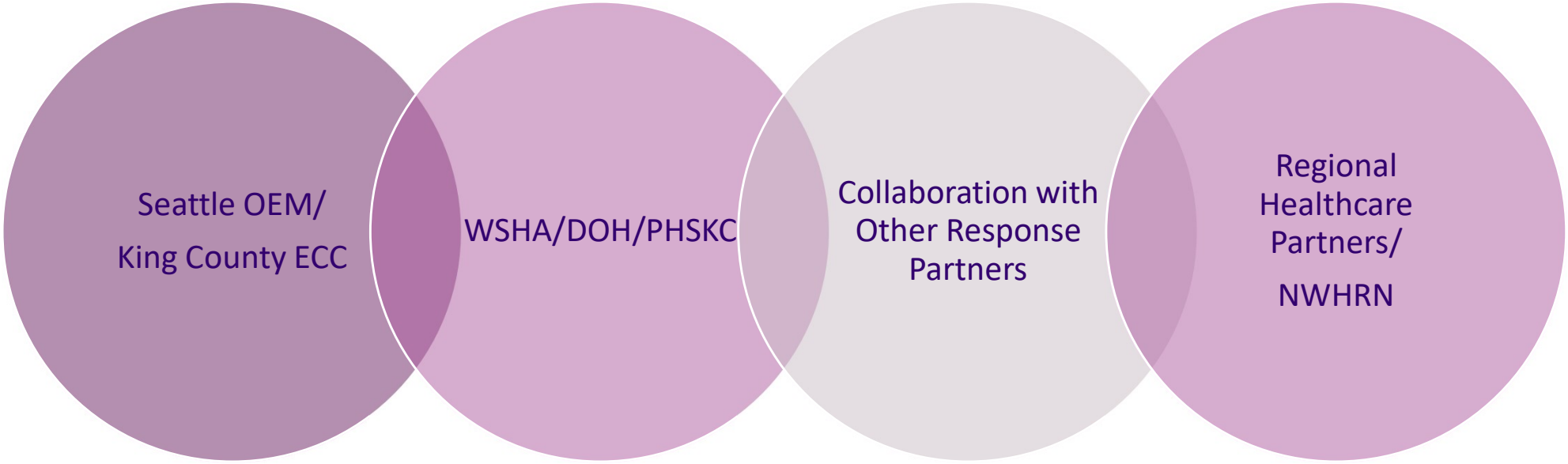




Levels of Activation

UW MEDICINE LEVELS OF ACTIVATION: Triggers and Indicators to Move Through Phases							Current Status: 09/27/2021
EOC Level of Activation	State Phases Roadmap to Recovery Metrics:	Washington State Coronavirus Response (COVID-19)	King County COVID-19 Rate (#/100/14 Days)	COVID Admissions	Census	Staffing	PPE Availability	Phase Definition
High	Phase 1	>175	COVID Patients >12%	95% full to set up beds by total and/or by type of bed across the system for >10 days and approaching 90% full in surge areas for 4+ days	Crisis staffing ratios	Supply shortages occurring Contingency or crisis for use of PPE	**Altered and Crisis Capacity** - Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care. Agency is level loading and leveraging surge plans. Need for additional ICS support.
Mid-High	Phase 2	150 to 174 **159.0**	COVID Patients >10%	95% full to set up beds by total and/or by type of bed across the system for 10+ days	Contingency staffing ratios	Contingency use on PPE due to policy or supply shortages, or both	**Contingency Capacity** - The spaces, staff and supplies used are not consistent with daily practices but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). Agency is level loading and leveraging surge plans due to COVID-19. Need for additional ICS support.
Mid	Phase 2	100 - 149	COVID Patients <10%	95% full to set up beds by total and/or by type of bed across the system for 8+ days **95.2%** (AVG 97.3 over 30 days)	Contingency staffing ratios	Some changes in use to contingency Supply shortages anticipated	**Contingency Capacity** - The spaces, staff and supplies used are not consistent with daily practices but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). Agency is level loading and leveraging surge plans due to COVID-19. Need for additional ICS support.
Low-Mid	Phase 2	50 to 74	COVID Patients <7.5% **6.77%**	95% full to set up beds by total and/or by type of bed across the system for 6+ days	Conventional staffing ratios	Some changes in use to contingency Supply shortages anticipated	**Conventional/Contingency** – This is a transitional period wherein the agency is moving from Conventional to Contingency. Some areas may still be reporting contingency, but operations are moving towards Conventional. Agency is not in surge or level loading due to COVID-19; Agency has multiple operational groups requiring support and command/control.
Low	Phase 3	0 to 49	COVID Patients <5%	95% full to set up beds by total and/or by type of bed across the system for 6+ days	Conventional staffing ratios	No anticipated shortages No change in policy regarding PPE usage	**Conventional Capacity** - the spaces, staff and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. Agency may have a need for ICS support in identified areas.
Monitoring	Open	0 to 49	COVID Patients <5%	95% full to set up beds by total and/or by type of bed across the system for 6+ days	Conventional staffing ratios	No anticipated shortages No change in policy regarding PPE usage	**Conventional Capacity** - the spaces, staff and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. Agency may have a need for ICS support in identified areas.

Collaboration with Community Partners

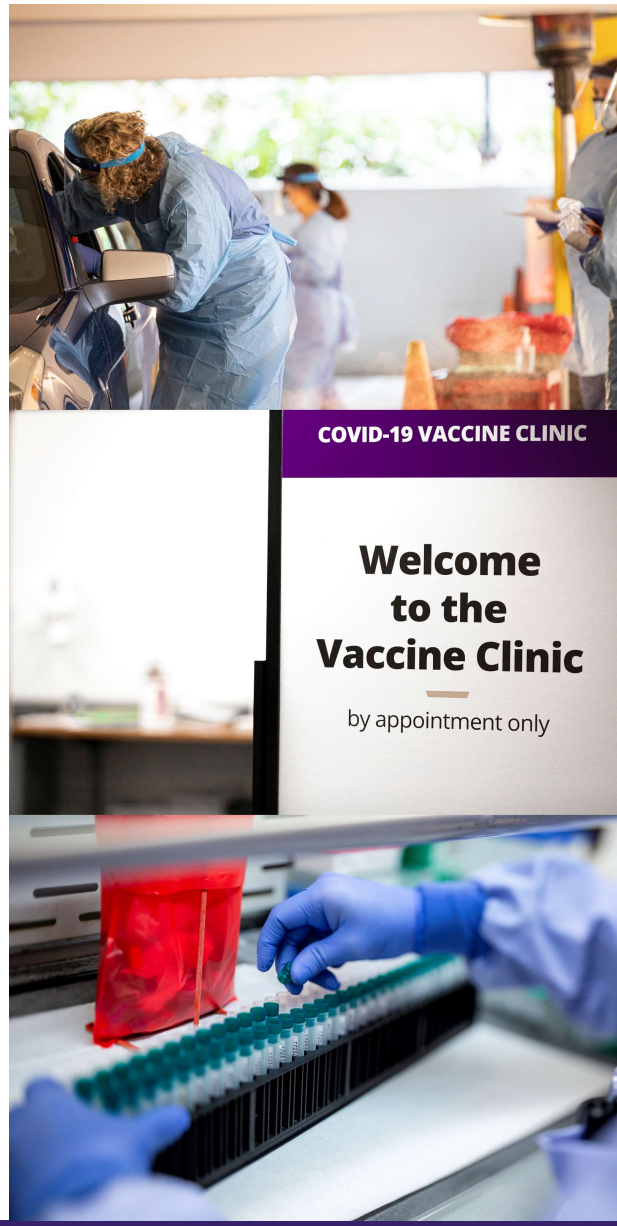


Collaboration with Community Partners

COORDINATION WITH PHSKC

SHELTER AT HARBORVIEW HALL

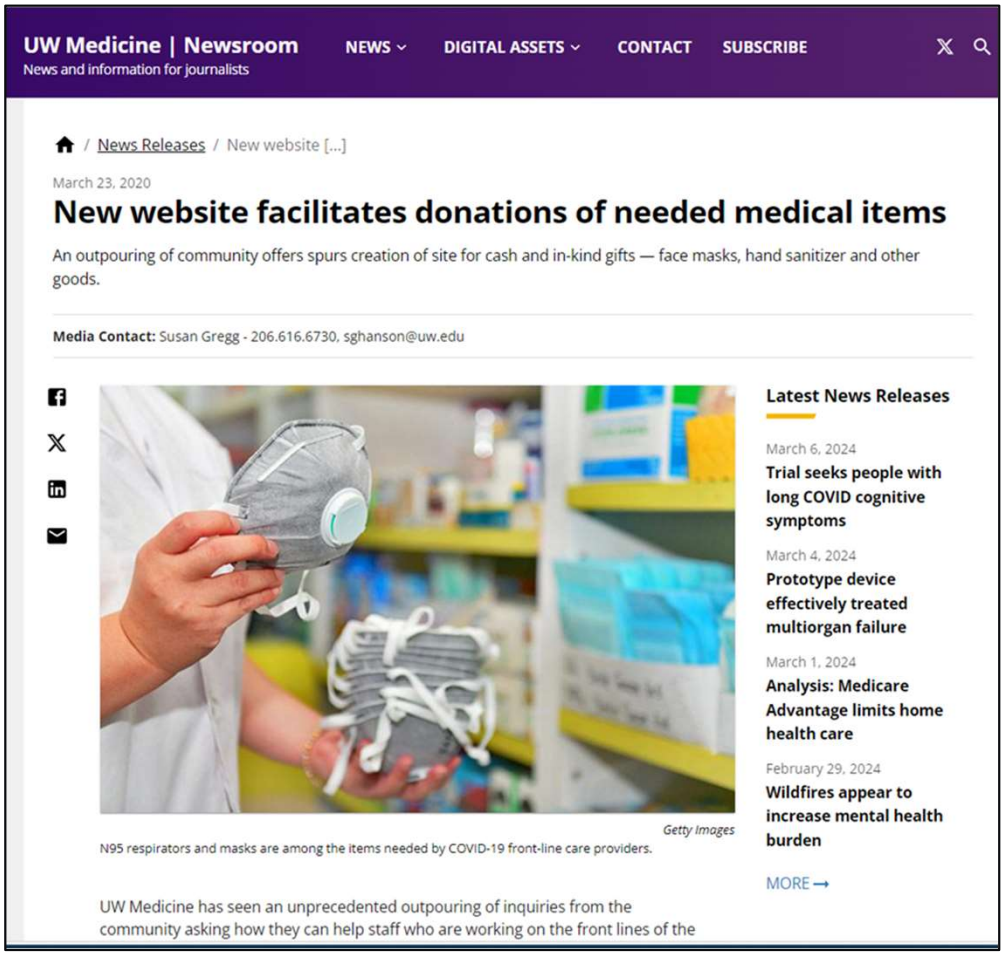
PARTICIPANT IN SEATTLE OEM DMC MEETINGS



Donations Management

Received over 1.6M items in first two months

- Donations flooded to the front doors of hospitals early & quickly
- Borrowed Donation Management Plan from Elenka Jarolimeck, City of Seattle OEM
- Stood up donation site within 2 weeks of initial activation; also established a website to direct people how/where to donate
- UW Medicine Advancement led the effort and partnered with UW Facilities, Surplus and EH&S



UW Medicine | Newsroom
News and information for journalists

NEWS DIGITAL ASSETS CONTACT SUBSCRIBE

/ News Releases / New website [...]

March 23, 2020

New website facilitates donations of needed medical items

An outpouring of community offers spurs creation of site for cash and in-kind gifts — face masks, hand sanitizer and other goods.

Media Contact: Susan Gregg - 206.616.6730, sghanson@uw.edu

Getty Images

N95 respirators and masks are among the items needed by COVID-19 front-line care providers.

UW Medicine has seen an unprecedented outpouring of inquiries from the community asking how they can help staff who are working on the front lines of the

Latest News Releases

March 6, 2024
Trial seeks people with long COVID cognitive symptoms

March 4, 2024
Prototype device effectively treated multiorgan failure

March 1, 2024
Analysis: Medicare Advantage limits home health care

February 29, 2024
Wildfires appear to increase mental health burden

MORE →

Donations Management

Donation Guidelines Established December 2020

- Shifted to large-scale donations of specific PPE, such as medical grade gloves
- Created a kudos board to share words of encouragements and support for healthcare workers
- Items not within UW Medicine approved items were distributed to other organizations, including Long Term Care, Childcare Providers and other Healthcare Organizations
- Food/meals for healthcare workers had to be pre-arranged and screened by Advancement
- Gift cards were not accepted due to financial reporting requirements and tax rules
- Equity across units/departments was considered in distribution of gifts for our teams
- Technological gifts were evaluated and approved by IT Services and Infection Prevention

Resource Requesting

Made first resource request March 4, 2020 for PPE

- Calculated normal usage by anticipated burn rate with new infection prevention masking policies/increased demand

Staffing requests

- Clinical
- Non-clinical

WASHINGTON STATE HEALTHCARE MULTI-AGENCY COORDINATING GROUP

The purpose of this document is to provide information on contracted staffing costs for medical facilities. The cost structure for staffing includes five different components of cost, each contribute to the total staffing cost.

FTE Cost per hour - Base hourly rate per FTE, rate differs based on position expertise and training. This expense does not include any travel or lodging costs. Overtime is calculated at 1.5 x base hourly rate.

Airfare – Economy roundtrip airfare to and from the assigned location, this is a one-time cost per FTE.

Rental car – Daily rate per car rental. Cost can be spilt among four FTEs when sharing a rental car.

Per Diem – Washington State daily per diem rate per FTE for meals and incidental expenses.

Lodging – Daily rate for lodging accommodations per FTE.

Overview of costs per FTE

FTE Cost (range)	Airfare	Rental Car	Per Diem	Lodging
$43.20 - $450.00/hour	1,200.00	$75.00/day	$71.00/day	$116.00/day

Sample Costs

Sample breakdowns of cost by position are detailed below, these breakdowns include a select few positions.

