Mid-South
Emergency Planning Coalition

COVID-19 Response

After-Action Report/Improvement Plan

March 13, 2020 – September 30, 2020

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Specific to this report, the exercise objectives align with the Assistant Secretary of Preparedness and Response's (ASPR) National Guidance for Healthcare Preparedness and the Hospital Preparedness Program Measures. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

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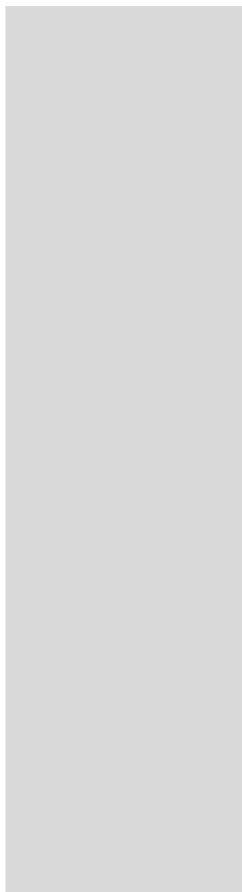
EVENT OVERVIEW

Event Name	COVID-19 Response
Exercise Dates	March 13, 2020 – September 30, 2020
Scope	This is an evaluation of a real-world event affecting multiple locations within the jurisdiction of the Mid-South Emergency Planning Coalition (MSEPC) Region. The dates chosen should give an in-depth review of response activities that were occurring from the presidential emergency declaration (March 13, 2020) until after the first surge and subsequent decrease in positive cases (September 30, 2021).
Mission Area(s)	Response
Core Capabilities, Objectives, and Activities	**Hospital Preparedness Program (HPP)** ***Capability 1: Foundation for Health Care and Medical Readiness*** **Objective 2: Identify Risk and Needs** Activity 2: Assess Regional Health Care Resources Activity 4: Assess Community Planning for Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs, Including People with Disabilities, and Others with Unique Needs **Objective 4: Train and Prepare the Health Care and Medical Workforce** Activity 1: Promote Role-Appropriate National Incident Management System Implementation Activity 3: Plan and Conduct Coordinated Exercises with Health Care Coalition Members and Other Response Organizations Activity 5: Evaluate Exercises and Responses to Emergencies ***Capability 2: Health Care and Medical Coordination*** **Objective 2: Utilize Information Sharing Platforms** Activity 1: Develop Information Sharing Procedures Activity 3: Utilize Communications Systems and Platforms **Objective 3: Coordinate Response Strategy, Resources, and Communications** Activity 1: Identify and Coordinate Resource Needs during an Emergency Activity 3: Communicate with Health Care Providers, Non-Clinical Staff, Patients, and Visitors during an Emergency



Capability 3: Continuity of Health Care Service Delivery

Objective 3: Maintain Access to Non-Personnel Resources during an Emergency

Activity 1: Assess Supply Chain Integrity

Objective 5: Protect Responders' Safety and Health

Activity 1: Distribute Resources Required to Protect the Health Care Workforce

Activity 2: Train and Exercise to Promote Responders' Safety and Health

Capability 4: Medical Surge

Objective 2: Respond to a Medical Surge

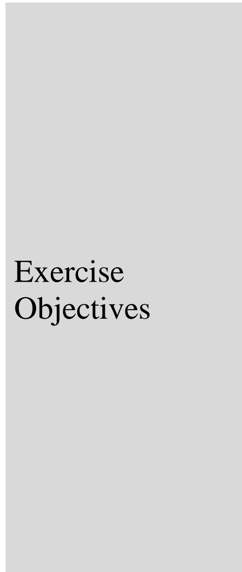
Activity 1: Implement Emergency Department and Inpatient Medical Surge Response

Activity 4: Provide Pediatric Care during a Medical Response

Activity 7: Provide Trauma Care during a Medical Surge Response

Activity 8: Respond to Behavioral Health needs during a Medical Surge Response

Activity 11: Manage Mass Fatalities



Exercise Objectives

1. Incident Command: Evaluate the facilities' ability to effectively activate and maintain incident command or emergency plans in a timely and effective manner.
2. Resources: Demonstrate the facilities' ability to manage the COVID-19 response by appropriately procuring resources necessary to maintain employee and patient safety.
3. Infection Prevention: Ensure patient and employee safety by effectively managing infection prevention practices during the rapidly evolving guidance from government and regulatory entities by utilizing current or newly developed protocols.
4. External Partners: Ensure patient and employee safety by effectively maintaining relationships and communication with external partners including local, state, and federal government and regulatory agencies; vendors and supply chain partners; and other support agencies.

Threat or Hazard: Pandemic - COVID-19

Scenario	COVID-19 is a real-life global pandemic that requires multi-agency, multi-jurisdictional coordination for the response. For the purposes of this documentation, MSEPC developed an evaluation document to capture the responses from all participating entities. The dates were chosen to give an in-depth review of response activities that occurred from the presidential emergency declaration (March 13, 2020) until after the first surge and subsequent decrease in positive cases. It is understood that response activities were happening before and well after the dates for this document. Questions from the evaluation tool on the following four pages. Each entity's individual responses can be found in the body of this document. If a respondent's question was unanswered, it was removed from the individual responses. The answers are included as they were submitted with only minor grammatical or spelling edits.

COVID-19 Real World Event EVALUATION DOCUMENTATION

As previously discussed among Coalition membership, completion of this documentation and successful submission by the provided deadline will satisfy your facility's requirements to be included in the MSEPC COVID-19 2020 Response After Action Report.

Expectations

- All questions will be answered collectively by each facility.
- ONE submission per facility will be returned to HFortner@midsouthepc.org by June 30, 2021.

Directions

1. Hold an internal Hot Wash with all applicable staff to complete the attached questions.
2. OR share questions with all applicable staff and compile responses into a single submission.
3. Type answers into word document to complete submission.
4. Save document as FacilityNameCOVIDAAR before sending.
5. Email document to HFortner@midsouthepc.org by June 30, 2021.

INCIDENT COMMAND

Objective: Evaluate the facilities' ability to effectively activate and maintain incident command/emergency plans in a timely and effective manner.

1. When did you activate your facility incident command or emergency plan? (date)
2. How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?
3. How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence.
4. Which components of incident command were activated (i.e., which positions/groups were named)?
5. What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command?
6. How was information disseminated throughout the facility to keep staff informed?
7. Provide THREE strengths related to INCIDENT COMMAND.
8. Provide THREE opportunities for improvement related to INCIDENT COMMAND.
9. Narrative – Name at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.

RESOURCES

Objective: Demonstrate the facilities' ability to manage the COVID-19 response by appropriately procuring resources necessary to maintain employee and patient safety.

1. When did you begin to have supply chain disruptions leading to limited resources? How long did this last?
2. What resources did you have difficulty procuring? How did you fulfill these needs?
3. What procurement sources or vendors did you utilize that were new or unfamiliar to your organization?
4. Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
5. How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?
6. Provide THREE strengths related to RESOURCES.

7. Provide THREE opportunities for improvement related to RESOURCES.
8. Narrative – Name at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.

INFECTION PREVENTION

Objective: Ensure patient and employee safety by effectively managing infection prevention practices during the rapidly evolving guidance from government and regulatory entities by utilizing current or newly developed protocols.

1. What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.)
2. What new materials/PPE/resources did you utilize that you had not previous utilized?
3. Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)?
4. How did your facility address extended use and/or reuse guidance for PPE?
5. How did your facility address COVID-19 patient and employee testing?
6. What standard or innovative infectious disease barrier control methods did you use, if any?
7. What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue?
8. Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?
9. Did you have any issues with staff and/or patient compliance to new infectious disease policies?
10. Provide THREE strengths related to INFECTION PREVENTION.
11. Provide THREE opportunities for improvement related to INFECTION PREVENTION.
12. Narrative – Name at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.

EXTERNAL PARTNERS

Objective: Ensure patient and employee safety by effectively maintaining relationships and communication with external partners including local, state, and federal government and regulatory agencies; vendors and supply chain partners; and other support agencies.

1. What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications?
2. What were the topics of community meetings or work groups that your organization participated in?
3. What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)?
4. How did your organization address the distribution of federal, state, and local guidance?
5. How did your organization address the distribution of federal, state, and local funding opportunities?
6. What community partners did you work with during the pandemic that you had not previously worked with?
7. Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement?
8. Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported.
9. How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
10. Provide THREE strengths related to EXTERNAL PARTNERS.
11. Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
12. Narrative – Name at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.

Sponsor	Mid-South Emergency Planning Coalition
Participating Organizations	Participating organizations include all Health Care Coalition (HCC) member facilities, local emergency management officials, first responder agencies, and public health. A complete list of participating agencies is included in Appendix B.

Points of Contact	Heather Fortner, Executive Director Mid-South Emergency Planning Coalition HFortner@midsouthepc.org Jennifer Skelton, Vulnerable Populations Coordinator Mid-South Emergency Planning Coalition JSkelton@midsouthepc.org

GENERAL INFORMATION

Exercise Objectives and Core Capabilities

The following objectives in Table 1 describe the expected outcomes for the exercise. These objectives are linked to Exercise Objectives and Core capabilities, which are distinct critical elements necessary to achieve the specific mission area(s). The objectives and aligned core capabilities are guided by elected and appointed officials and selected by the Exercise Planning Team.