Base Staff Costs

Staff Rates			One-time Cost
Position	Hourly Rate	Overtime Rate	Airfare
Registered Nurse	$225.00	$337.50	$1,200.00
Charge Nurse	$243.00	$364.50	$1,200.00
CNA	$81.00	$121.50	$1,200.00
Housekeeping	$45.00	$67.50	$1,200.00
Laundry Staff	$45.00	$67.50	$1,200.00
Kitchen staff (Cooks, meal prep)	$45.00	$67.50	$1,200.00

Resource Requesting

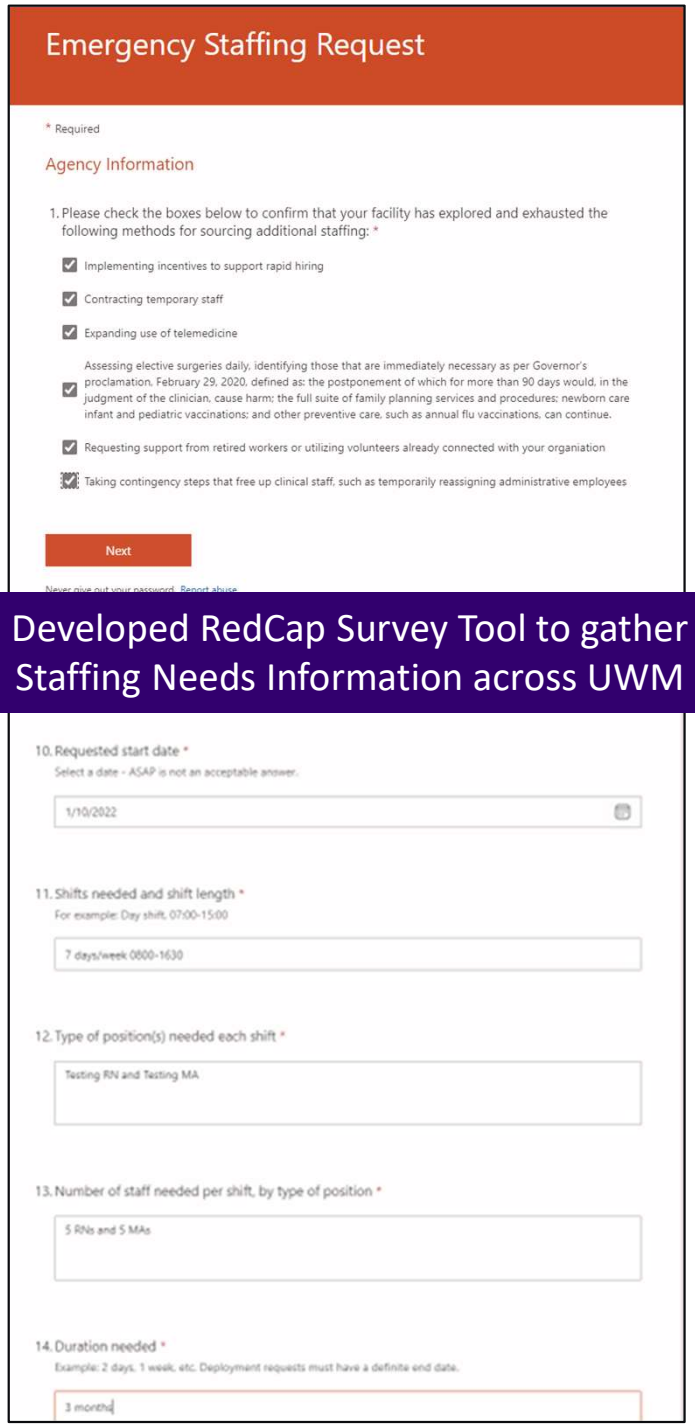
Clinical Staffing Requests

- Must exhaust all normal staffing channels
- Gather situational awareness for all staffing needs
- New DOH process was implemented that facilitated access to additional staff through a GSA contract.
- GSA contract required that hospitals paid upfront and would then qualify for FEMA reimbursement at 100% if staff only worked with COVID patients
- Complicated staffing practices to verify they were only working with COVID related patients

Resource Requesting

Non-Clinical Staffing Requests

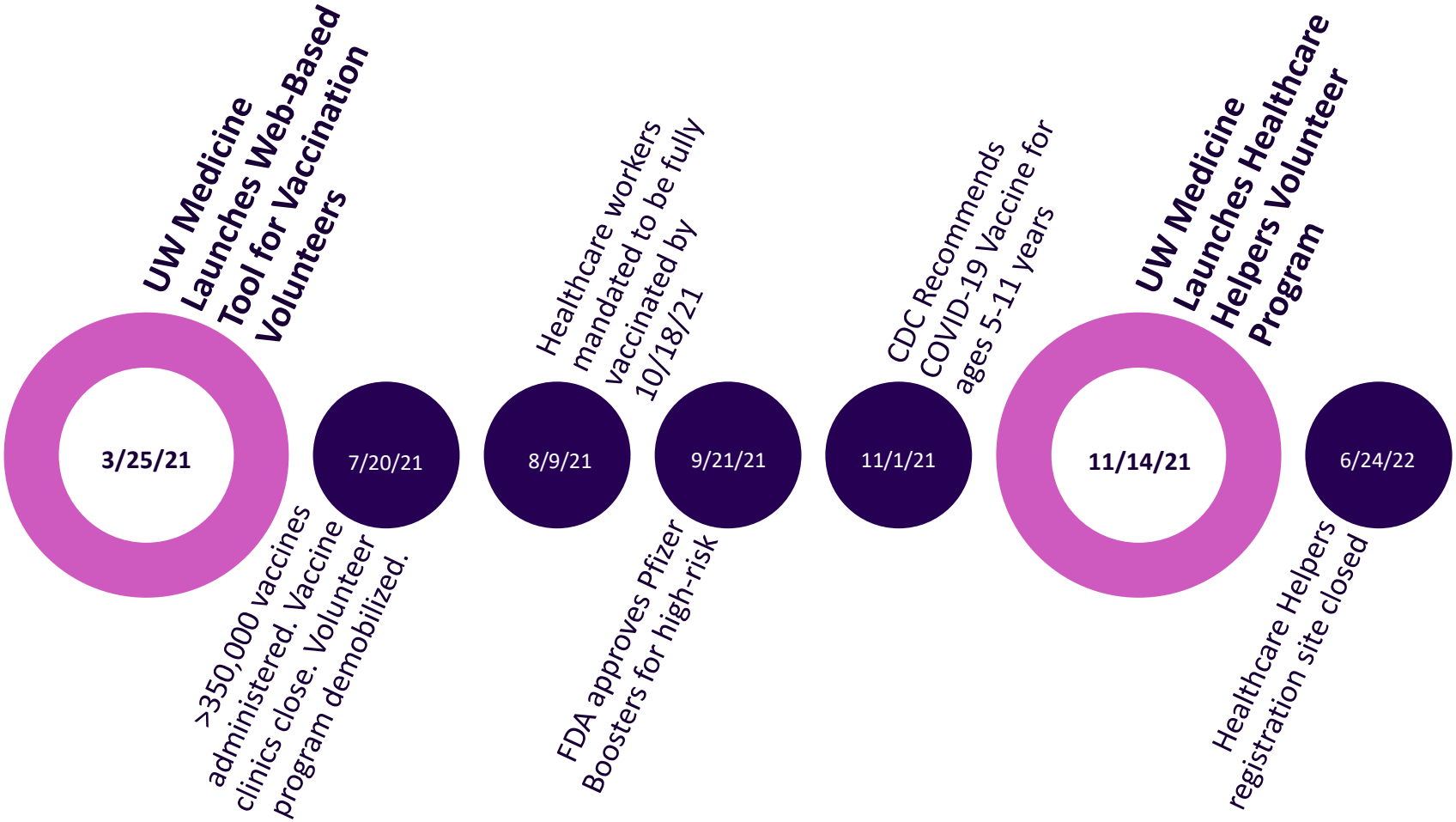
- Must exhaust all normal staffing channels
- Gather situational awareness for all staffing needs
- Request sent to King Co ECC
  - List of registered volunteers assigned
  - Shift availability was inconsistent



Developed RedCap Survey Tool to gather Staffing Needs Information across UWM

Volunteer Management

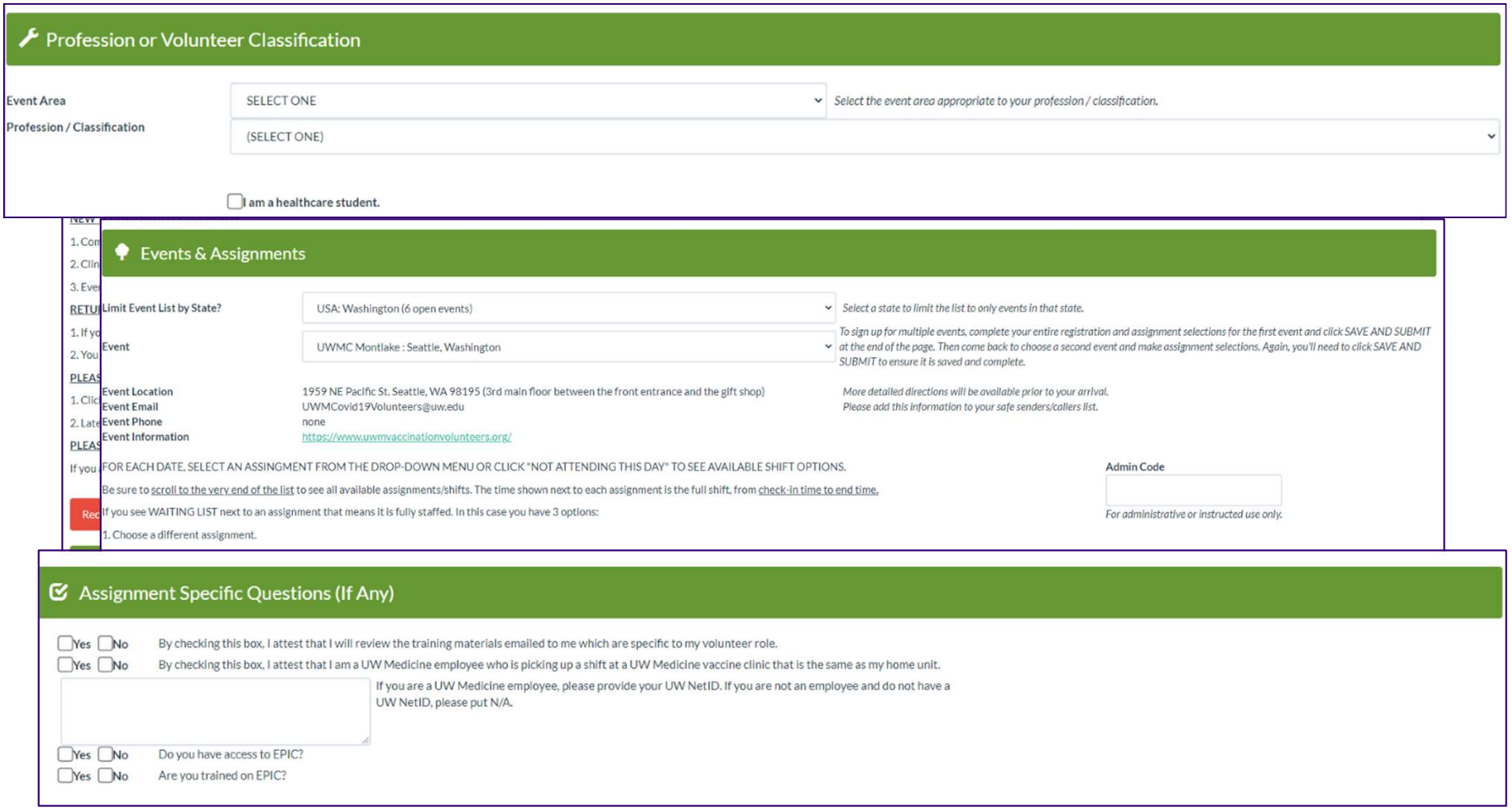
Volunteer Management



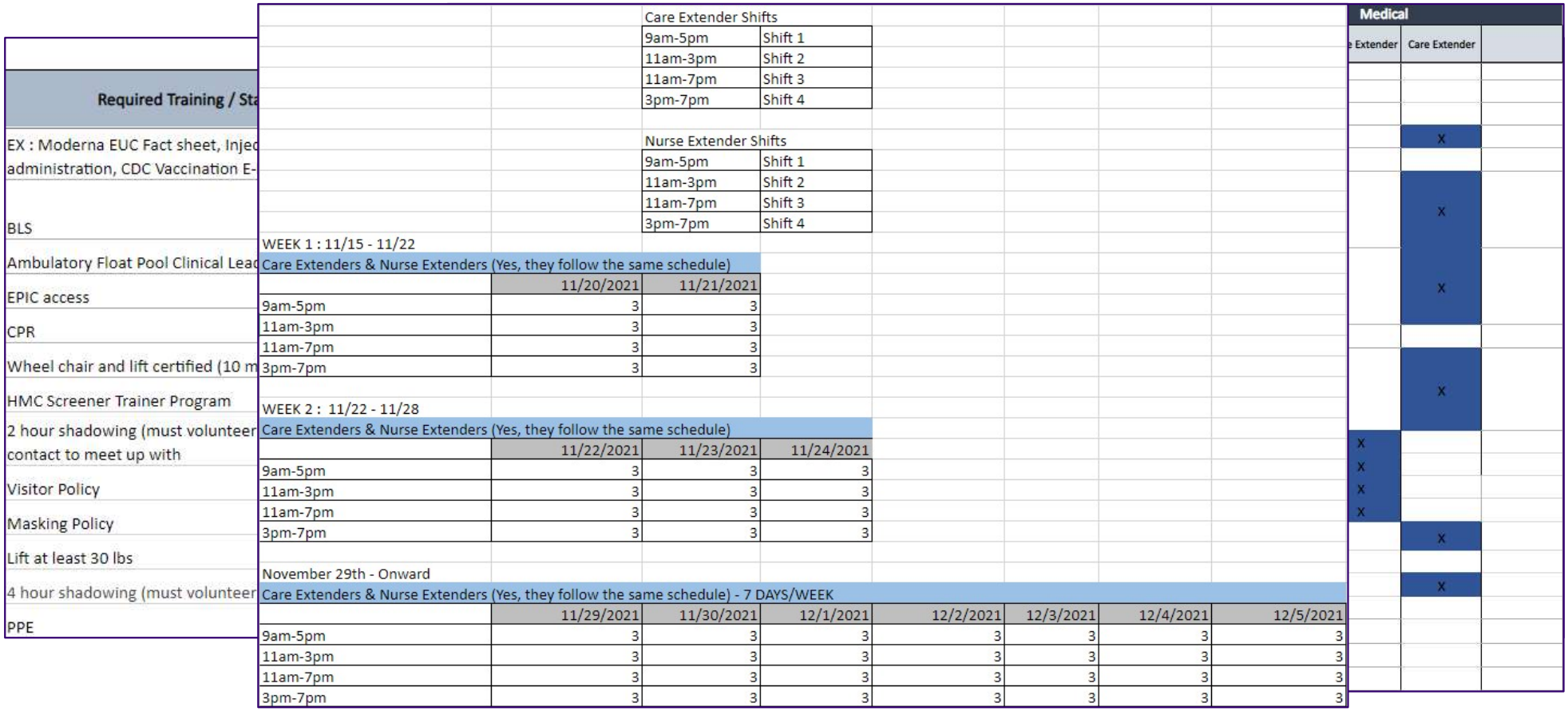
Volunteer Management

- Stood up a volunteer program to help staff vaccine clinics at Harborview, UWMC- ML, and UWMC-NW.
- Contracted with The Spark Team to create a volunteer registration site that would allow us to register, track, verify, schedule, and communicate with volunteers from the community and from within UW Medicine.
- Created workflows and add on tools to ensure the platform met the needs of vaccination sites.
- Worked with HR to verify volunteers were licensed, background checked, and not floating across campus.
- Volunteer roles included: Vaccinators and Way Finders/Traffic Control

Volunteer Registration Website



Volunteer Registration Website



Required Training / Sta
EX : Moderna EUC Fact sheet, Injec administration, CDC Vaccination E-
BLS
Ambulatory Float Pool Clinical Lead
EPIC access
CPR
Wheel chair and lift certified (10 m
HMC Screener Trainer Program
2 hour shadowing (must volunteer contact to meet up with
Visitor Policy
Masking Policy
Lift at least 30 lbs
4 hour shadowing (must volunteer
PPE

Care Extender Shifts	
9am-5pm	Shift 1
11am-3pm	Shift 2
11am-7pm	Shift 3
3pm-7pm	Shift 4

Nurse Extender Shifts	
9am-5pm	Shift 1
11am-3pm	Shift 2
11am-7pm	Shift 3
3pm-7pm	Shift 4

WEEK 1 : 11/15 - 11/22

Care Extenders & Nurse Extenders (Yes, they follow the same schedule)

	11/20/2021	11/21/2021
9am-5pm	3	3
11am-3pm	3	3
11am-7pm	3	3
3pm-7pm	3	3

WEEK 2 : 11/22 - 11/28

Care Extenders & Nurse Extenders (Yes, they follow the same schedule)

	11/22/2021	11/23/2021	11/24/2021
9am-5pm	3	3	3
11am-3pm	3	3	3
11am-7pm	3	3	3
3pm-7pm	3	3	3

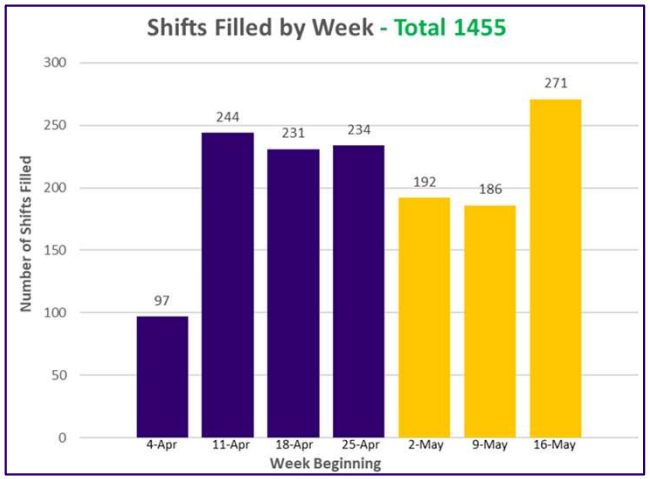
November 29th - Onward

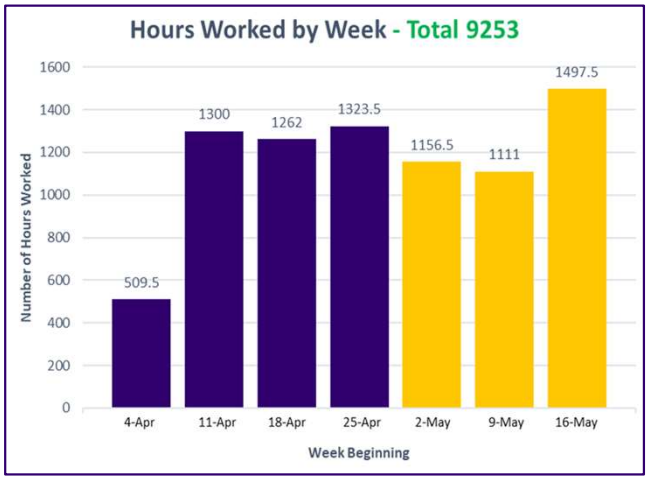
Care Extenders & Nurse Extenders (Yes, they follow the same schedule) - 7 DAYS/WEEK

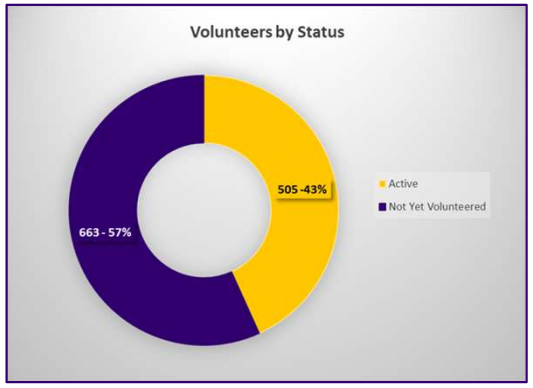
	11/29/2021	11/30/2021	12/1/2021	12/2/2021	12/3/2021	12/4/2021	12/5/2021
9am-5pm	3	3	3	3	3	3	3
11am-3pm	3	3	3	3	3	3	3
11am-7pm	3	3	3	3	3	3	3
3pm-7pm	3	3	3	3	3	3	3

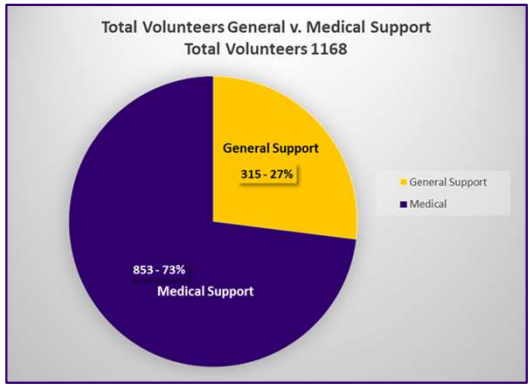
Medical		
e Extender	Care Extender	
	X	
	X	
	X	
	X	
X		
X		
X		
X		
	X	
	X	

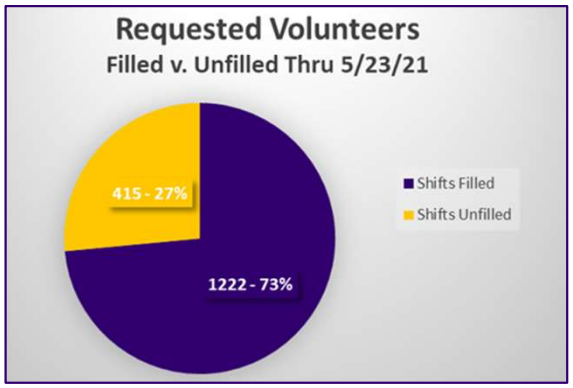
Vaccination Volunteer Data











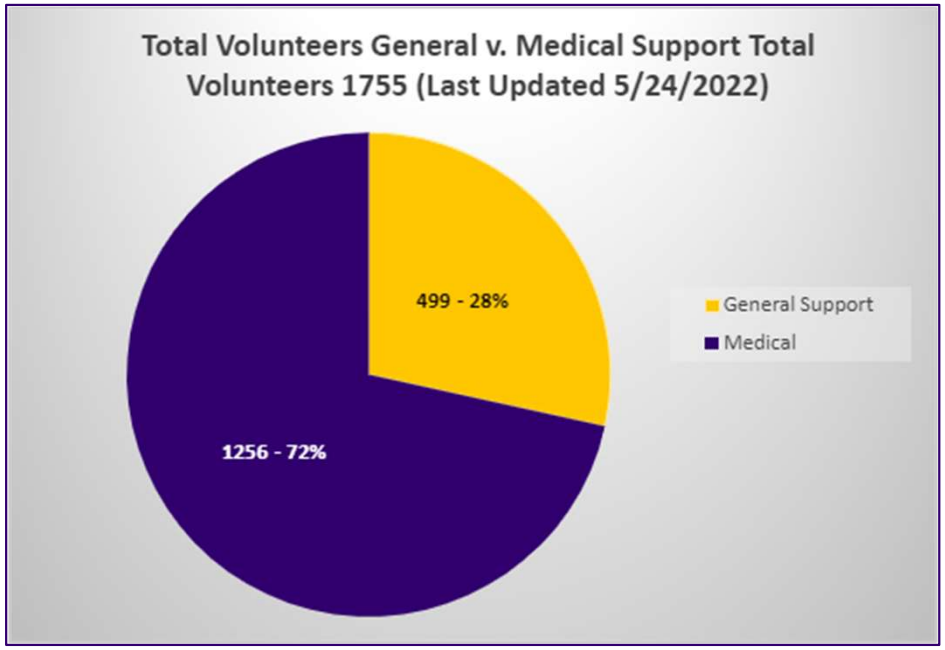
Healthcare Helpers

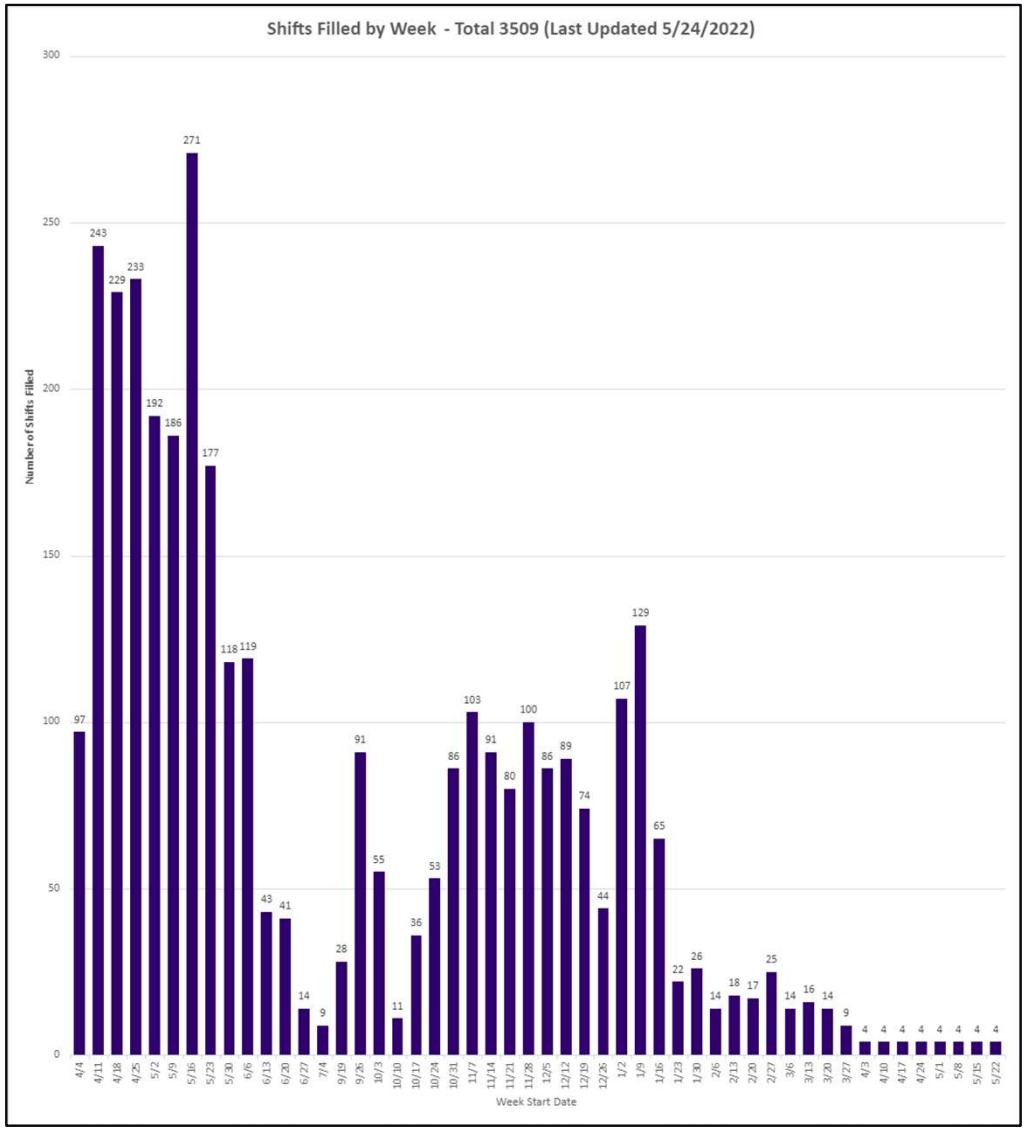
Healthcare Helpers provided volunteers for Harborview, UWMC-ML, and UWMC-NW

Volunteer roles included:

- ✓ Entry Screeners
- ✓ Supply Chain Medical Store Support
- ✓ Patient Transporters
- ✓ Unit Support
- ✓ Care Extenders
- ✓ Outpatient Support
- ✓ Medical Assistants
- ✓ Nurse Extenders

Overall Volunteer Data





A Culture of Innovation

Implementing Virtual Operations

Cultural shifts allowed for efficient remote work environment

- Formed centralized administration team that supported all EOC operations
- Initially consisted of administrative & executive assistants and program operations volunteers
- Added fixed-term duration employees, a new position hire, project managers

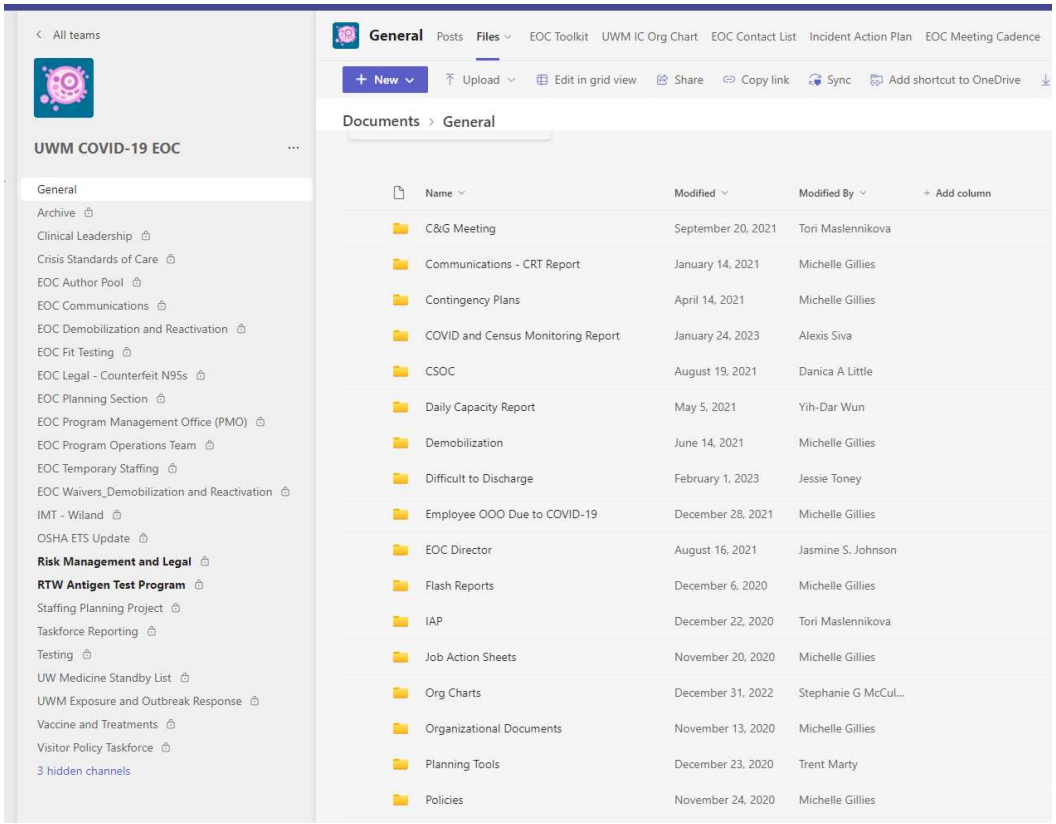
Created a Virtual EOC "on the fly"