Exercise Objective	HPP Capability, Objective, and Activity
1. Evaluate the facilities' ability to effectively activate and maintain incident command/emergency plans in a timely and effective manner.	Capability 1, Objective 4, Activity 1 Capability 1, Objective 4, Activity 3 Capability 1, Objective 4, Activity 5 Capability 4, Objective 2, Activity 1
2. Demonstrate the facilities' ability to manage the COVID-19 response by appropriately procuring resources necessary to maintain employee and patient safety.	Capability 1, Objective 2, Activity 2 Capability 1, Objective 2, Activity 4 Capability 2, Objective 2, Activity 1 Capability 2, Objective 2, Activity 3 Capability 2, Objective 3, Activity 1 Capability 2, Objective 3, Activity 3 Capability 3, Objective 3, Activity 1 Capability 3, Objective5, Activity 1
3. Ensure patient and employee safety by effectively managing infection prevention practices during the rapidly evolving guidance from government and regulatory entities by utilizing current or newly developed protocols.	Capability 1, Objective 2, Activity 4 Capability 2, Objective 3, Activity 2 Capability 3, Objective 3, Activity 1 Capability 3, Objective 5, Activity 2 Capability 4, Objective 2, Activity 1 Capability 4, Objective 2, Activity 4 Capability 4, Objective 2, Activity 7 Capability 4, Objective 2, Activity 8 Capability 4, Objective 2, Activity 11
4. Ensure patient and employee safety by effectively maintaining relationships and communication with external partners including local, state, and federal government and regulatory agencies; vendors and supply chain partners; and other support agencies	Capability 1, Objective 2, Activity 2 Capability 2, Objective 2, Activity 1 Capability 2, Objective 2, Activity 3 Capability 2, Objective 3, Activity 1 Capability 2, Objective 3, Activity 3 Capability 3, Objective 5, Activity 1

Table 1. Exercise Objectives and Associated Core Capabilities

EXECUTIVE SUMMARY

The response to the COVID-19 global pandemic stressed the healthcare communities in ways never experienced before. The Memphis area was no exception. Every healthcare entity was impacted to varying degrees. MSEPC members including acute care hospitals, long term care facilities, assisted living facilities, rehabilitation facilities, renal care, hospices, home health agencies, ambulatory surgery centers, public health, emergency medical services, and emergency management entities each played an important role locally, as well as State and Federal partners.

Documenting the actions taken and the policies/procedures that worked well is important for the purposes of improving future responses. It is equally important to document things that may not have gone as well as desired to be able to implement strategies for improvement. This documentation and subsequent improvements will benefit the whole community by providing more efficient and effective responses to emergencies.

MSEPC developed a series of questions from four basic categories: Incident Command, Resources, Infection Prevention, and External Partners. There were 64 participating entities. The individual responses to these questions should provide insight into the triumphs and struggles of each responding entity.

Although almost all facilities initiated Incident Command at some point in March 2020, it was evident by the terminology used in the responses that there are still many entities that do not understand even the basic concepts of Incident Command.

Safer at Home directives affected each facility differently based on requirements or necessity to temporarily halt services, visitor access, or operation. Developing procedures around limited entry points, monitoring temperatures and symptoms of clients and visitors upon entry, and social distancing within the facility were the most common responses from facilities. Operationally, facilities also had to juggle the implementation of virtual meetings for both internal staff and offering telemedicine for patients if available.

Supply chain issues were rampant among all the acute care facilities and most of the non-hospital entities. Essentials like face masks, N-95 masks, gowns, and gloves were not easily acquired once supplier allocations were in place. Most hospital systems could source supplies quicker than healthcare entities not part of larger corporate systems. Staffing also became an issue when the travel nursing industry began compensating at a much higher rate than local facilities. High demand items like ventilators, CPAP machines, high flow oxygen, PAPRs, and others quickly became harder to source. There was also an issue with sourcing items from other countries did not have the same medical supply standards as the United States. Employee overuse of items like masks and gowns already in short supply further stressed facilities' inventories.

As expected, infection prevention was an enormous area of concern. Almost all responding entities reported they followed the CDC guidelines for the pandemic. The issue, however, was that those guidelines changed frequently and sometimes were not the same as the Centers for Medicare and Medicaid (CMS), state, or local health directives. Communication flow was reported to have gone well with command staff and upper management but the flow of information to front-line staff on infection prevention measures was an area of weakness. This is something that should be explored further for future responses.

The use of Plexi-glass barriers in traffic locations was the most frequently reported innovative measure used by facilities to protect their clients and staff. The use of negative pressure rooms for COVID positive patients also proved to be very effective.

Many facilities indicated vendors could not or would not enter the facilities initially, which further complicated the scarce resource issues when equipment was left un-serviced or undelivered. Although state and federal partners often provided supplies to facilities through disbursements to the Coalition, those supplies were sometimes expired or otherwise unsuitable for use in healthcare settings. This issue should also be explored further in the planning processes because the Strategic National Stockpile may not be as helpful as once thought.

Overall, the members of the Mid-South Emergency Planning Coalition jurisdiction should be commended for the unprecedented response to this pandemic. There is no doubt that sharing resources, strategies, and ideas helped the whole community fight the pandemic leading to a healthier, safer Memphis area.

ANALYSIS OF HEALTHCARE PREPAREDNESS CAPABILITIES

Aligning exercise objectives and healthcare preparedness capabilities allows for a more consistent approach to exercise evaluation to support preparedness reporting and trend analysis. Table 1 includes the exercise objectives, aligned core capabilities, and performance ratings for each core capability as observed during the exercise and determined by the evaluation team. The following sections provide an overview of the performance related to each exercise objective and associated core capability, highlighting strengths and areas for improvement.

For detailed associated tasks and activities, refer to "Exercise Overview" section, "Core Capabilities, Objectives, and Activities" and "Exercise Objectives" beginning on page 2.

Objective	Healthcare Preparedness Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
Evaluate the facilities' ability to effectively activate and maintain incident command/emergency plans in a timely and effective manner.	Capability 1 Capability 4			M	
Demonstrate the facilities' ability to manage the COVID-19 response by appropriately procuring resources necessary to maintain employee and patient safety	Capability 1 Capability 2 Capability 3			M	
Ensure patient and employee safety by effectively managing infection prevention practices during the rapidly evolving guidance from government and regulatory entities by utilizing current or newly developed protocols.	Capability 1 Capability 2 Capability 3 Capability 4			M	
Ensure patient and employee safety by effectively maintaining relationships and communication with external partners including local, state, and federal government and regulatory agencies; vendors and supply chain partners; and other support agencies	Capability 1 Capability 2 Capability 3			M	

Ratings Definitions:

- Performed without Challenges (P): The targets and critical tasks associated with the healthcare preparedness capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Performed with Some Challenges (S): The targets and critical tasks associated with the healthcare preparedness capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.
- Performed with Major Challenges (M): The targets and critical tasks associated with the healthcare preparedness capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.
- Unable to be Performed (U): The targets and critical tasks associated with the healthcare preparedness capability were not performed in a manner that achieved the objective(s).

Table 3. Summary of Healthcare Preparedness Capability Performance

ACUTE CARE HOSPITALS

BAPTIST COLLIERVILLE

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 15, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?

- Closed all entrances except ED, Main, and Employee
- Closed all waiting areas except for the Emergency Room
- Limited visitation
- Reviewed all surgeries for appropriateness
- Reviewed positions with possibility of working from home (3 positions were appropriate)
- Outpatient procedures were cancelled unless emergent (mammos, wellness, therapies)
- Opened entrances were monitored by staff for temps and symptoms
- Cafeteria stopped all self service
- In person meetings and events cancelled or moved to virtual meetings

How often did that group meet/engage? 2 times a day then to once a day and as needed

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Narrowed the number of manager/director for administrative on call to be only Senior Leadership

How was information disseminated throughout the facility to keep staff informed? Twice daily leadership huddle shared to units via safety huddles every shift

Provide THREE strengths related to INCIDENT COMMAND.

1. Centralized communication (administrative, Infection prevention, system, etc.)
2. Controlled inventory of PPE and other supplies
3. Teamwork within the entity and through Baptist system

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Organization and dissemination of the information that was ever changing
2. Better division of time of Senior Leaders on call, i.e., to divide and take shifts
3. Better organized communication with using smart applications

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Communication channels through chain of command to frontline

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Immediately upon onset of pandemic resources became increasingly difficult to obtain.

How long did this last? N95 masks, for approximately 3 months. We had to have systematic process for departments to have PPE distributed/allocated from centralized entity allocation run by senior leaders out of incident command center storage.

What resources did you have difficulty procuring? N95, gowns and small gloves

How did you fulfill these needs? Being a part of a hospital system, we have the ability to borrow from other entities and the power of bulk buying at a corporate level. Additional ventilators, hi-flow machines were needed and able to borrow from another facility or rent from external company with many days during peak months of all those devices in use for patient care.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? This was a corporate system procurement, for example Cardinal

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Normal Material Management procedures were altered in that our corporate Supply chain created daily monitoring tool to determine estimated usage and need for specific PPE supplies. Bulk ordering was handled by our corporate supply chain and then supplies were distributed to entities by determined need. At the entity level, the senior leaders of the command center led the dept distribution allocation based on pt. load and need from a separate locked storage area with limited access.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Ordering, distribution and allocation to departments was more centralized and closely monitored for inventory.

Provide THREE strengths related to RESOURCES.

1. Hospital system support and resource sharing
2. Ability to buy in larger bulk amounts for distribution throughout system
3. Daily Inventory Tracking

Provide THREE opportunities for improvement related to RESOURCES.