- Developed tools and workflows
- Re-assigned staff & rotating shifts (7-day coverage per week) maintaining 3 deep in Command and General Staff positions
- Onboarding and offboarding of EOC resources
- Records Retention
- Prioritization of workstations (IT supply chain challenges)

Implementing Virtual Operations

Leveraged Teams and SharePoint as our virtual tool for coordination among teams

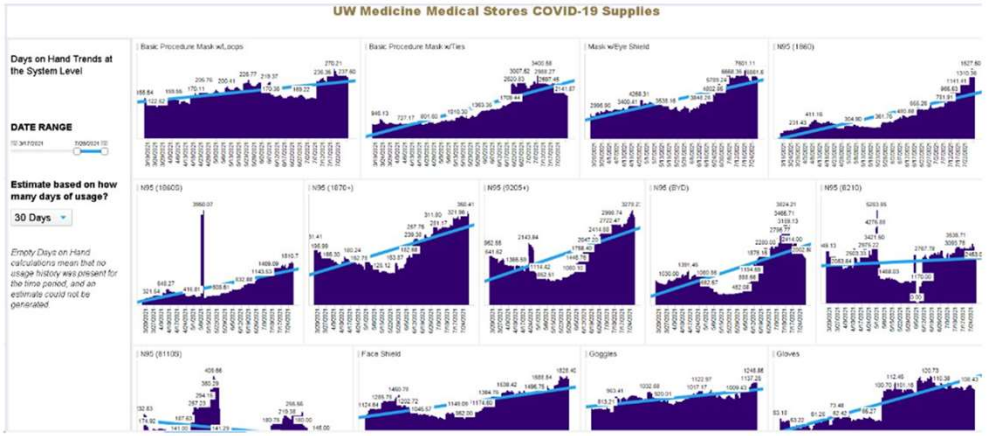
- Formed centralized administration team that supported all EOC operations
- Initially consisted of administrative/executive assistants and program operations team members who were reassigned to the response
- Added fixed-term duration employees, a new position hire, and project managers



Supply Chain Management

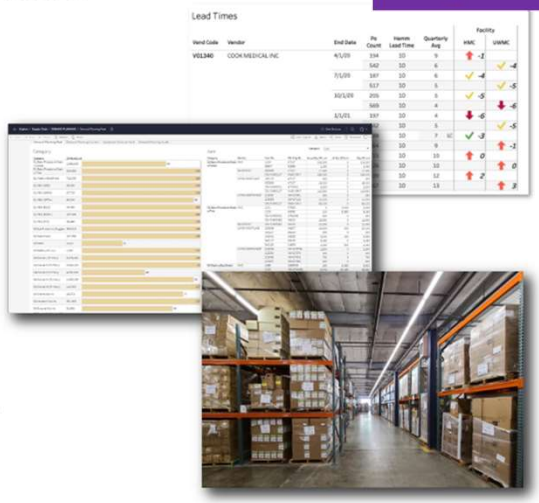
- Established ICS structure for departmental operations
- Created COVID Dashboards
- Implemented Supply Chain mitigation tactics

COVID Supplies Dashboard



UW Medicine Supply Chain Mitigation Tactics

- Improved internal reporting (Tableau dashboards) on projected inventory shortages
- Increased coordination with key manufactures and distributors (BD, Smiths, Teleflex, Baxter, Molyncke, 3M)
- Improved coordination between purchasing, inventory control, and key clinical partners for substitutions and alternative products
- Additional inventory storage (Sandpoint Warehouse) to provide a backstop for many constrained products; currently stocking over 750 unique items worth $10.6M; our team pulls daily from this inventory to support our hospitals/clinics



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UW Medicine SUPPLY CHAIN

Innovations Team

Officially stood up March 30, 2020 to March 17, 2021

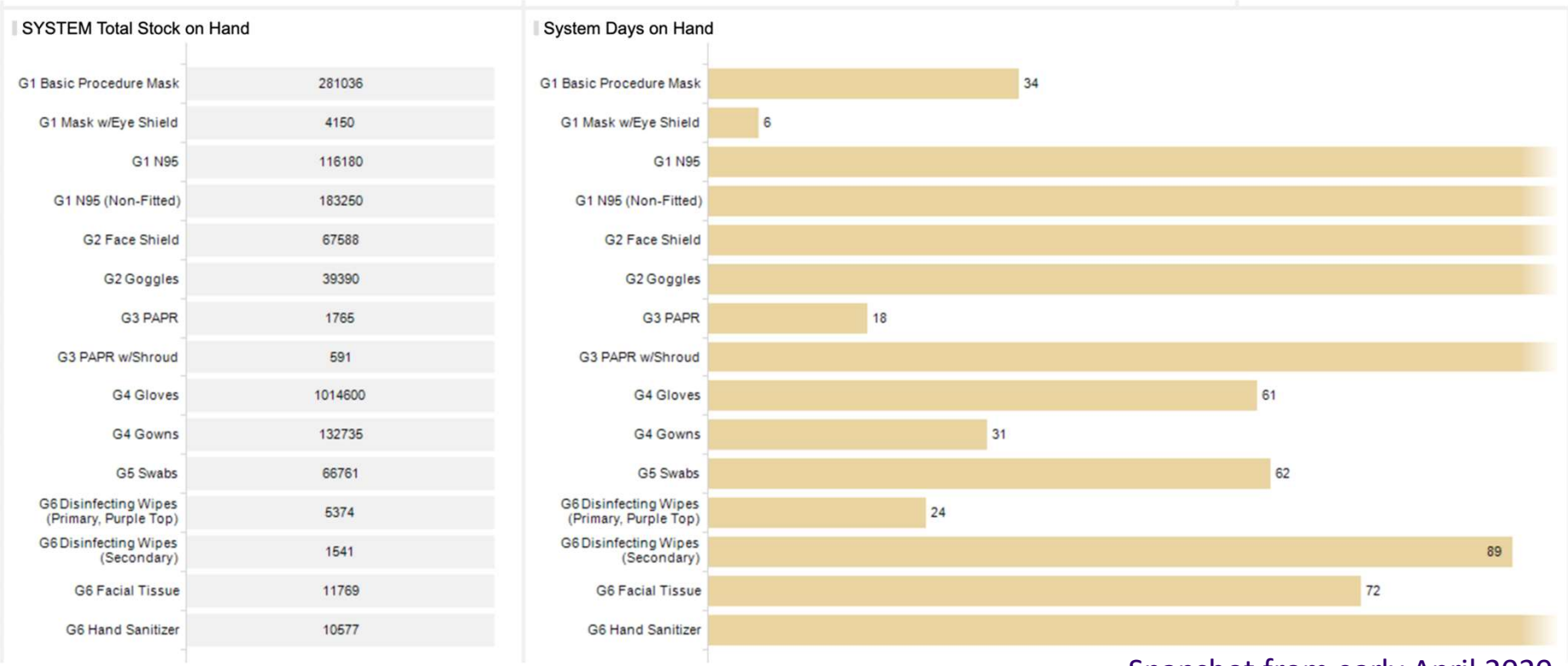
- Created reusable and disposable masks; face shields; PAPR hoods; hand sanitizer; aerosol boxes; gowns; and ventilator parts
- Sought FDA approval for each and published for anyone to use
- Researched conservation strategies (decontamination of equipment/infection prevention measures)

Collaborative effort among different UW Schools

- UW Medicine Research, UW Medicine Simulation/WISH, Mechanical Engineering, Computer Science and Engineering, UW Medicine Cardiology, School of Drama, UW Medicine Emergency Medicine, UW Medicine Radiology

Innovations Team

- Met weekly
- Evaluated Supply Chain inventory for needed items



Snapshot from early April 2020

Innovations Team

Identified needs were assigned to subgroups to research, design and test for feasibility

Subgroups:

- Face Shield
- Masks
- Gowns
- Ventilators and Ventilator Parts
- Respiratory Care Surgery Box
- FDA/Safety
- Conservation Strategies

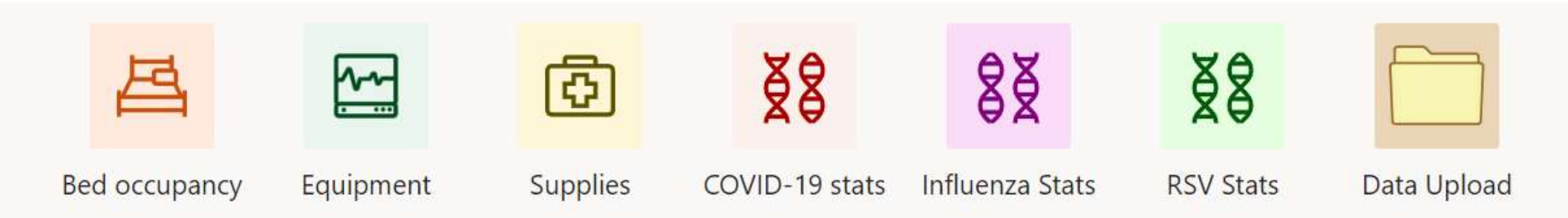
[Face Shield Assembly and Production - DFab (uw.edu)]

[Gown Assembly and Production - DFab (uw.edu)]

Reporting

Reporting

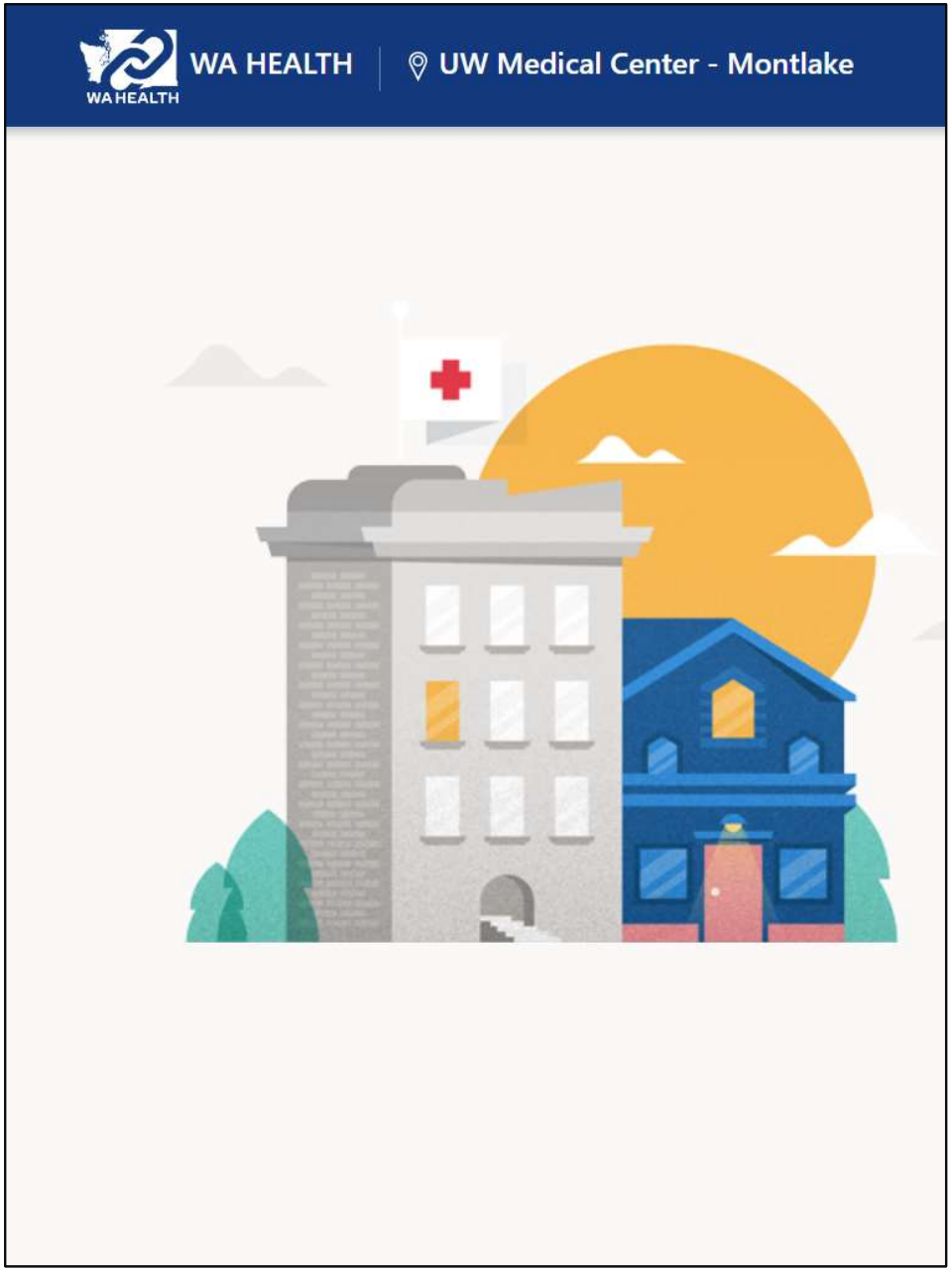
- During COVID-19, hospitals were required to collect and submit data daily to the State and Federal Governments through WA Health and TeleTracker.
- The Reporting Team rotated completing the task each week (Mon-Sun) led by the Situation Status Leader



Reporting

Development of Reporting Infrastructure

- Started with excel spreadsheets for data input and daily coordination with operational leaders for data points
- Leveraged IT analytics to create dashboards within Epic, HBI and other data infrastructure to collect information for reports
- Evolved into electronic submissions
- WA State data was used for situational awareness at the State level
- Reporting continues to be a daily mandatory requirement