1. Availability of N95 masks, had the need to sanitize and reuse N95 for a period of time to maintain supply
2. Limitation of timely ambulance transport, staffed hospital admission capacity – ICU, SD and MedSurg
3. Availability of needed equipment – ventilators, CPAP, high-flow machines.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Development of closer monitoring of supplies, daily inventory tracking tool and process for allocation of resources

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) PAPRs, N95, goggles, CDC guidelines, retail stores, COVID Cares Shared site within Baptist intranet

What new materials/PPE/resources did you utilize that you had not previous utilized? Changed vendors for N95 masks

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Unknown continued processes that will stay in place when fully out of emergency pandemic. However, currently we still have in place the employee entrance self-attestation absence of temp and symptoms, mask mandate, limitation of visitors, entrance health screeners for public entrances, evolving employee furlough process

How did your facility address extended use and/or reuse guidance for PPE? Based on supply and demand, there was a period of time that N95 masks were issued to frontline staff and instructed to submit mask after each shift to a sanitation process, then returned to employee for 3 shifts use. Over time as supply was more available, N95 masks were expected to be used for one shift then discarded.

How did your facility address COVID-19 patient and employee testing? Patient testing started with send out testing for all admitted patients and maintaining Enhanced Respiratory Precautions for suspected patients until results are completed. Only symptomatic patients being admitted were issued a rapid test to help to diagnosis and determine admission location plan. As testing became more available, all admitted patients received a rapid test to screen for precautions needed for admission. Determined by testing availability, discharge ED patients were tested with send out testing until rapid testing became plentiful available. Employee testing was performed hospital wide once during the pandemic with send out tests.

What standard or innovative infectious disease barrier control methods did you use, if any? Plexiglas or glass barriers built around registration and nursing stations, social distancing, breakroom limited seating and signage, cafeteria line and dining seating social distancing and signage, mask mandate for all employees, patients and visitors.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? None implemented. Quotes received to expand morgue capacity, send bodies to larger facilities with morgue room opening, or held in patient care area.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes, we have an infection disease surge plan. Strengths included seasoned Infection Prevention and Employee Health nurses, support of the hospital system level PPE supply distribution from hospital system level, created isolation precaution specific for Enhanced Respiratory Precautions. Weaknesses are limited bandwidth of leadership in small facility to share burden of on call time, PPE supply with limited N95 masks at times, challenge to get communication out to all frontline team members efficiently and timely.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes, initially some employees wanted to over utilize PPE compared to established guidelines at the time, later some employees wanted to decrease use of PPE once COVID + patient numbers decreased, vaccinations increased, such as non-compliance wearing eye protection in non-COVID patient rooms.

Provide THREE strengths related to INFECTION PREVENTION.

1. Research used to back up guidelines that were developed as guidelines changed over time.
2. Seasoned IP and EH RNs and ID MD.
3. Support of the Baptist hospital system.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Better method to disseminate communication to the frontline team members timely.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Teamwork with frontline teams was strengthened as we worked together through this pandemic.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Baptist Corporate Supply chain communicated with distributors for PPE and other supplies needed, Entity command center leaders communicated with Baptist patient placement center for hospital bed availability within the Baptist system and to connect with external hospitals in the area as well as with ambulance services for transport needs.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? All of the above

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Shelby County and TN Health Departments

BAPTIST DESOTO

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 3, 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Baptist Desoto was not under the "Safer at Home" directives. However, the facility was under specific executive orders from the Governor of the State of Mississippi and the Mississippi Department of Health, for example:

- Elective surgeries were cancelled,
- Strict visitation guidelines were put in place,
- PPE guidelines, social distancing signage placed throughout hospital,
- Limited seating in breakrooms, and the cafeteria was changed to takeout only,
- Some remote working for eligible employees.
- To supplement labor needs Travel RN and RT contracts were utilized.

Which components of incident command were activated (i.e., which positions/groups were named)?

- Incident Commander and the Command Center Recorder
- Command Staff
    - Medical Staff Officer
    - Public Information Officer
    - Liaison Officer
    - 3 Medical/Technical Specialist Positions: Infection Control, Infectious Diseases & Emergency Medicine
- General Staff
    - Finance Section Chief
        - Materials Management Unit Leader
    - Operations Section Chief
        - Medical Care Branch Director
            - Inpatient Unit Leader
            - Outpatient Unit Leader
            - ED Unit Leader
            - Clinical Support Until Leader
        - Infrastructure Branch Director
            - Facility Services Unit Leader
            - Information Services Unit Leader
            - Security Unit Leader
    - Planning Section Chief
        - Resource Unit Leader
        - Documentation Unit Leader
        - Patient Tracking Unit Leader

- Logistics Section Chief
  - Support Branch Director
    - Employee Health Unit Leader
    - Environmental Services Unit Leader
    - Laboratory Unit Leader
    - Food Services Unit Leader
    - Labor Pool Unit Leader
    - Pharmacy Unit Leader
  - Service Branch Director
    - Family Care Unit Leader
    - Pastoral Care Unit Leader

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence.

- Beginning March 3, 2020, Incident Command met twice daily at 10am and 2pm.
- Beginning 03/23/20 and continuing until 04/23/20, Incident Command was staffed 24 hours per day, 7 days per week utilizing appropriate leaders moving into the role as Incident Commander overnight to provide support for hospital staff.
- Daily at 3pm an "Update Briefing" attended by all Directors and Managers was convened, headed by the Incident Commander, to provide a situational update, provide guidance and to answer any questions.
- The daily "Update Briefing" changed from a standing meeting on May 26, 2020. The briefing changed to a "called" meeting and thereafter convened as determined by the Incident Commander based on the situation.
- In mid-April, Incident Command reduced its frequency to meeting daily at 10:00, and on May 29, 2020, changed to Monday, Wednesday and Friday at 10am.
- Incident Command has now transitioned to 1-2 days a week depending on needs as determined by the Incident Commander

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? All positions needed are already a part of our Incident Command Structure. Any additional positions where specific, specialized medical input, knowledge and guidance were opened as part of the Command staff and listed as Medical/Technical Specialists in that area of expertise as listed above

How was information disseminated throughout the facility to keep staff informed?
Planning section met daily with specific task assignments as specified by the Incident Commander to develop Incident Action plans needed based on needs. All Incident Action Plans were developed with recommendations from the Medical/Technical Specialists as needed. Incident Actions Plans were then brought back to Incident Command for approval by the Incident Commander and operationalized by the appropriate Sections Chief(s). The Incident Actions Plans were shared on the department level by their leadership during their huddles and via email. Message

Provide THREE strengths related to INCIDENT COMMAND.

1. Collaboration between Hospital Incident Command and external Emergency Management collaborates on the County, State and Federal level utilizing the tenants of an appropriate Command Structure.
2. Communication among Incident Command staff.
3. Orderly Organization of Incident Command structure and the ability to make quick changes in a safe yet effective manner.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. At times, Incident Command General Staff would break from the structure of Incident Command as some Sections Chief, Branch Directors, and Unit Leaders responsibilities "overlapped" other leaders or conflicted with their hospital job titles.
2. Communication outside of Incident Command Members – in the beginning the flow of information often did not flow from Incident Command to other leaders and front-line staff as efficiently as we liked. The 3:00 pm update meeting helped in this area.
3. Staying on task and following incident command structure could have tremendously helped w/ time management and completion of activities, i.e. Clearly defined "Operational Period" with specific objectives and "Action Plans" were adhered to in the beginning, but as time passed and the "Incident" seemed to become routine, it became easy to drift away from utilizing incident command structure and revert to assigning task based on a person's hospital job title rather than their assigned position under Incident Command.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
Initially, meetings held to make plans and prepare for the eventuality that we were highly likely to see COVID-10 patients in our hospital, were cumbersome, lengthy and largely unproductive. At times, the meetings seemed to be nothing but questions from Managers and Directors directed towards Administration with very little if any real progress. Once we moved "Incident Command" mode and initiated HICS, we had a clearer ability to identify incident objectives. The Incident Commander relied heavily on the "Planning Section" to develop the action plans with specific tasks and objectives. The Incident Action Plans were reviewed, approved and then carried out during the next defined "operational period" by the appropriate Section(s) with a clear "Span of Control". Objectives and goals were clear, concise, obtainable and easier to track for progress. By utilizing Incident Command properly, we were better equipped, to prepare, respond, mitigate and recover from the pandemic.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? 4-6 weeks into the pandemic, we began having issues with readily availability of resources, particularly PPE. Due to the high volume of daily usage with gloves, this resource is still in very high demand and as such id monitored closely and reported daily to Incident Command.

What resources did you have difficulty procuring? How did you fulfil these needs?
Facemask, N95 masks, gowns, gloves, nasal swabs, COVID testing media. By reaching out to our internal system's resources, partnering w/ MEMA

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? During the beginning of the pandemic and continuing well into the height of it, many vendors placed restrictions on many items, specifically PAPRS, PAPR Hoods, N95 masks, gowns, gloves, etc. items that could be ordered were based on "allotment"; meaning the quantity that could be ordered and received was based on the "buy history" of those items prior to the pandemic. Therefore, we reached out to direct manufacturers of many of the items to procure. In most instances, the manufacturer, 3M for example, refused sale directly to the hospital. We depended on several vendors who were willing to source items from their network of suppliers and then sale to us.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
Our materials management team, both from a facility and corporate level, did a tremendous job of ensuring that resources were available.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The pandemic provided us a "real life" picture of how limited and short supplies could be. It brought forward the challenges of balancing an adequate supply of resources, compounded by vendors willingness to supply based on "history"; with the challenges of storage space and "expiration dates" on many of the items.