Policy Development

Policy Group/Clinical Leadership

- Clinical Leadership met daily for the first 6 months
  - Adjusted based on activation levels and need
  - Deliberated on high level strategic decisions for the organization overall
- Approved new proposed policies
  - Close to 100 policies implemented for response: testing policies, visitor policies, masking policies, staffing policies, etc.
- Developed policy change process
- Supporting this work required centralized admin support and robust documentation management
- Standardized process for documentation management
- Supported internal and external websites for posting/sharing information as it changed

Policy Change Request

STATUS: Cafeteria Change Request

Current Status

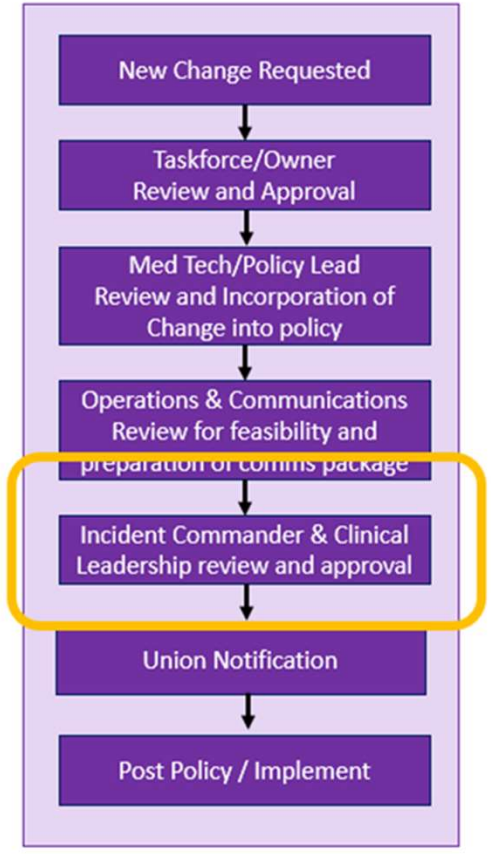
- Policy update approved by CNOs and Operations
- Policy update to go to CL on 8/16 for final approval

Communications Package Plan

- Distribute update via Dr. John Lynch message & nurse manager distribution list
- Create signage for cafeteria registers

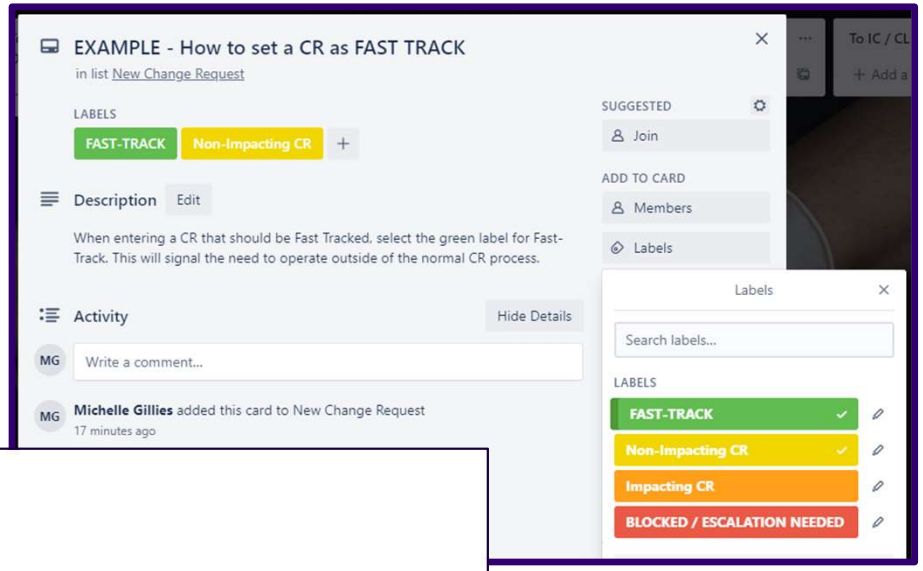
Anticipated Timeline

- Targeted post date: 8/19
- Send to Unions on 8/16-17
- Message to go out in 8/19 Dr. Lynch message; same day as nurse managers



Policy Fast-Track

- A Fast-Track change request approval process will exist for expedited intake, scheduling and execution of change
- Use of the Fast-Track process should be



Fast-Track Criteria

Fast-Track change requests have an urgency for near-term execution. They must meet one of the criteria below to be considered for fast track.

1. Clinical & Patient Safety Impacts • **Urgent** action needed to protect critical patient, staff and family health & safety – Change in EOC level of activation
2. Legal & Regulatory Impacts • Urgent action needed to comply with required regulatory changes and orders. • Not acting would result in significant penalty or loss of accreditation.
3. Clinical Leadership Directive

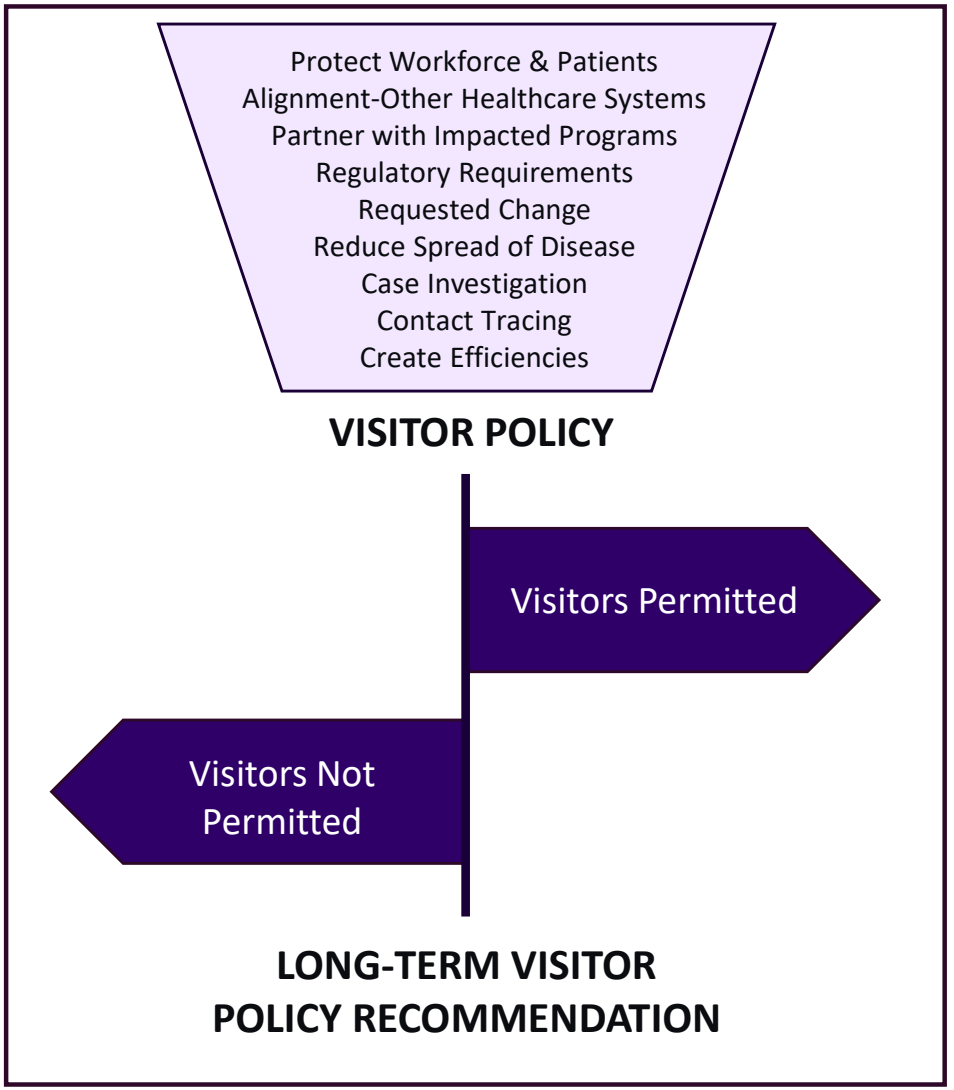
og designated as

e meeting, but

in the delay or

Visitor Policy

- Ensure the wellness and safety of all healthcare personnel, patients, and visitors.
- Formed the Visitor Policy Taskforce.
- Created the Visitor Policy Change Request process and tools; identified roles within the change request process.
- Met on a regular cadence according to level of activation.



UW Medicine COVID-19 Visitor Policy Taskforce

Key Activities

- Monitor and plan for changes in regulatory requirements impacting the visitor policy
- Review other healthcare system visitor policies for gaps; provide regular updates and guide policy decisions based on positioning in the current landscape
- Capture, evaluate, and implement improvement actions ongoing
- Capture and plan for impacts from/to any other policies that affect or are affected by the Visitor Policy
- Change Request Log: Approve/deny change requests
  - **Non-Impacting Change Request:** Rapid implementation of minor language changes without committee review and approval (no impact to ongoing operations that would require communications and training)
  - **Impacting Change Request:** Review and approval prior to initiation of efforts to make a change
- Review and guide long-term visitor policy recommendation, as needed

What are the indicators & triggers?

UW MEDICINE LEVELS OF ACTIVATION: Triggers and Indicators to Move Through Phases — **Current Status: 09/27/2021**

EOC Level of Activation	State Phases Roadmap to Recovery Metrics:	King County COVID-19 Rate (#/100/14 Days)	COVID Admissions	Census	Staffing	PPE Availability	Phase Definition
High	Phase 1	>175	COVID Patients >12%	95% full to set up beds by total and/or by type of bed across the system for >10 days and approaching 90% full in surge areas for 4+ days	Crisis staffing ratios	Supply shortages occurring Contingency or crisis for use of PPE	**Altered and Crisis Capacity** - Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care. Agency is level loading and leveraging surge plans. Need for additional ICS support.
Mid-High	Phase 2	150 to 174 **159.0**	COVID Patients >10%	95% full to set up beds by total and/or by type of bed across the system for 10+ days	Contingency staffing ratios	Contingency use on PPE due to policy or supply shortages, or both	**Contingency Capacity** - The spaces, staff and supplies used are not consistent with daily practices but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). Agency is level loading and leveraging surge plans due to COVID-19. Need for additional ICS support.
Mid	Phase 2	100 - 149	COVID Patients <10%	95% full to set up beds by total and/or	Contingency staffing ratios	Some changes in use to	**Contingency Capacity** - The spaces, staff and supplies used are not consistent with daily practices but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily
Low-Mid	Phase 2	5(					
Low	Phase 3	0 t					
Monitoring	Open	0 t					

Community Policy Crosswalk: Number of Visitors

WA State

Swedish
- As of 7/13, **1 visitor** per patient (5am-9pm)

Overlake
- As of 5/21, ED & surgical/procedural patients may have **1 visitor** per day (7am-7pm)

Evergreen
- As of 7/20, **1 visitor** a time per patient (7am-7pm)

Multicare
- As of 8/12, **1 visitor** per patient (8am-8pm)

Providence
- Allowing **1 visitor** per patient (12-4pm)

Across the Country

Baton Rouge General - LA
- As of 7/24, **1 visitor** per patient (2pm-6pm)

Mission Health - NC
- As of 7/27, **1 visitor** per patient (9am-8pm)

Sutter Health - CA
- Allowing **1 visitor** per patient
- As of 8/11, Sutter hospital visitors **must verify** that they're fully vaccinated or provide documentation of a – COVID-19 PCR 72 hours before their visit (12pm-6pm)

University of Mississippi Medical Center - MS
- As of 8/16, **1 visitor** per patient (10am-7pm) ICU (10am-2pm)

DATE	Total # of COVID-19+ Patients	% of Occupied Total Beds	% of COVID-19+ Patients	King Count COVID-19 Rate (#/100K 7 days)
16-Aug	62	91.5%	6.20%	*151.9*
15-Aug	71	91.6%	7.09%	*151.9*
14-Aug	68	95.7%	6.50%	*151.9*
13-Aug	68	95.8%	6.49%	151.9
12-Aug	65	98.2%	6.06%	142.2
11-Aug	64	97.6%	6.00%	130.5
10-Aug	59	96.8%	5.58%	121.7
9-Aug	57	91.7%	5.69%	177.9
8-Aug	50	92.5%	4.95%	169.3
7-Aug	39	95.3%	3.74%	166.5
6-Aug	34	95.9%	3.24%	158.8
5-Aug	34	96.7%	3.22%	151.1
4-Aug	34	98.0%	3.22%	142.2
3-Aug	28	99.2%	2.58%	133.0
2-Aug	22	93.0%	2.17%	121.7
1-Aug	26	91.1%	2.61%	112.3
31-Jul	25	93.6%	2.44%	111.9
30-Jul	25	97.6%	2.34%	106.7
29-Jul	26	97.0%	2.45%	98.8
28-Jul	26	99.2%	2.40%	90.4
27-Jul	22	98.5%	2.04%	84.7
26-Jul	22	95.2%	2.12%	79.3
25-Jul	20	95.5%	1.92%	74.1
24-Jul	17	97.6%	1.59%	72.3
23-Jul	14	98.4%	1.30%	66.6
22-Jul	9	99.0%	0.83%	61.7
21-Jul	10	98.7%	0.93%	57.7
20-Jul	13	97.0%	1.23%	54.4
19-Jul	14	92.1%	1.39%	49.5
18-Jul	14	94.8%	1.35%	44.5
17-Jul	13	96.0%	1.24%	44.5
16-Jul	13	96.9%	1.23%	44.6
15-Jul	13	97.5%	1.22%	43.5