Provide THREE strengths related to RESOURCES.

1. Ability of our corporate supply to source supplies
2. Strong relationships with our County & State Emergency Management partners who were willing to go the extra mile to help get supplies from all their sources.
3. Our constant monitoring of the number of supplies on-hand and our ability to conserve them while still maintaining proper use of them to keep our patients and staff safe.

Provide THREE opportunities for improvement related to RESOURCES.

1. Sourcing and being able to utilize those who may not currently be set up as vendors with BMHCC.
2. Additional storage space for emergency supplies.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
The supply of necessary PPE, which initially was a major concern, has become a valuable strength for our organization.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients. (I.e., masks face shields, half masks, etc.)

- Staff: Gloves, gowns, masks, N95 respirators, PAPRS, eye shields, goggles, face shields, shoe/boot covers
- Patient: facemask

What new materials/PPE/resources did you utilize that you had not previously utilized?
Not new, but increased use of all PPE and negative pressure rooms

Does your organization have any plans of keeping any of your COVID-19 employees or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes – staff, screening visitors, vendors, and patients as well as visitation restrictions, facemask use for all in the building. Our corporate Incident Command in accordance with CDC guidance will determine other policies or changes as deemed necessary.

How did your facility address extended use and/or reuse guidance for PPE?
For extended use/reuse – we followed the guidance as described by CDC for the PPE. Extended use was preferred over reuse due to the increased risk of contamination with reuse.

How did your facility address COVID-19 patient and employee testing?

- All patients were screened and tested. We are currently moving away from testing patients with documented proof of vaccination.
- Employees with high-risk exposure or those who were symptomatic were tested. Both patients and employees utilized a drive through COVID testing area. Employee Health Services can provide more insight into employee testing with respect to exposures at work vs. community exposure.

What standard or innovative infectious disease barrier control methods did you use, if any?

- Co-horting of COVID patients, dedicated transportation routes for COVID suspects throughout the hospital, room downtime for terminal cleaning (per air exchanges), use of negative pressure by bringing up negative pressure by stacks.
- Intubation boxes were used until FDA recommended not using them. Plastic desk shields at all intake desks in admissions and ED. PPE as mentioned in #1. Designation of a COVID pathway throughout the facility along with designated elevators for COVID and non-COVID patients.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue?

- Created policy for storage of body, cleaning of body bag, transportation of body to morgue, and notification to funeral home of COVID suspect/positive body.
- Created policy for the correct handling and disposition of deceased COVID suspect/positive personal property.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?

- Although a Surge Plan was already in place, a separate COVID Specific Surge Plan was created.
  - Strengths include specific identified space to overflow into and inventory that needed to convert into patient care areas in a reasonable amount of time and effort.
  - Weaknesses included staffing of healthcare providers during a surge.
- The hospital also had in place a flu pandemic plan and Ebola plan, parts of which were utilized for the response to the pandemic. On the other hand, COVID 19 presented its own separate challenges requiring changes and additions specific to respiratory infectious diseases were made.
- The COVID 19 plan consists of multiple parts, many of which are department specific and related to the unique services provided by and patients seen in these departments.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?

- Somewhat – with all the changes and moving parts, it was hard to develop trust in everyone due to frequent changes in CDC guidelines
- Most of the noncompliance issues were related to the donning of eye protection with all patient encounters and maintaining 6 feet separation with co-workers when eating lunch. Also had incidents where coworkers mingled without PPE after work.
- As community mandates are lifted, we continue to get many questions about PPE, visitors, and screening/testing.

Provide THREE strengths related to INFECTION PREVENTION.

1. Immediate formation of incident command team to create processes and provide standardized communication to staff.
2. Excellent structural and engineering capabilities to provide large amount of negative pressure rooms throughout the building.
3. Hand hygiene stations. About a year or less before COVID, we installed ETOH dispensers outside of each patient room.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Need for additional dedicated and well-educated IP staff. Infection Prevention has become extremely complex and requires more work than can be handled by two IPs.
2. Managers to take a more active role in assessing the numbers of isolation boxes on their units and order more when more are needed.
3. When there are many infectious patients, waste removal should occur more frequently in the areas where they are located. Garbage quickly piled up in the COVID cohort areas.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Compliance with hand hygiene requirements and proper donning, doffing and proper use of PPE has tremendously improved.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic?
MSDH, MEMA, Vaccine Finder

Who were the responsible parties/job titles responsible for maintaining those communications?
Security Director, Quality Director, IP Manager, Administrative House Supervisor, Nursing Office Secretary

What were the topics of community meetings or work groups that your organization participated in? MSDH Vaccine Roll Out, MSDH COVID Systems of Care

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, phone, virtual meetings

How did your organization address the distribution of federal, state, and local guidance?
Via our HICS Incident Command Format

How did your organization address the distribution of federal, state, and local funding opportunities? Via our Corporate Finance Department

What community partners did you work with during the pandemic that you had not previously worked with? Vaccine Finder

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement?
None to my knowledge

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. During the pandemic, BMH-Desoto maintained close and frequent contact with Desoto County Emergency Services who were then in contact with Mississippi Emergency Management. Desoto County through MEMA and FEMA assisted in getting needed resources, i.e. swabs, vaccines, PPE; Federal – 1153 Waivers. One of the most urgent resources we could obtain was 12 ventilators through a request forwarded through Desoto County Emergency Services and routed to FEMA.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Although our planning as it relates to the question above will not necessarily change, the benefits of maintaining a strong relationship with Desoto County Emergency Services, MEMA and the Mississippi Department of Health's Emergency Planners became obvious during this pandemic. We will continue to work closely with them and preserve our close working relationship, as they are vital to our ability to prepare and respond to disasters in the future.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Thorough Communication
2. Collaboration
3. Professionalism

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Ease of contact – Issues getting in touch with the appropriate contact at MSDH who was responsible for receiving various reports and/or vital information form BMH-Desoto.
2. The overwhelming number of requests from facilities throughout the state sometimes slowed the ability of the state to respond as quickly as we would have liked. We do realize, however, that requests such as PPE or sanitizer were prioritized based on many factors and understand that these types of supplies were needed more urgently by other facilities.
3. Some of the PPE supplied via MEMA from the Strategic National Stockpile could not be used in the hospital.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Initially, the supply of PPE, specifically gloves, gowns and masks and disinfectant were a major concern. We monitored and reported on the number on hand daily. PAPR's and PAPR hoods were not readily available. Eventually, however, due to lots of hard work and diligent efforts by our corporate leadership, PPE seemed to be available and at no time did we ever run out of these needed resources.

Baptist Memphis

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 03/08/2020

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? Elective Surgeries canceled, visitation restricted, electronic meetings only, vendor projects suspended

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Met daily throughout the response. Various departments changed the frequency of their meetings, but the leadership team met daily.

Which components of incident were activated (i.e. which positions/groups were named)? Incident Commander, Supply Chain, Logistics, Planning, Operations

How was information disseminated throughout the facility to keep staff informed? Incident Command was maintained for months, daily safety huddle, EOC committee meetings, patient safety meetings, leadership meetings w/staff

Provide THREE strengths related to INCIDENT COMMAND.

1. Excellent process set up for processing support requests
2. Supply chain was very effective
3. Operations good job on converting negative pressure rooms

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Planning/Response
2. Perimeter Security
3. Supplies

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Planning/Response-We didn't have enough supplies or an effective plan in place for a pandemic response. We are much more prepared and our staff are much more confident after the pandemic.

*Facility did not submit evaluation documentation for the RESOURCES, INFECTION PREVENTION, or EXTERNAL PARTNERS sections.

BAPTIST TIPTON

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/14/21

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)?

- All elective surgeries were cancelled
- Closed the front entrance to monitor traffic through facilities
- Elective procedures rescheduled for future appointment
- Orientation for new staff on hold temporarily
- Visitation was cancelled
- No family members allowed in the ED-exceptions
  - Children
  - Vulnerable adults
  - One support person for those unable to speak English
- Staff deployed to help with monitor entrance points
- Staff deployed to help with COVID designated areas

Which components of incident were activated (i.e. which positions/groups were named)?

- Command Center
- Safety Briefing with:
  - Admin/Safety Coordinator
  - Infection Control Preventionist
  - Security
  - ED manager/Ambulance Service

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence.

- We had Daily Briefing facility huddles morning & evenings
- Corporate communication each evening & thru out the day with changes
- Command Center manned 24 hrs. around clock

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command?

- HR for staffing requirements and staff furloughs
- Materials Manager/EVS/LAB for daily updates on PPE/Lab Supplies/Cleaning Challenges
- Ancillary Director/Physician Clinic Admin Team/Clinic Staff

How was information disseminated throughout the facility to keep staff informed?
Emails/Face to Face/2 Way Radios/Unit Communication books/Unit Safety Huddles/Shift Handoff /Staff Videos

Provide THREE strengths related to INCIDENT COMMAND.

1. Quick Activation
2. Team Work to man the center
3. Corporate Support
4. Development of Resource Manuals
5. Procurement of Supplies needed
6. Lots of education for staff around the clock

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.