Long-Term Planning

Section of Policy	2 VISITORS	1-2 VISITORS
EOC Levels of Activation	Low Impact Incident Low-Mid Impact Incident	Low-Mid Impact Incident Medium Impact Incident
Triggers	Large Protest/Demonstrations, Short Term Utility outage, football games, graduation Pandemics, HAZMAT Incidents, Severe Storms, Floods, Major Utility outages	Pandemics, HAZMAT Incidents, Severe Storms, Floods, Major Utility outages
Policy Communication	Any exceptions to this policy must be cleared by the clinical area admin, Director, AOC, or CNO. The exception list applies provided that there is absence of symptoms on screening. All visitors must stay in room during duration of visit. Each patient may have 2 visitors. Minors under 12 must be with parent. Minors between 12-16 should not be left alone with inpatient. Visitation will be limited by facility visiting hours and policies. Applies to UWM employees who have family members in hospital Visitors can consume foods in patient rooms if extended stay. Timing to be coordinated with care team and person should keep 6 feet away from patient while eating. No eating while Medical Team staff are present. Consuming food/beverages in waiting areas or lobbies is not allowed.	Any exceptions to this policy must be cleared by the clinical area admin, Director, AOC, or CNO. The exception list applies provided that there is absence of symptoms on screening. All visitors must stay in room during duration of visit. Each patient may have 1-2 visitors. Minors under 12 must be with parent. Minors between 12-16 should not be left alone with inpatient. Visitation will be limited by facility visiting hours and policies. Applies to UWM employees who have family members in hospital Visitors can consume foods in patient rooms if extended stay. Timing to be coordinated with care team and person should keep 6 feet away from patient while eating. No eating while Medical Team staff are present. Consuming food/beverages in waiting areas or lobbies is not allowed.
Visitor Screening	All Visitors will be screened at deisgnated restricted entry points for viral symptoms. Only asymptomative visitors will be allowed. All visitors will submit required screening attestation. **(link attenstation decision policy here)**	**See Previous** *(Low Impact/ Low- Mid Impact Activation)*
Source Control	All individuals over two-years of age entering the hospital must wear a mask covering the mouth and nose at all times in accordance with the Required and Extended Use Masking Policy and Masking Accommodation Policy.	**See Previous** *(Low Impact/ Low- Mid Impact Activation)*
Testing & Vaccination Requirement	Negative test within 72 hours and fully vaccinated required.	**See Previous** *(Low Impact/ Low- Mid Impact Activation)*
Visitor Movement	Visitors must stay in the patient's room execpt when arrive or departing the facility or to obtain food or beverages during an ***approved*** extended duration visit.	**See Previous** *(Low Impact/ Low- Mid Impact Activation)*

Lessons Learned

Lessons Learned

First Debrief and Lessons Learned

Held several team huddles to gather feedback throughout April/May 2020

Opportunities for improvement assisted with:

- Internal communications and improved staff handoffs between EOC shifts
- Policy implementation and standardization in IC guidance and priorities
- Development of policy approval process
- Creation of data team to streamline collection of required reporting data
- Improved coordination among entity IC's and system level IC's
- Include Supply Chain in policy decisions that require additional resources (i.e. PPE policy changes)

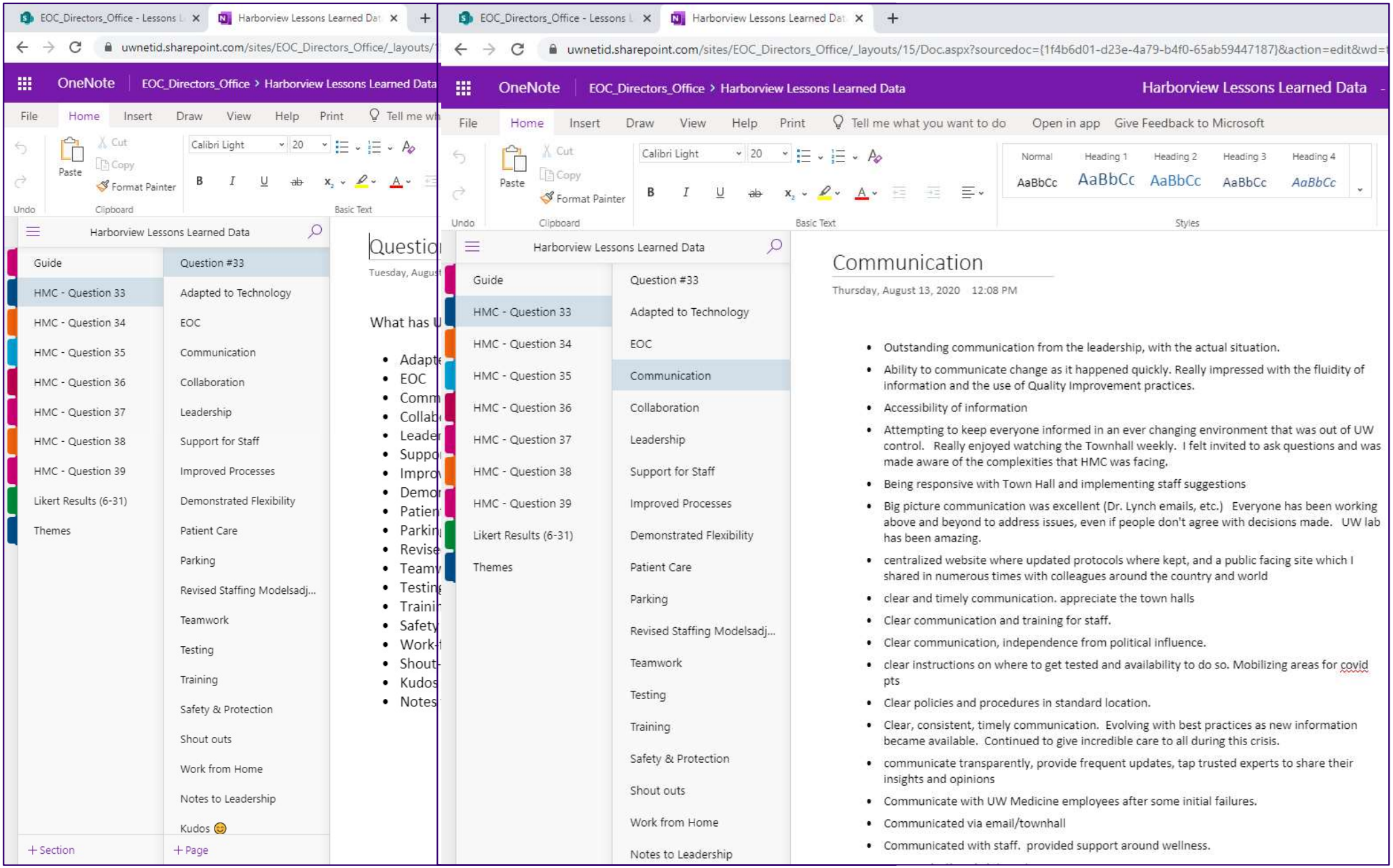
Lessons Learned

GOAL: Gather feedback from all staff about how UW Medicine has done in their response to COVID-19.

Launched lessons learned surveys in June 2021 and March 2022

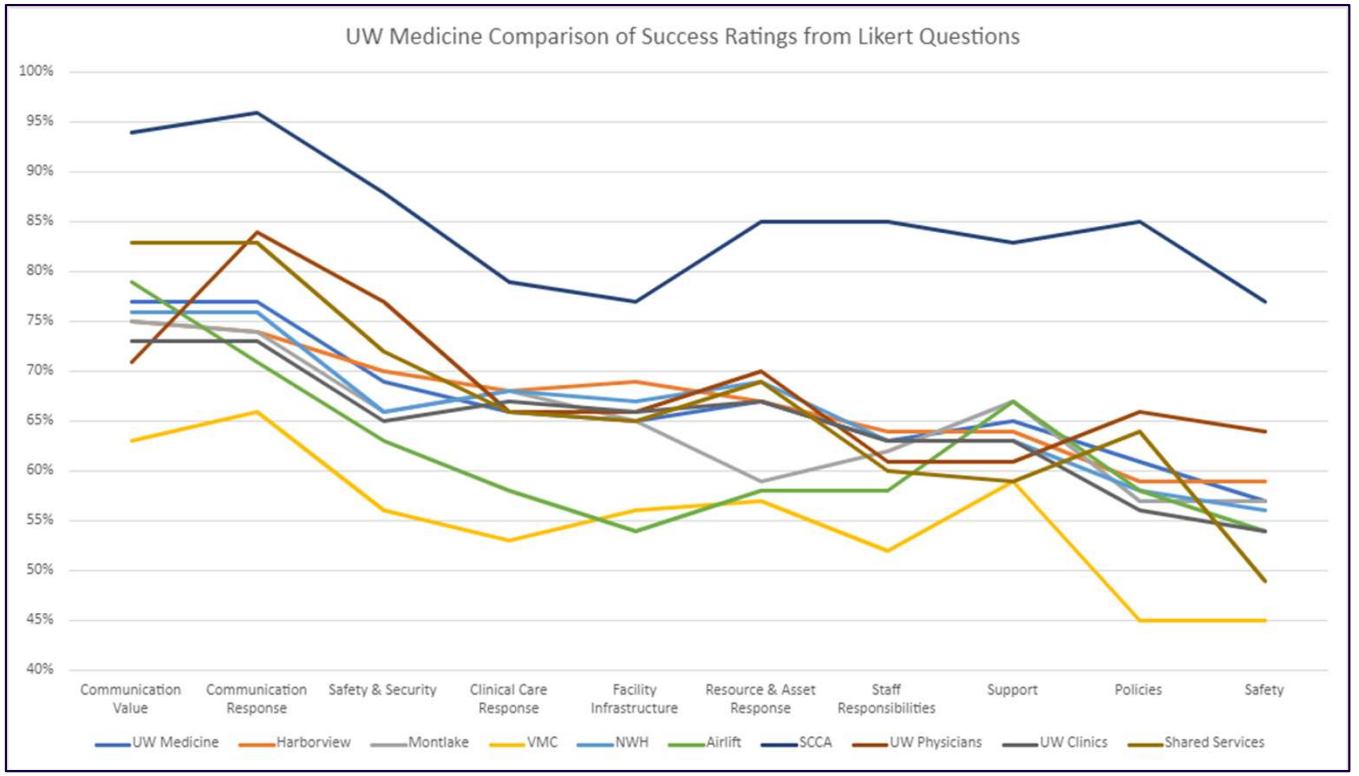
- Multi-faceted approach to gathering lessons learned data; In-person (virtual) small-group debriefs by 204 work assignment & REDCap Survey.
- Ran the survey twice during the COVID-19 response
- The first survey received 3,691 responses (37% response rate)
- Categories were outlined by Joint Commission for Emergency Management
- Survey was included in both Likert and Free Form Questions

Lessons Learned Data Notebooks



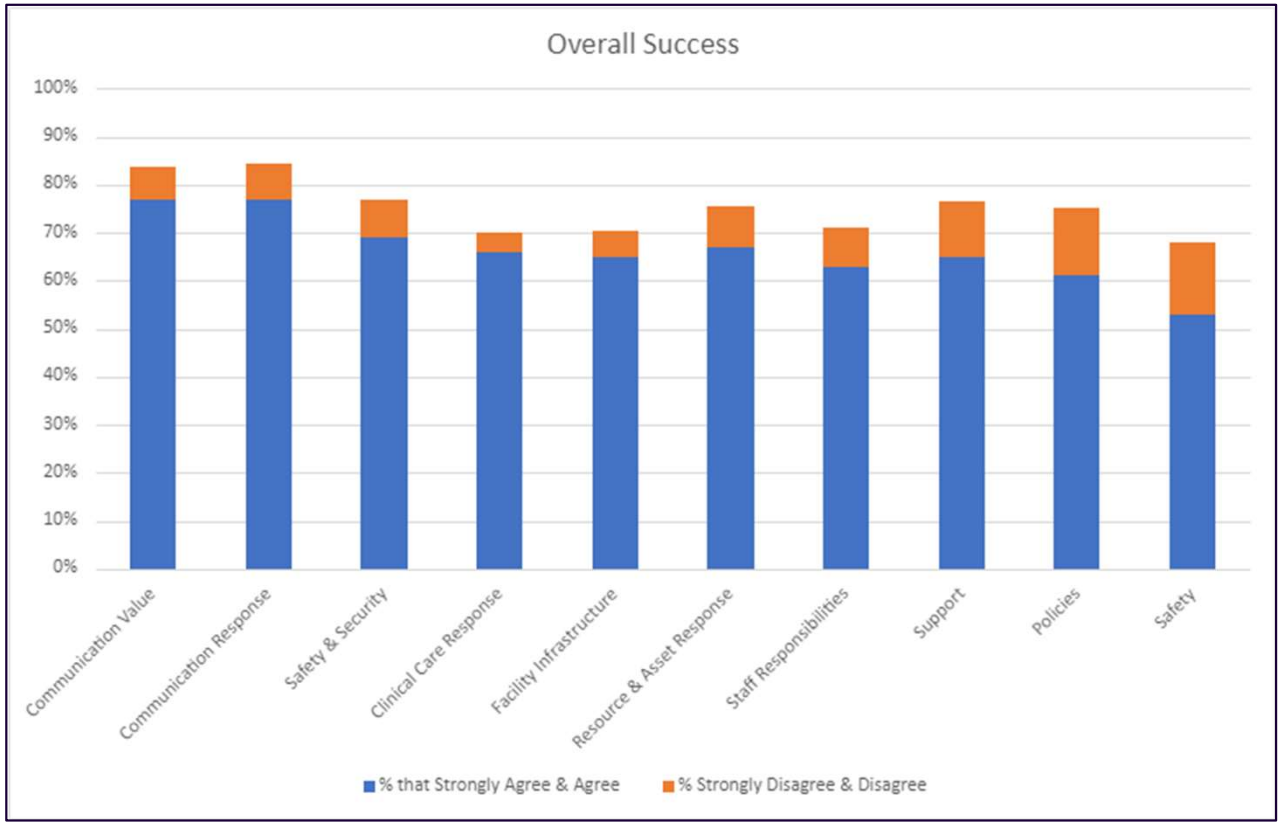
Success by Entity

"There were so many emails coming so frequently and including procedural changes on a near daily basis in the beginning of the response, it was hard to keep up and sometimes overwhelming. After settling into the update format they began using with the stats, it became more helpful and less overwhelming. The Fit for Work criteria were very clear and helpful."



Lessons Learned – Likert Responses

"The timeliness and transparency of the COVID-19 communications from leadership have been invaluable and commendable. As a non-clinician, I was desperate for info, and the daily updates, town halls, and other forums served our organization well to keep everyone informed."



Communication

77% of respondents agree the communication response was successful

Challenges:

- Too many emails, improved distribution lists needed
- Communication around policy changes

Successes:

- Town Halls well received
- Visibility of top leadership

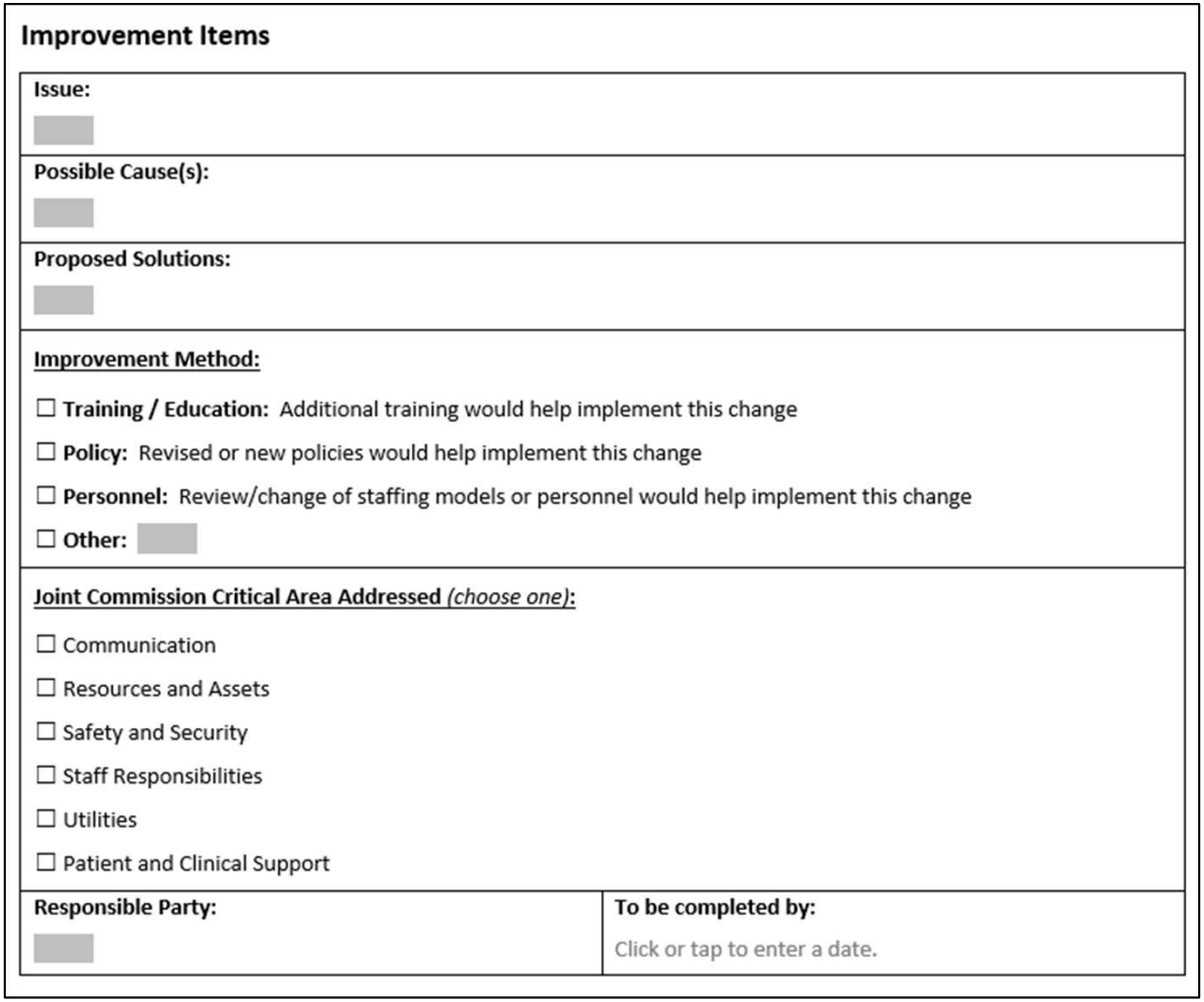
"John Lynch was a Rockstar! I appreciated his consistent messaging about PPE, and that no one would go into a COVID room without PPE. The way he calmly asserted this every time I heard him speak made me feel better and reassured those around me. "

"I think the administration has done a fantastic job at the communications. The daily updates, the CONSISTENT webinars, the over communication has all worked. You must be exhausted, but you hold it together and present a supportive, calm, unified front. Well done."

"It's as though the supporting services who don't provide direct patient care have been forgotten."

Improvement Items

- Support and strengthen capacity for future preparedness and response
- Reduce the impact of the ongoing incident
- Resolve issues before the next wave of an ongoing incident or of a future incident
- Improve overall safety
- Providing insights into organizational risk



Improvement Items

Issue:

Possible Cause(s):

Proposed Solutions:

Improvement Method:

☐ **Training / Education:** Additional training would help implement this change

☐ **Policy:** Revised or new policies would help implement this change

☐ **Personnel:** Review/change of staffing models or personnel would help implement this change

☐ **Other:**

Joint Commission Critical Area Addressed *(choose one)*:

☐ Communication

☐ Resources and Assets

☐ Safety and Security

☐ Staff Responsibilities

☐ Utilities

☐ Patient and Clinical Support

Responsible Party:	**To be completed by:**
	Click or tap to enter a date.

Demobilization, Maintenance & Reactivation (DMR)

‘The Pandemic Playbook’

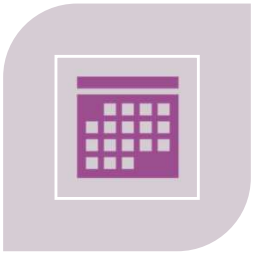
Demobilization and Reactivation

April 2020: launched Recovery and Reactivation

Goal: Outline path to efficiently and flexibly track, demobilize, remobilize and support COVID-19 and non-COVID-19 operations with the virus circulating for the foreseeable future

Three Phases:

EXPAND URGENT SURGERIES AND PROCEDURES CONSISTENT WITH GOVERNOR'S ORDER FOR THOSE CASES WHERE DELAYING FOR MORE THAN 3 MONTHS WOULD CAUSE PATIENT HARM



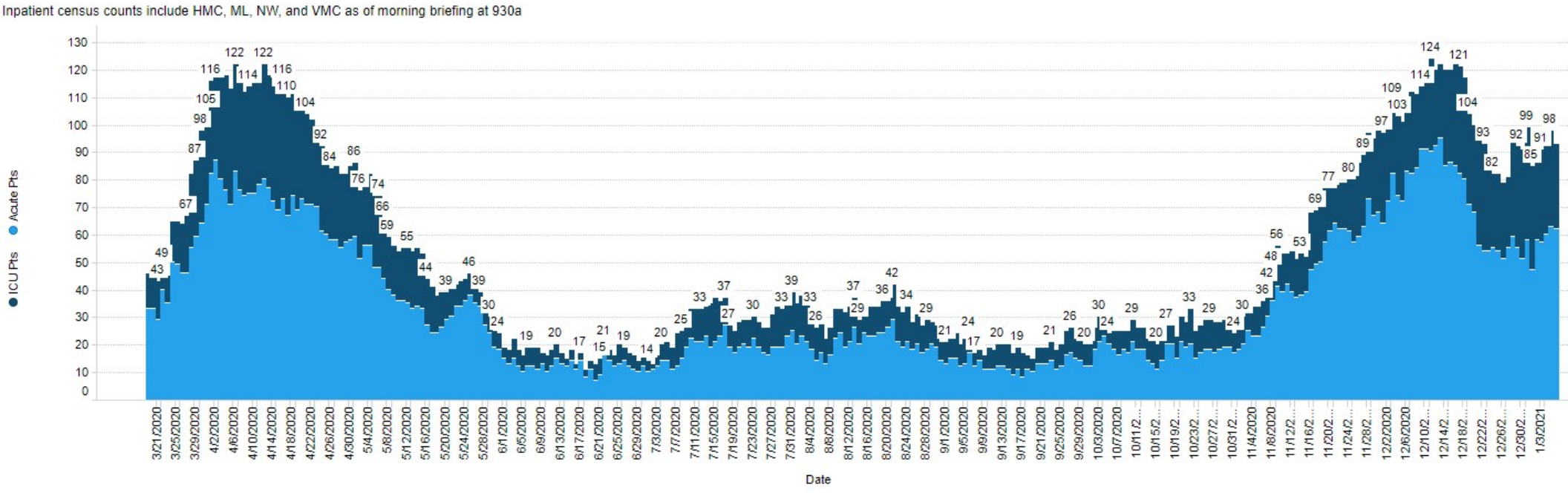
BEGIN SCHEDULING CLINIC VISITS AFTER MAY 4TH WHEN THE GOVERNOR'S STAY-AT-HOME ORDER ENDS

RESUMPTION OF ELECTIVE AND NON-URGENT SURGERIES AND PROCEDURES AFTER GOVERNOR'S ORDER ENDS ON MAY 18TH

Demobilization and Reactivation

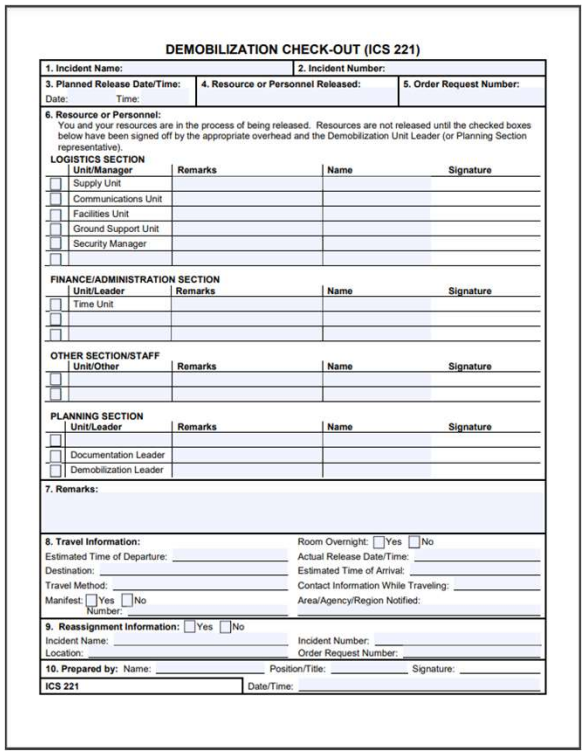
January 2022: began development of full demobilization and reactivation plan

Goal: Outline steps for demobilization and create a playbook to fully reactivate for any future pandemic event



The Pandemic Playbook

The purpose of this document is to outline the processes by which UW Medicine will scale back or increase COVID-19 Hospital Incident Command System operations.



DEMOBILIZATION CHECK-OUT (ICS 221)

1. Incident Name: | 2. Incident Number:

3. Planned Release Date/Time: Date: Time: | 4. Resource or Personnel Released: | 5. Order Request Number:

6. Resource or Personnel:
You and your resources are in the process of being released. Resources are not released until the checked boxes below have been signed off by the appropriate overhead and the Demobilization Unit Leader (or Planning Section representative).

LOGISTICS SECTION Unit/Manager	Remarks	Name	Signature
☐ Supply Unit			
☐ Communications Unit			
☐ Facilities Unit			
☐ Ground Support Unit			
☐ Security Manager			
☐			

FINANCE/ADMINISTRATION SECTION Unit/Leader	Remarks	Name	Signature
☐ Time Unit			
☐			
☐			

OTHER SECTION/STAFF Unit/Other	Remarks	Name	Signature
☐			
☐			

PLANNING SECTION Unit/Leader	Remarks	Name	Signature
☐			
☐ Documentation Leader			
☐ Demobilization Leader			

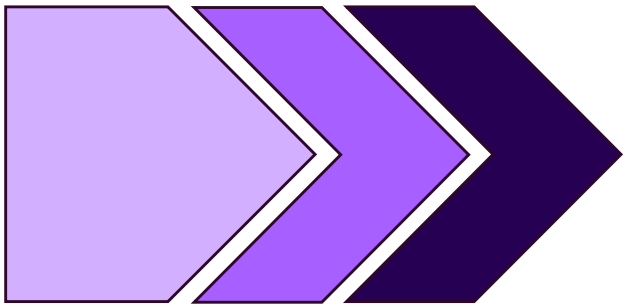
7. Remarks:

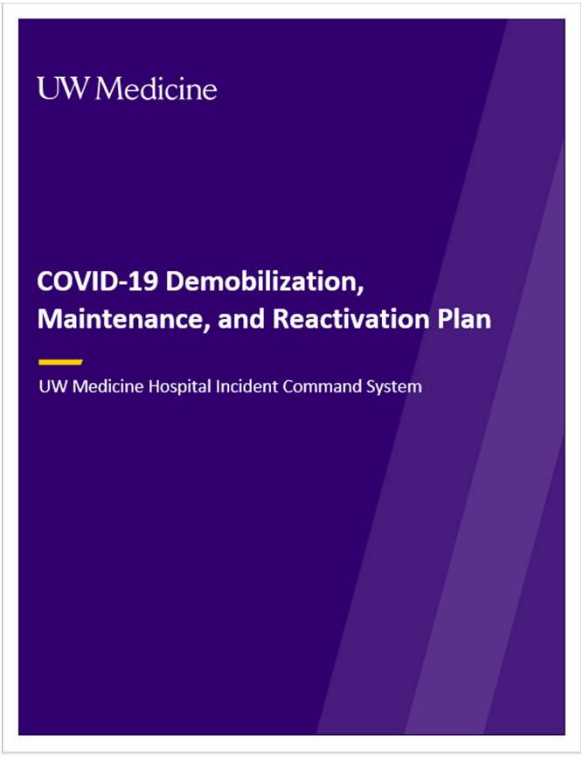
8. Travel Information:
Estimated Time of Departure:
Destination:
Travel Method:
Manifest: ☐ Yes ☐ No Number:
Room Overnight: ☐ Yes ☐ No
Actual Release Date/Time:
Estimated Time of Arrival:
Contact Information While Traveling:
Area/Agency/Region Notified:

9. Reassignment Information: ☐ Yes ☐ No
Incident Name:
Location:
Incident Number:
Order Request Number:

10. Prepared by: Name: Position/Title: Signature:

ICS 221 | Date/Time:





Right-size Resources

UW MEDICINE LEVELS OF ACTIVATION: Triggers and Indicators to Move Through Phases

EOC Level of Activation	State Phases Roadmap to Recovery Metrics: | Washington State Coronavirus esponse (COVID-19)	King County COVID-19 Rate (#/100/14 Days)	COVID Admissions	Census	Staffing	PPE Availabil
High	Phase 1	>175	COVID Patients >12%	95% full to set up beds by total and/or by type of bed across the system for >10 days and approaching 90% full in surge areas for 4+ days	Crisis staffing ratios	Supply shortage occurrin Continge or crisis use of PP
Mid-High	Phase 2	150 to 174	COVID Patients >10%	95% full to set up beds by total and/or by type of bed across the system for 10+ days	Contingency staffing ratios	Continge use on Pl due to p or supply shortage both
Mid	Phase 2	100 - 149	COVID Patients <10%	95% full to set up beds by total and/or by type of bed across the system for 8+ days	Contingency staffing ratios	Some changes use to continge Supply shortage anticipat
Low-Mid	Phase 2	50 to 99	COVID Patients <7.5%	95% full to set up beds by total and/or by type of bed across the system for 6+ days	Conventional staffing ratios	Some changes use to continge Supply shortage anticipat
Low	Phase 3	0 to 49	COVID Patients <5%	95% full to set up beds by total and/or by type of bed across the system for 6+ days	Conventional staffing ratios	No anticipat shortage No chan policy regardin PPE usage
Monitoring	Open	0 to 49	COVID Patients <5%	95% full to set up beds by total and/or by type of bed across the system for less than 6 days	Conventional staffing ratios	No anticipated shortages No change in policy regarding PPE usage

ROLE	HIGH		MID-HIGH		MID		MID-LOW		LOW		MONITORING	
	System	Entity	System	Entity	System	Entity	System	Entity	System	Entity	System	Entity
EOC Director	X		X		X		X		X			
IC	X	X	X	X	X	x	X	X	X	X		
EOC Advisor/IC	X		X		X		X		X			
Communications	X		X		X		X		X			
Safety	X	X	X	X	X		X					
Liaison	X		X		X		X		X			
Entity Liaisons	X		X		X		X					
Operations	X	X	X	X	X	X	X	X	X	X		
Branch Directors (3)	X		X		X		X					
Plans	X	X	X	X	X	X	X	XX	X			
Logistics	X	X	X	X	X	X	X	XX	X			
Supply	X		X		X		X		X			
Facilities	X		X		X		X					
Ground Support	X		X		X		X		X			
Finance	X		X		X		X		X			
ITS	X		X		X		X		X			
Resource Unit Leader	X		X		X		X					
Situation Unit Leader	X		X		X		X		X			
Documentation	X		X		X		X		X			
Med Tech	X		X		X		X		X			
Clinical Leadership	X		X		X		X		X			
Legal	X		X		X		X		X			
Policy	X		X		X		X		X			

Conventional Capacity - the spaces, staff and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. Agency may have a need for ICS support in identified areas.