1. Development of Resource books
2. Checklist for the staff
3. Toolkit for next challenge
4. Training of 2nd and 3rd layers of Resources for the Command Centers.
5. Developed More Job Action Sheets

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources?
About month into the Pandemic

How long did this last? A few weeks nothing that interfered with staff having what they needed

What resources did you have difficulty procuring? How did you fulfil these needs?
A few challenges with gloves/gowns, corporate procurement

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Numerous not sure of all their names, but prices were the most challenges and these zoom 100%-200% at times

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
We did through most of our normal vendors, but corporate did search for other companies and vendors to secure. Lots of sister hospitals shared and swapped to meet the needs of the staff and pts. We shared services and patient placements as well. All 3 states used and further at times to meet the needs and placement of the pts. when bed capacity was reached.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? To be very generic in thinking and procurement. To have components of kit and not just the kit. We were able to pull together things we needed.

Provide THREE strengths related to RESOURCES.

1. Thinking out of the box, using staff suggestions, lots of rounding and support for staff.
2. Especially stress relievers and giving staff day off and away.
3. Remote work, when possible, Telehealth, Zoom, WebEx,

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.

1. Having our Disaster supplies inventory updated quarterly was a big help to know what was or was not current, expiration dates etc.
2. Ability to rotate and swap supplies

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients.
(i.e., masks, face shields, half masks, etc.) Occasionally Google

What new materials/PPE/resources did you utilize that you had not previous utilized?
Face shields at bedside/Googles

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e. screening, visitation, etc.)? Presently still using screeners at entrances, not sure how long

How did your facility address extended use and/or reuse guidance for PPE?
We did not have to use our PPE/ Process for cleaning face shields if they're intact. Staff education and guidance by Facility IC Preventionist and Corporate IC and use of CDC guidelines

How did your facility address COVID-19 patient and employee testing?

- Staff were testing.
- Pt were tested in ED for symptomatic presentation or IP Admit,
- All elective invasive procedures or emergency surgeries or procedures were tested

What standard or innovative infectious disease barrier control methods did you use, if any?
Shields/Plexi glass/Social Distances/closed waiting room initially/ Later open up with distances btw/Reverse flow isolation room/closed dining room

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We use the CDE guidelines for our Morgue holds/Back up plan for surge if it occurred/Barrier bags for deceased victims/MOU with local funeral homes

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We do have a plan and we reviewed with IC, Admin team/ED manager/Physician Staff. Did not have to activate

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No. Just visitors initially. Lot of signage/Security/ Local campaign and authorities

Provide THREE strengths related to INFECTION PREVENTION.

1. Current monitoring of Infection Rates
2. Number of COVID 19 test
3. Developed a SharePoint site for IC Command tests/numbers/infection rate for communications
4. Increased the number of Trained Staff for Fit testing

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.

1. Isolation precautions in Negative Pressure rooms/ Staff understanding the process of Air borne Isolation/PPE etc. lot s of education regarding COVID 19
2. Flutter test
3. COVID 19 symptoms

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles responsible for maintaining those communications? CDC/State of Tennessee/Mid- South Partners

What were the topics of community meetings or work groups that your organization participated in? Update for guidelines for CDC symptoms/Social distances/Testing/Quarantines

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Emails/social media/Hospital Website/Podcasts/ Videos/Group messaging

How did your organization address the distribution of federal, state, and local funding opportunities? Handled at a Corporate level

What community partners did you work with during the pandemic that you had not previously worked with? none

Provide THREE strengths related to EXTERNAL PARTNERS.

1. City and County leader support for staff
2. Ambulance and Police support
3. West Tenn. Health department
4. Local Health Department

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
Helping schools and colleges

Baptist Women's and Children's

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 11, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Canceled elective surgeries; modified visitation policy; mandatory masks; canceled community cases; converted all meetings into virtual meetings; restricted entrance to the hospital and posted screeners at all open entrances to provide masks, ask screening questions and take temperatures; closed dining room; provided social distancing in all breakrooms; redistributed staff to larger areas to maintain social distancing; created a COVID suspected waiting area for ED (see attached). Educated staff on COVID and how to contact infection control/employee health which included a pager so staff could contact easily and quickly. Added additional hand sanitizing stations; removed the salad bar and all self-serve lines in the cafeteria; all meals were served by a designated employee or were pre-packaged. Completed COVID report on PPE, ventilators, and departments for the state; additional PAPRs for staff and initiated a prioritized fit testing procedure; pre-admission COVID testing for all surgery and OB patients that could not be canceled; testing for entire facility; vaccine confidentially distributed.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily and weekly.

Which components of incident were activated (i.e., which positions/groups were named)? Logistics; incident command; finance

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Infection control, employee health plus tracers to follow positive employees and all exposures reassigned an employee to assist with this.

How was information disseminated throughout the facility to keep staff informed? Email, staff meetings, web ex meetings, corporate updates.

Provide THREE strengths related to INCIDENT COMMAND.

1. Quick action
2. Quick communication
3. Thoroughness of response.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Formalized education was delayed waiting for it to be completed for system
2. Supplies on shortage not expecting what was going to be needed

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began?
Staff are more aware of coming to work ill.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? About a month into the pandemic and it lasted about two months.

What resources did you have difficulty procuring? How did you fulfil these needs?
N95 masks were used for 3 days and disinfected using ultraviolet light.
Filled peri bottles with hand sanitizer from old machines that were being stored.
Isolation gowns. Surgical bonnets and shoe covers were replaced with cloth hats for non-surgery.
Non-sterile gloves

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Corporate procurement

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
Our current policies worked, and we stockpiled what we could while trading with other hospitals for specific items needed to get a better balance of materials.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Corporate – keeping more in house

Provide THREE strengths related to RESOURCES
Larry Edwards and corporate procurement.

Provide THREE opportunities for improvement related to RESOURCES.

1. Review par levels for supplies more frequently
2. Corporate review of resources.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Corporate involvement with purchase of PPE

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, N95, gloves, gowns, goggles, face shields and PAPRs.

What new materials/PPE/resources did you utilize that you had not previously utilized?
Face shields

Does your organization have any plans of keeping any of your COVID-19employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes. We are still screening patients and visitors.

How did your facility address extended use and/or reuse guidance for PPE? N95 ultraviolet lights

How did your facility address COVID-19 patient and employee testing? Have ability to test employees if this need is there. We can test inpatient if there is a need or outbreak.

What standard or innovative infectious disease barrier control methods did you use, if any?
Plexiglass screens, screens for bed spaces in ED and NICU.

What preparedness efforts did you on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We accepted bodies for Baptist Memphis.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes. No adult ICU in facility which created a need to transfer. Never implemented a large-scale testing for the community.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?

- Compliance with social distancing during meals.
- Removing masks as entering and leaving the facility.
- Hesitating to ask a patient to put a mask on.
- Some MDs did not want to wear a mask.

Provide THREE strengths related to INFECTION PREVENTION.

1. Infection prevention nurse and newly assigned employee health employee were vital to complete tracings and walked facility.
2. We did our own tracing.
3. Immediate communication to avoid spread.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Additional resources needed
2. training for employee health

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Communication improved up and down the chain of command to staff.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communication? TN DOH and Shelby County DOH. Heather Fortner, Memphis Disaster Coordinator.
Dr. Sweet at Health Department in Epidemiology.

What were the topics of community meetings or work groups that your organization participated in? No community meetings were attended.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, phone

How did your organization address the distribution of federal, state, and local guidance? Leadership cascaded down to managers/directors then distributed to employees.

How did your organization address the distribution of federal, state, and local funding opportunities? Corporate

What community partners did you work with during the pandemic that you had not previously worked with? Youth Villages

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Corporate

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. State and Federal provided vaccines. Help with PPE suppliers at the beginning but our corporate procurement took over and did a splendid job.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Direct line with Memphis Fire Department
2. Youth Villages

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Direct line with Memphis Fire Department
2. Youth Villages

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Direct line with Memphis Fire Department and Youth Villages

LAUDERDALE COMMUNITY

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 16, 2020

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? Loss in revenue and productivity

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. "Our COVID task force" met weekly

Which components of incident were activated (i.e. which positions/groups were named?
EMS, all clinical staff, Chief of Staff, Hospitalist, Maintenance, City and County Mayors

What, if any, additional position and/or responsibilities were identified that were not part of the traditional incident command? Daily updates from CDC and the President's Task Force

How was information disseminated throughout the facility to keep staff informed? Morning director meetings for new current surge updates and developing trends

Provide THRREE strengths related to INCIDENT COMMAND.

1. Preplanning
2. Information sharing
3. Sharing of information with front line workers

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Back up suppliers for PPE
2. Infrastructure needs for negative air pressure rooms
3. Back up ventilators

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began?
Having adequate supplies on hand for PPE, sanitizer, sterile wipes, sanitary supplies, etc.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? 03/2020 How long did this last? The issues are still current today as we continue to have allocated items due to the pandemic.

What resources did you have difficulty procuring? ALL PPE (All masks, gowns, gloves, goggles) How did you fulfill these needs? Received emergency supplies from EMA and consistently having interactions with our vendors.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? EMA

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes, the only change made was a more enforced strict number of PPE/supplies given out.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The COVID-19 pandemic has made us more aware of the policy/procedures and operations for EMA and our vendors.

Provide THREE strengths related to RESOURCES

1. Able to supply and care for our employees
2. No significant shortage due to diligence in assessing need during pandemic
3. Employee competence in proper use of PPE.

Provide THREE opportunities for improvement related to RESOURCES.

1. Storage
2. Storage
3. More storage

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Continue attention to the supply chain as stated above to ensure there are no shortages of resources.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks (N95, surgical, procedures) jumpsuits, gloves, gowns, goggles, face shields, PAPRs, and other resources in place are protective barriers, hand sanitation stations.

What new materials/PPE/resources did you utilize that you had not previously utilized?
Barrier placement

Does your organization have any plans of keeping any of your COVID-19employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? As COVID continues to evolve, we will make determinations on practices to keep in place and renew, discontinue, or adjust based on the current situation.

How did your facility address extended use and/or reuse guidance for PPE? LCH follows recommendations of CDC

How did your facility address COVID-19 patient and employee testing? We have been able to provide rapid in-house testing and PCR verification through a contracted lab.

What standard or innovative infectious disease barrier control methods did you use, if any? We implemented source control and installed plexi-glass barriers.

What preparedness efforts did you on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? To date we have not exceeded the capability of our morgue.

Did your facility have or use and infectious disease surge plan? At this time, we have not had to place our disaster/surge plan into action. What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Our disaster plan has been adapted to include COVID.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Not at the present time.

Provide THREE strengths related to INFECTION PREVENTION.

1. Our employee's attention to compliance and patient safety.
2. Availability of proper PPE even through the pandemic.
3. Availability of testing in house.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Availability of all rooms.
2. Availability of separation of well/COVID patients.
3. Attention to revision of existing policy in relation to lessons learned in real world COVID experience.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Improvement to advance that in-house testing already identified as a strength to PCR testing.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communication? Norman Hendren CEO and entire admin staff worked together with MSEPC, City & County Mayors and boards, EMS, Local and State TN Department of Health officials, Homeland Security. Norman Hendren was a primary communicator.

What were the topics of community meetings or work groups that your organization participated in? Access to PPE and related supplies. Access to back up staff if an internal outbreak occurred.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? All the above. First time I ever communicated via ZOOM meeting.

How did your organization address the distribution of federal, state, and local guidance? Too all information very seriously and made sure it was available to all employees.

How did your organization address the distribution of federal, state, and local funding opportunities? All funding was a God send.

What community partners did you work with during the pandemic that you had not previously worked with? Numerous local clinics and nursing facilities where we conducted COVID testing because we had quick testing in house.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? We rented mobile negative air pressure machines with a local rental company for COVID related ventilation.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Absolutely. Received PPE help from MSEPC, ventilators from National Guard, and Federal HRS funding.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? It takes local, state, and federal cooperation to address a pandemic size problem.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Rapid response
2. Adequate resources
3. Communication

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Rapid response
2. Adequate resources
3. Communication

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
The COVID challenges dealing with life and death situations was something new to a lot of partners.

LE BONHEUR CHILDREN'S

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/19/2020

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? Significant impact. Tremendous loss of surgical volume and daily census. Massive negative fiscal impact. Sweeping visitation policy modification creating additional challenges to families caring for inpatient pediatric patients.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Unified command groups met daily during the peak of the pandemic including system IC meeting, facility IC meeting and separate Operations Division daily meeting. Scaled back to three-days a week. Resumed daily following the second wave, then back to three days, now ongoing once per week system IC and facility IC.

Which components of incident were activated (i.e. which positions/groups were named)? Black Team: IC, Med/Tech Specialists, Safety Officer, PIO, Liaison, Blue Team: Planning Chief, Red Team: Operations Chief, Infrastructure Branch Director, Yellow Team: Logistic Chief, Labor Pool Unit Leader, Green Team: Finance Division Chief

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? None unless a coordinated staff of full time Screeners at every entrance would be considered additional to the HICS operations

How was information disseminated throughout the facility to keep staff informed? Scheduled meetings, email, digital and fixed signage

Provide THREE strengths related to INCIDENT COMMAND.

1. Once HICS was established excellent consistency in management, reporting, and communication
2. Excellent communication services and response from PIO and team
3. Good, mirrored structure from corporate IC to facility IC

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. As always, leadership challenges with the understanding, implementation, expectation, roles and responsibilities within the HICS structure

2. Initially good HICS form and documentation adherence with Scribe support but faded over time. Understandable considering the unique extended duration of a pandemic event
3. Lack of awareness/communication of overall specific pandemic plans or complete lack of a plan altogether from a state, county, system, and facility

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The stated issue of leadership issues with understanding and implementing the HICS structure has been improved a great deal by the consistency of our Incident Command meetings. Its positive results have led to the activation of other Incident Command groups for non-pandemic related events. The persistent use of the structure and terminology has become more familiar and accepted.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? We didn't have any limited resources.

What resources did you have difficulty procuring? How did you fulfil these needs?
We were able to fulfil our needs and no disruption of procuring

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Medline and Owens Minor

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Normal material management mechanisms/policies/procedures continued to work. We also began daily reports of PPE supply levels and weekly inventory cycle counts.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We learned to rotate stock more frequently for emergency storage and used the items before expiration.

Provide THREE strengths related to RESOURCES.
1. Having correct par levels
2. Cycle counting
3. Having process control by having a distribution or issue plan.

Provide THREE opportunities for improvement related to RESOURCES.
1. Knowing what is available
2. Knowing who to get the resources from

3. Having adequate storage for surplus levels of supplies.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The opportunity of cycle counting and knowing what your inventory levels are and being more accurate.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e. masks, face shields, half masks, etc. PPE including N-95 mask, surgical mask, face shield/ eye protection, gowns, gloves, PAPRs, portable hepa95 mask, surgical mask, face shield/ eye protection, gowns, gloves, PAPRs, portable HEPA-filters.

What new materials/PPE/resources did you utilize that you had not previously utilized?
None – just increase in the volume and accessibility to PPE.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e. screening, visitation, etc.)? COVID related employee or patient safety policies will be archived and updated to avoid related employee or patient safety policies will be archived and updated to address any similar outbreaks in the future.in the future.

How did your facility address extended use and/or reuse guidance for PPE?
We implemented an extended use/ reuse process for N-95 mask, gowns and face shield mask, gowns and face shield/ eye protection in accordance with CDC recommendation in accordance with CDC recommendation.

How did your facility address COVID-19 patient and employee testing? We have implemented COVID -19 testing for both patient and associate testing. We developed a process for three different types of COVID test: Rapid antigen, PCR (Aries or Panther and antigen, PCR (Aries or Panther and Rapid PCR). We also developed a procedure on appropriate specimen collection in accordance with Rapid PCR). We also developed a procedure on appropriate specimen collection in accordance with established guidelines.

What standard or innovative infectious disease barrier control methods did you use, if any?
We have implemented various barrier control methods, these included:

- Intubation box made from PVC pipes and plastic clear materials.
- Movable containment wall units made from PVC pipes and plastic clear materials.
- Plexi glass barrier at counters.
- Solid walls made of heavy heavy-duty plastic materials and aluminum construction. Duty plastic materials and aluminum construction.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We reviewed our morgue resource capabilities and worked with hospital /system incident command for need of additional portable freezers if needed.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Strengths: Expert providers and staff, engaged leadership, staff availability, space availability. Weaknesses: Airborne Isolation rooms, Supply chain issues and PPE shortages: N-95masks, fit testing, lack of pediatric referral/ transfer facilities or alternate care sites.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes, particularly when guidance changed from the CDC and evolving such as mask and eye protection.

Provide THREE strengths related to INFECTION PREVENTION.

1. Highly qualified infection prevention staff.
2. Engaged hospital leaders from senior leadership to departmental level.
3. Adherence to basic policy and procedures on infection prevention

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Ensuring availability of PPE and cleaning supplies.
2. Communicate and operationalizing of evolving guidance from CDC to hospital staff
3. Limited Fit testing capabilities and resources prior to pandemic.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Ability to expand fit testing, increasing number of associates who are fit tested. Moreover, able to fit test different types of respirators.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Various vendors and manufacturers. Who were the responsible parties/job titles that were responsible for maintaining that communications? Materials Management Director and team

What were the topics of community meetings or work groups that your organization participated in? Various city related calls.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Calls, email

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated them through Incident Command, daily huddles, intranet link specific to COVID

How did your organization address the distribution of federal, state, and local funding opportunities? This was done through our system Finance team

What community partners did you work with during the pandemic that you had not previously worked with? Increased collaboration/activity with county and state maintaining/updating the many data points tracked. Worked with outside vendor spearheading mask reprocessing program.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? None

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Very well supported by Federal partners from a financial perspective. I have never worked through a pandemic event before so I am not sure what the expectations would be and perhaps most of the information and involvement was happening at the corporate level but did not feel engaged with county and state. Little if any communication and pandemic support activity awareness was provided at facility level.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Financial support (Federal)
2. Resources & Supplies
3. Committed support when asked

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Confusing and contradictory information and guidance (Federal)
2. Outdated or non-existent pandemic planning
3. Lack of general communication and engagement with frontline facilities
4. Finding and sharing best practices from across the region and nation

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Posted from OVERALL Comments (as requested by evaluation author)

Did you feel as if pre-COVID community drills, exercises, trainings, advanced planning, and communication accurately represented the actual response to COVID-19? In other words, did you feel prepared to response to this pandemic? Please explain. Somewhat. Transitioning to an emergency management HICS structure via consistent drills and exercises has been beneficial in

building familiarity to the process. However, there is still so much work to be done regarding improving staff understanding, importance of EM culture and buy in. I can't say we "felt" we were more prepared for the response from any one exercise or training. To the contrary, pandemic plans at every level were not current or existent. Acknowledging the external support provided, I believe our ongoing success was due more to the gifted, committed, and innovative leadership and staff that flexed and scaled to address the constantly changing landscape.

How can MSEPC better partner, plan, exercise, and communicate with Coalition membership and other community members on behalf of Coalition membership? Consider options/technologies/services for improved communication to coalition members at the facility level during events. I did not feel engaged at all with coalition regarding general information and activities related to the pandemic response from the city, county and state. Any general or even informal communication touch point with any consistency would have been appreciated.