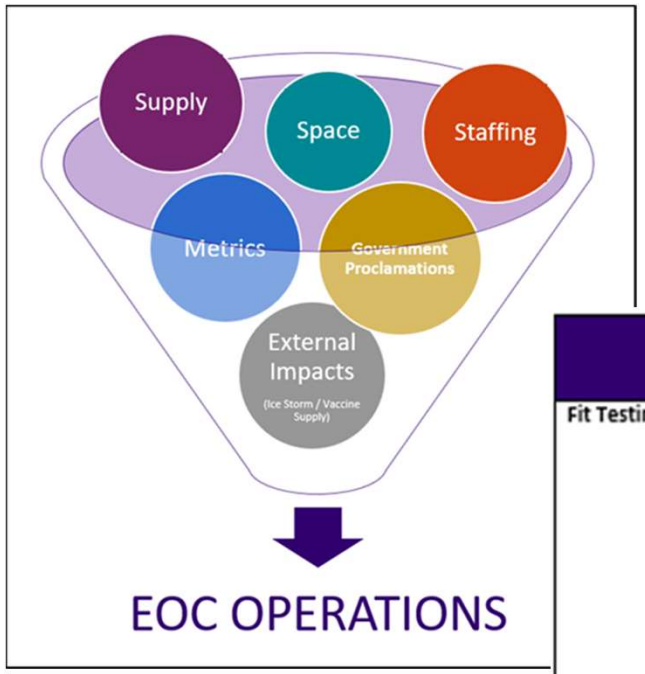
EOC Meeting Cadence by Phase

Right-size EOC Meeting Cadence

UWM COVID-19 Logistics Leadership Meeting	MID-HIGH	2 Days/Wk (Tues/Thurs) – 7:30am
IMT Command (Wiland)	MID-HIGH	5 Days/Wk (Mon-Fri) – 7:30am
UWM COVID-19 Operational Briefing	MID-HIGH	5 Days/Wk (Mon-Fri) – 8:00am
IMT Command & General Staff Meeting (Wiland Internal)	MID-HIGH	5 Days/Wk (Mon-Fri) – 8:30am
UWM COVID-19 IMT (Wiland)/Agency Administrators	MID-HIGH	5 Days/Wk (Mon-Fri) – 9:00am
UWM COVID-19 Command & General Staff Meeting	MID-HIGH	5 Days/Wk (Mon-Fri) – 9:30am
UWM COVID-19 Tactics Meeting	MID-HIGH	2 Days/Wk (Mon, Thurs) – 10:30am
Med Tech	MID-HIGH	5 Day/WK (Mon-Fri) 1:00 pm
UWM COVID-19 Clinical Leadership Agenda Meeting	MID-HIGH	5 Days/Wk (Mon-Fri) – 2:00pm
UWM COVID-19 1-2-3 Document Review/Approval Meeting	MID-HIGH	2 Days/Wk (Mon, Thurs) – 2:15pm
UWM COVID-19 Strategic Planning 1-2-3	MID-HIGH	1 Day/Wk (Fri) – 2:30pm
IMT (Wiland) Command & General Staff (w/others)	MID-HIGH	5 Days/Wk (Mon-Fri) – 3:30pm
Clinical Leadership	MID-HIGH	5 Days/Wk (Mon-Fri) – 4:00pm (Optional HOLD Sat 10am)
UWM COVID-19 Logistics Leadership Meeting	MID	2 Days/Wk (Tues/Thurs) – 7:30am
IMT Command (Wiland)	MID	TBD
UWM COVID-19 Operational Briefing		
IMT Command & General Staff Meeting (		
UWM COVID-19 Command & General Sta		
UWM COVID-19 Tactics/Strategic Plannir		
Med Tech		
UWM Command Huddle	MID	1 Days/Wk (Mon) - 10:00am
Clinical Leadership	MID	2 Days/Wk (Mon, Thurs) – 4:00pm

Movement between levels of activation results in the addition or removal of EOC meetings or changes the frequency with which they are held.

Identification of Indicators, Triggers & Tactics



Identify and examine potential indicators and triggers that represent and inform the actions taken at specific thresholds that guide incident recognition, response, and recovery.

Group	Indicator	Trigger	Tactic - Recommendation (Scale/Maintain/Operationalize/Sunset)
Fit Testing	OHM fit-testing compliance report https://one.uwmedicine.org/coronavirus/Pages/Fit-Testing-Data-Management.aspx	➢ Best Fit contract ends	**RECOMMENDATION:** Sunset this activity once the Best Fit contract ends. ➢ Transition new tools for Medical Clearance review and compliance reporting to Employee Health ➢ Formalize plan for importing REDCap Medical Clearance data and paper Medical Clearance forms into OHM or TBD future employee health EMR ➢ Hal Ungerleider is the operational lead of the effort until fully sunset from EOC operations and handed off to Employee Health
Exposure Notification	REDCap Patient Investigations & Disclosures: UWMC COVID - 19	➢ Transition employee adverse reaction calls to employee health when disclosure work is handed back to EH/ IPC/ Risk Management ➢ Cluster outbreaks / exposure events should be evaluated – number of cases, time sensitivity of notification, level of risk ➢ Deactivation – input from IPC, EH and Risk Management	**RECOMMENDATION:** ➢ Handoff to Employee Health for adverse reaction or vaccine related issues ➢ Identify administrative support resources to assist IPC with disclosure process ➢ Reactivate dedicated exposure notification team utilizing standard processes for outbreaks larger than ? ➢ Modify standard process as needed adapting to exposure event

Detailed Plan

Branch **EMERGENCY OPERATIONS CENTER**	Group **EMERGENCY MANAGEMENT TEAM**
Existing EOC Owner Danica Little	**Proposed Owner (If to be Operationalized)** XXX
Team to Include Jane Doe / Role Janine Doe / Role	 John Doe / Role Carlton Banks / Role

SUMMARY *(Describe impacts, interdependencies, & options considered/alternatives, if any)*

INDICATOR(S) *(Include links to any dashboards/metrics/status reports identified)*

TRIGGER(S)

CONSIDERATIONS *(Include TJC/Regulatory Compliance issues/Policy Changes – Note Specific policy if known)*

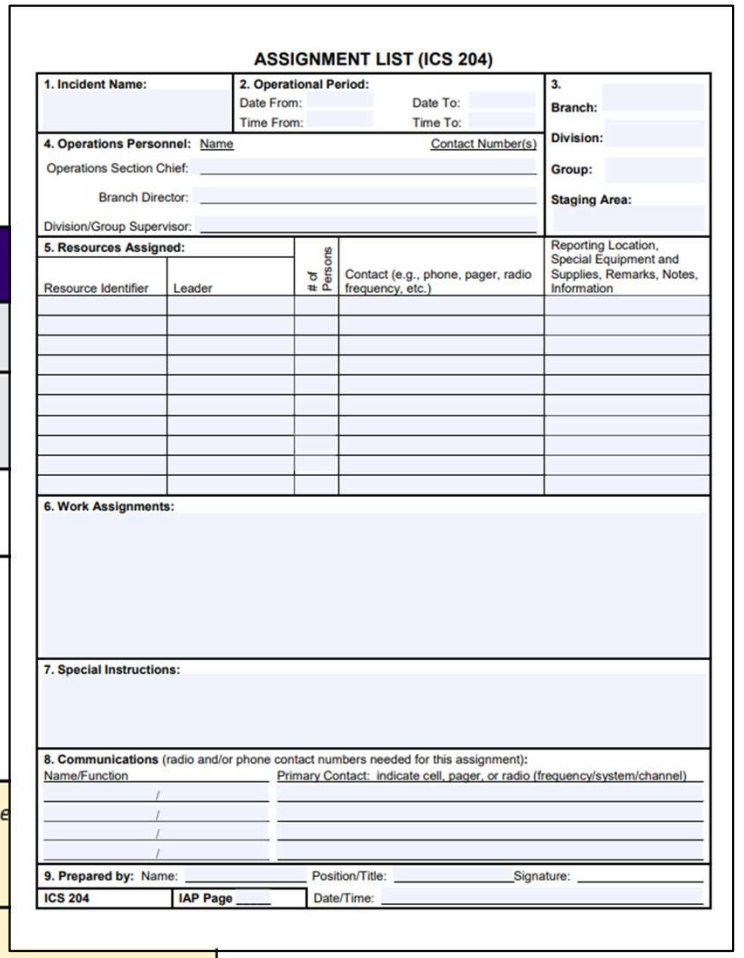
- *Please identify any policies that might act as triggers (if known)*
- *How can we improve?*

DEMOBILIZATION / SUNSET *(Include process and/or structural changes to support transition, long-term resources, gaps that require ne support of operations)*

MAINTENANCE

TRANSITION TO NORMAL OPERATIONS *(Include process and/or structural changes to support transition, long-term resources, gaps that require new owners, continued support of operations)*

REACTIVATION



ASSIGNMENT LIST (ICS 204)

1. Incident Name:

2. Operational Period: Date From: Date To: Time From: Time To:

3. Branch: Division: Group: Staging Area:

4. Operations Personnel: Name — Contact Number(s)

Operations Section Chief:

Branch Director:

Division/Group Supervisor:

5. Resources Assigned:

Resource Identifier	Leader	# of Persons	Contact (e.g., phone, pager, radio frequency, etc.)	Reporting Location, Special Equipment and Supplies, Remarks, Notes, Information

6. Work Assignments:

7. Special Instructions:

8. Communications (radio and/or phone contact numbers needed for this assignment):

Name/Function	Primary Contact: indicate cell, pager, or radio (frequency/system/channel)
/	
/	
/	
/	

9. Prepared by: Name: Position/Title: Signature:

ICS 204 | **IAP Page** | Date/Time:

Example – Detailed Plan

Branch	Group
ASSESSMENT & PREVENTION	**FIT TESTING**
Existing EOC Owner Hal Ungerleider	**Proposed Owner (If to be Operationalized)** Employee Health Managers at HMC (Mary Dirksen), UWMC (Kathy Strand)
Team Marjorie Parkison/EOC Operations Chief Alex Petermen/Best Fit Contract Owner	 Ellen Robinson/Data Analyst Adam Parcher/Executive Sponsor

SUMMARY

UW Medicine Contracted with Best Fit to refit employees from 1860, 1860s, and 1870 to an alternative respirator. This is a limited time contract. When the contract is over Employee Health will resume normal fit testing operations with consideration to revise who needs to be fit tested in the future. Consideration needs to be made in conjunction with Infection Prevention to understand if respirators will be used for all Aerosol Generating Procedures in the future especially with influenza patients.

INDICATOR(S)

A team enters fit test results into SharePoint. A report from this data tracks the number of staff that need to be fit tested. These reports are sent to Site Champions two or more times per week. Results are shared with Clinical Leadership 2 times a week and results are presented at the Morning Briefing. The data is here: https://one.uwmedicine.org/coronavirus. Reports are on UWMC Emergency Management SharePoint Site. Adam Parcher maintained the original data upload. Ellen Robinson, pulls the data, and Hal Ungerleider distributes the results. When the project is done the results will be formatted to be uploaded by Anish Abraham into OHM (employee Health Record). A

TRIGGER(S)

- Best fit contract ends
- A disruption in the supply of Respirators may requ
  - Supply Chain has triggers within th action.
- Surge can may require UW Medicine to utilize tested.

CONSIDERATIONS

- Employee Health will need to decide who needs t

DEMOBILIZATION / SUNSET

1. Medical Clearance forms from the first contract with Best Fit remain in RedCap. The Leadership of Employee Health needs to determine how they would like to proceed with the medical clearances. Generally, these are uploaded manually to OHM. There are 3500 individual documents to be moved. The team is looking to determine if this can be done in bulk, put into a different repository, or wait until the new Employee Medical records program is determined.
2. Medical Clearance forms from this contract need to be uploaded to OHM.
3. SharePoint data needs to be formatted to allow importing into OHM
4. A final report will be given to Site Champions and Clinical Leadership

TRANSITION TO NORMAL OPERATIONS

1. Employee Health will resume normal operations and consider updating schedules and communicating with their leadership on their campuses.
2. Employee Health to consider which employee groups will need to remain fit test compliant.
3. UWMC-NW prior to COVID did not perform fit testing on their campus. Equipment will need to be purchased to improve the efficiency of fit testing.

REACTIVATION

The Allocation Committee is the place in which a recommendation will be made for Clinical Leadership to implement a Fit Testing Program.

Summary – How to Organize DMR Planning

1. ***Identify key response strategies and actions*** that the agency would use to respond to the demobilization and reactivation of efforts in an incident.
2. ***Identify and examine potential indicators*** that inform the decision to initiate these actions. (Indicators may be comprised of a wide range of data sources.)
3. ***Determine trigger points*** for taking these actions. Triggers may be derived from certain indicators. If identified triggers are inappropriate because the indicators require additional assessment and analysis, it will be important to determine the process for arriving at final triggers (i.e., who is notified/briefed, who provides the assessment and analysis, and who makes the decision to implement the tactic).
4. ***Determine tactics*** that could be implemented at these trigger points. Triggers may appropriately lead to tactics and a predefined response .

Closing Remarks

COVID-19 disaster ended May 11, 2023; ***Over 1100 days of activation***

Success was possible because of:

- Collaboration and community
- Dedication from our teams
- Strong internal coordination and communication
- Leadership engagement and support
- Innovation
- Teamwork, teamwork, teamwork!

QUESTIONS?