How can the MSEPC better expose and/or educate its member organizations about other member organizations and partners? Annual conference with participation from members from all coalitions. Sharing of best practices and lessons learned from across the state and nation.

METHODIST GERMANTOWN

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 3, 2020

How your facility was affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? We canceled elective surgeries; the incident comment systematically went through the different aspects of the closures to define policies, processes etc. Visitor policies revised and restricted.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initial meetings about surgical cancellations and reopening were held daily; then three times a week and finally weekly. Daily IC calls and meetings the first 7 – 8 months, currently reduced to weekly (mid-week).

Which components of incident were activated (i.e. which positions/groups were named)? AT THE SYSTEM LEVEL: Incident Commander, Operations section chief, safety officer, logistics, communication, planning and Finance officer, Specialist – Infection Prevention.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? None to my knowledge

How was information disseminated throughout the facility to keep staff informed? Telephone calls, daily email updates, Cornerstone/Learning management system, verbal huddles, meetings, COVID specific link on our intranet.

Provide THREE strengths related to INCIDENT COMMAND.

1. Robust communication to leaders for filtering information down to associates
2. Daily communication to address issues
3. Linkage to community organizations and Dept of Health

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. The approach was standardized and sometimes the variations in practice environments were not considered
2. Sometimes decisions would be made outside of the IC structure and communication would be challenging

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Getting practice changes made by IC to the front-line staff in a timely manner. We have

improved this with better communication through MOLLI and leadership

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Set up with IC implementation. How long did this last? On-going, still have some products on allocation or limited supplies.

What resources did you have difficulty procuring? N-95 masks, isolation gowns, gloves. How did you fulfill these needs? Sourced from different vendors and used some supplies from our Disaster Distribution Center (DDC).

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Furniture manufacturers started making isolation gowns.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. A great deal of the supply procurement was organized at the system level, and we did not change materials management policies, but shared resources within the system.

Provide THREE strengths related to RESOURCES.

1. Daily inventory emails regarding PPE assisted with assessing levels.
2. Began a rotation plan for items at the DDC to keep within date items in circulation and dispose of out-of-date items as directed.

Provide THREE opportunities for improvement related to RESOURCES.

1. Staffing was the most problematic aspect of resources.
2. Sometimes alternate PPE (gowns or masks) would show up without explanation impacting staff confusion. Substitutions were not always clearly communicated to the end user.
3. Received items at the DDC that we cannot rotate into our planned stock.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Clearly communicating in a rapid fashion to the end users that there are alternative products being put into circulation that may appear of function slightly differently from the ‘normal’ product supplied.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e. masks, face shields, half masks, etc.) N-95 masks, gloves, surgical masks, gowns, face shields, PAPRs for aerosolizing procedures, goggles.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields most consistently, PAPR

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e. screening, visitation, etc.)? Yes, security revisions on our campus limiting the number of unlocked entrances to the facility.

How did your facility address extended use and/or reuse guidance for PPE? Evidence-based practice

How did your facility address COVID-19 patient and employee testing? COVID-19 Associate testing was done through the IOC on a need to have basis – meaning, routine testing was not done, it was only done when Associates were symptomatic. We also opened a drive through model for testing of symptomatic people, pre-surgical testing on campus and later moved it off campus due to traffic flow issues.

What standard or innovative infectious disease barrier control methods did you use, if any? Barrier walls, co-horting units, HEPA scrubbers in patient rooms, negative pressure rooms.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Our utilization of the morgue was at the same level as that of normal times. We used the same capacity processes.

Did your facility have or use an infectious disease surge plan? Yes, it was tiered based on COVID volume. What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Strengths include the proactive and monitoring process employed with its use; weakness was that it assumed continued cessation of elective procedures because of the plan for reallocation of staff. As time progressed, and elective surgeries and procedures increased, the availability of surge staffing diminished. Additional staffing from Le Bonheur and ambulatory sites was based on the Associate's willingness to work, which minimized the pool of resources system wide.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Visitation was the major complaint. As COVID numbers began to diminish, portions of units were established for co-horting of COVID+ patients. A few comments were made by visitors in non-COVID rooms when they saw the signs that they were concerned that they were near COVID patient rooms.

Provide THREE strengths related to INFECTION PREVENTION.

1. Evidence-based approach
2. Constantly reassessed
3. The "why" was communicated to stakeholders.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Could have leveraged more infectious disease MDs for feedback
2. As operations moved toward pre-COVID levels, maintaining entire units for co-horting was challenging.
3. Clear direction, based on the evidence, regarding HEPA filters and pseudo-negative pressure rooms was challenging.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Use of HEPA scrubbers to create a near negative pressure environment on units co-horting patients. Our ability to quickly implement and install window inserts with exhaust directed outside the building.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? The system has a presence in community groups. Our president (facility IC) communicated with physicians and community partners. Who were the responsible parties/job titles that were responsible for maintaining that communications? At the facility level, it was directed by the incident commander (president)

What were the topics of community meetings or work groups that your organization participated in? Status updated, importance of supporting infection control practices, testing and Memphis Mayor's update (through corporate representation).

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Calls, e-mails, GoToMeeting/Zoom sessions

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated/coordinated through the system Incident command structure, daily huddles, intranet link specific to COVID.

How did your organization address the distribution of federal, state, and local funding opportunities? At the system level, processes were established for data collection and each facility provided information, using that template for performance, to the State by our finance team.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Germantown facilitated the partnership with US Army Reserve medics for staffing assistance for several weeks of additional coverage at the COVID drive through testing and ED.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Communication opportunity related to work in the hospital by vendors when the census was low at the peak of COVID in the community and state lock down. Vendors would not come into the hospital, even after cleared for fear of being around COVID patients.
2. Prioritization of services should have healthcare as a top priority, especially in a pandemic.
3. Inflated prices of products or services because of demand or shortages.

Methodist North

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 3, 2020

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? Elective surgeries were cancelled, NO visitors. Many policies were developed strictly for COVID. Entrances/Exits were restricted. Associates were screened for COVID prior to entry.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. There were daily IC calls and meetings for the first 7-8 months. They have scaled back to weekly. Zoom meetings rapidly replaced our face-to-face meetings due to social distancing. ZOOM exploded after the initial learning curve and bumpy road. We were able to post helpful charts and graphs during presentations. We also enjoyed a moment of levity from the background scenery in various offices. Those meetings were every day and prn.

Which components of incident were activated (i.e. which positions/groups were named)? What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? We opened the corporate command and section chiefs immediately. The section chiefs opened other positions as were needed**.** We utilized poster size "Post it Notes" to communicate with other branches so we maintained social distance. Area surfaces in our command center were cleaned between uses. Specialist – Infection Prevention was added and contributed tremendously.

How was information disseminated throughout the facility to keep staff informed? Meetings, phone calls, established COVID specific link on our intranet home page. Bulletin boards. Laminated information flyers posted by the time clocks and on exit doors and associate elevators. PBX announcements as needed (Day hours).

Provide THREE strengths related to INCIDENT COMMAND.

1. Established a chain of direct command as soon as assignments were made.
2. Streamlined communication with daily briefings.
3. Assignments allowed the Command staff to review their own roles and then know who to communicate with directly when issues came up.
4. Each of the command staff were responsible for reporting off to someone in their absence.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Need to continue education on roles and responsibility of IC.
2. Forms need continued review and update.
3. Establish a direct line of communication between IC and Corp.Logistics

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Each IC member was issued their packet for their review and use. (Clipboard with role /responsibility and vest). They were very positive and supportive of each other as we were immersed in COVID. We all learned that if we worked together, we could all achieve our goals.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Almost immediately How long did this last? There are still some products on allocation or limited resources

What resources did you have difficulty procuring? N95, gowns, gloves How did you fulfill these needs? Sourced from different vendors and used supply from our disaster distribution center (DDC).

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Manufacturers of furniture made gowns.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. We did not change materials management policies, but we did share resources within the system

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Began a rotation plan for items we are keeping at the DDC to be able to keep in-date items for the next event

Provide THREE strengths related to RESOURCES.

1. We were able to source many items.
2. We made requests to our facilities logistics chief.
3. Those requests were forwarded to our corporate logistics and supplied when they were available. Once resources were obtained, they were secured and distributed as needed.

Provide THREE opportunities for improvement related to RESOURCES.

1. We got items that we can't use after the pandemic or can't be rotated in our plan.
2. Supplies/Equipment are located at the DDC and we have no means to transport them to satellite hospitals.
3. Disaster supplies/equipment need a designated and secure storage space at each facility.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The organization of the supplies at the DDC and the implementation of a rotation schedule to keep items within their expiration dates.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? N95 for clinical, surgical masks for non-clinical, PAPR initially for aerosolizing procedures, face shields/goggles. Isolation Carts were purchased to provide protection and decrease sharing of PPE. To protect patients? Masks, face shields, half masks, and visitor restrictions.

What new materials/PPE/resources did you utilize that you had not previous utilized? PAPR

Does your organization have any plans of keeping any of your COVID-19 employees or patient safety policies in place when COVID-19 is no longer an emergency (i.e. screening, visitation, etc.)? Not yet decided

How did your facility address extended use and/or reuse guidance for PPE? Information was shared in bed huddles, email and flyers. Our infection control nurse and educators were instrumental in keeping everyone informed of the latest information and why's.

How did your facility address COVID-19 patient and employee testing? Education down the IC chain of command to the bedside nurse. Using Nursing educators and Infection control as facilitators.

What standard or innovative infectious disease barrier control methods did you use, if any? We used temporary doorways, Plexiglas, and plastic barrier walls. We labeled the units with **Hot Zone** **Warm Zone** and **Cool Zone** barrier ribbon on the doors and hallways. This was helpful as we extended and retracted our barrier walls. Our staff and physicians found it helpful on the stairwell doors and hall doors.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? North has a 4-body morgue. We did just in time training with our "Bio Seal" as needed. We also reviewed the guidelines for morgue surge from West Tenn. Regional Forensic Center. It was helpful to have the letter from WTRFC with name and phone numbers.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Recycling of the N95 was slow to catch on as a practice. Some nurses had questions about the safety of this practice. Some nurses were wearing N95 until they were soiled or worn out. "No visitors" was difficult for families, patients and staff.

Provide THREE strengths related to INFECTION PREVENTION.

1. Additional isolation carts were purchased and will be added to our inventory and used prn.
2. The training on appropriate handwashing and 6 ft. social distancing was well received.
3. Any information or training from infection control was well received.

4. Associates and visitors were eager to learn anything about the disease and how to protect ourselves in this pandemic.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. The N95 masks should have been distributed and made immediately available to FRONTLINE staff.
2. The supplies needed for the immediate barrier placement should be stored on the units.
3. To protect the staff and in-house patients. COVID information should be communicated daily with frontline staff at the beginning of the shift on the unit. Possibly a "COVID FACT SHEET" or a white board with the most current information on transmission and treatment.
4. All this information could be found on the internet BUT the frontline staff were not on the internet. They were down the COVID hallways caring for patients and answering their questions.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. One opportunity for improvement would be to invest in general PSA's promoting good general hygiene. Effective handwashing with soap and water, use of hand sanitizer when water is not available. The use and disposal of tissues when sneezing. How to clean high use surfaces. These things may seem over simplistic BUT they are NOT widely known or practiced.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Various vendors and manufacturers, Heather Fortner RHC. Who were the responsible parties/job titles that were responsible for maintaining that communications? Materials Management Director and team.

What were the topics of community meetings or work groups that your organization participated in? Various city related calls.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Calls, email, virtual meetings platforms.

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated them through Incident Command, daily huddles, intranet link specific to COVID

How did your organization address the distribution of federal, state, and local funding opportunities? This was done through our system Finance team

What community partners did you work with during the pandemic that you had not previously worked with? WTRFC: West Tenn. Regional Forensic Center

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what the topic of agreement was? Not at present.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. This was an unprecedented event for our country. Many opportunities were revealed. The lack of a stored stockpile of PPE was the most egregious. Yes, many local businesses provided meals for our associates on the front line.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Unsure

METHODIST OLIVE BRANCH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 3/30/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Cancelled elective surgeries, No visitation as a precaution for a surge of COVID in patient. Staff that were affected by surgeries were allocated to other units in the hospital.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily after 9:05 am Safety Huddle, COVID Task force meetings, after 2 months transferred to Monthly status. In 2021 rolled IC into the 9:05 meeting.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Commander, PIO, Safety Officer, Liaison, Operations Section Chief, Planning Section Chief, logistics Section Chief, Finance Section Chief. Fill in any as needed. What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? None

How was information disseminated throughout the facility to keep staff informed? Verbal huddles, Emails, Group Text, and Send Word Now

Provide THREE strengths related to INCIDENT COMMAND.

1. Good Communication
2. Reallocation of employees, resources, shared resources
3. Placement and direction of drive through
4. Patient placement.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Need more directors involved
2. Need more staff
3. Lost importance over time
4. Canceled meetings

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Communication

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Immediately

How long did this last? Still having issues
What resources did you have difficulty procuring? PPE, Meds, and Cleaning Supplies: How did you fulfill these needs? We made PPE/system sharing meds.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Corporate Supply chain team worked it with system level procurement. They dealt with vendor relations.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. PPE Distribution: Locked up and counted daily, it was managed closely with weekly reports.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Corporate Supply Chain Team, PPE Stored in different areas, Have a tracking system for PPE.

Provide THREE strengths related to RESOURCES.

1. Able to find PPE and distribute to units quickly
2. Daily updates on PPE and Usage
3. Paid Inventory app to track PPE
4. Signing out PPE.

Provide THREE opportunities for improvement related to RESOURCES.

1. Staff getting PPE at night and not signing out
2. Departments getting PPE from other departments
3. Keeping up with PPE and Supplies from other facilities could have been improved.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Signing out process improved.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Masks, Gowns, N95, Face Shield, Goggles, Gloves, Shoe Covers, Head Cover, Brown Paper Bags, PAPRs, Intubation Boxes To protect patients? Surgical Mask, HEPA Air Scrubbers

What new materials/PPE/resources did you utilize that you had not previously utilized? Air Scrubbers, Intubation Boxes, PAPR's

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not Sure

How did your facility address extended use and/or reuse guidance for PPE? New Policies
How did your facility address COVID-19 patient and employee testing? All admissions tested, Random associate testing, all scheduled surgeries tested

What standard or innovative infectious disease barrier control methods did you use, if any? COVID Hotline

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Associates – Did not want to always wear PPE; Patients – Taking mask off all the time

Provide THREE strengths related to INFECTION PREVENTION.

1. COVID Units worked well
2. HEPA filters in rooms
3. Limit staff in room with a code

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Staffing and burnout
2. COVID unit no windows caused patient delirium
3. Windows to assist staff in COVID unit.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. More people trained on N95 use, before COVID only select associates were trained.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? State of Mississippi for Meds and vaccine, other vendors from corporate supply chain.
Who were the responsible parties/job titles that were responsible for maintaining that communications? Materials Management Director and team.

What were the topics of community meetings or work groups that your organization participated in? Worked with congregational health network on community vaccination

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email and faxes from the State of Mississippi

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated them through Incident Command, daily huddles, intranet link specific to COVID

How did your organization address the distribution of federal, state, and local funding opportunities? Corporate Finance

What community partners did you work with during the pandemic that you had not previously worked with? WTRFC: West Tenn. Regional Forensic Center

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what the topic of agreement was? Not at present.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, the State of Mississippi provided support for med and COVID treatment. Vaccine distribution, and Army National Guard logistics for PPE.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Unsure

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Communication and support from the state.
2. Local community support and donations.
3. Army National Guard logistics and transporting PPE to the facility.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Vendors could not enter the facility to repair equipment
2. Vendors did not want to enter facility or COVID areas.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Community relations improved 100%, EMS partnership strengthened.

METHODIST SOUTH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 3, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? We canceled elective surgeries; limited campus access; restricted visitors; updated policies as CDC directives changed.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily IC calls for several months. Now we have calls once a week.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Commander reported facility issues up to the Methodist system Incident Command structure during the IC calls.

How was information disseminated throughout the facility to keep staff informed? Telephone calls, daily email updates, verbal huddles, meetings, COVID specific link on our intranet home page, MLH President daily update newsletter.

Provide THREE strengths related to INCIDENT COMMAND.

1. Daily communication between leaders and Associates helped push information out
2. System meetings and information sharing
3. Ability to address rapid changes using IC structure for policy and procedures to be updated

Provide THREE opportunities for improvement related to INCIDENT COMMAND.
Decisions made at various meetings that were not Incident Command. (system)

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. More IC positions should have been set up at the facility level to mirror MLH system IC. This may have helped with some of the communication issues we had initially - but communications did improve as we moved through the pandemic and set up additional resources and means for communication.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Almost immediately. How long did this last? On-going, still have some products on allocation or limited supplies.

What resources did you have difficulty procuring? N-95 masks, isolation gowns, gloves. How did you fulfill these needs? Sourced from different vendors and used some supplies from our Disaster Distribution Center (DDC).

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Furniture manufacturers started making isolation gowns.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. A great deal of the supply procurement was organized at the system level, and we did not change materials management policies, but shared resources within the system.

Provide THREE strengths related to RESOURCES.

1. Started daily inventories so we could better manage shortages and share resources.
2. Able to utilize the disaster distribution center (system) to house supplies and distribute as needed to hospital.

Provide THREE opportunities for improvement related to RESOURCES.

1. Staffing issues with staff out with COVID or leaving to seek agency work with higher wage opportunities.
2. Various types of PPE that we did not use in the past caused some confusion and were not communicated well.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. being able to have supplies at DDC that we can rotate.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) N-95 masks, gloves, surgical masks, gowns, face shields, PAPRs for aerosolizing procedures, goggles.

What new materials/PPE/resources did you utilize that you had not previous utilized? PAPR/ did not use face shields as much in the past and as widely as we did for pandemic

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e. screening, visitation, etc.)? Yes, campus hardening – limiting entry points.

How did your facility address extended use and/or reuse guidance for PPE? Evidence based

How did your facility address COVID-19 patient and employee testing? COVID-19 Associate testing was done through the IOC on a need to have basis – meaning, routine testing was not done, it was only done when Associates were symptomatic. We also opened a drive through

model for testing of symptomatic people, pre-surgical testing on campus and later moved it off campus due to traffic flow issues.

What standard or innovative infectious disease barrier control methods did you use, if any? Barrier walls, co-horting units, HEPA scrubbers in patient rooms, negative pressure rooms.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Our utilization of the morgue was at the same level as that of normal times. We used the same capacity processes.

Did your facility have or use an infectious disease surge plan? Yes, it was tiered based on COVID volume. What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Strengths include the proactive and monitoring process employed with its use; weakness was that it assumed continued cessation of elective procedures because of the plan for reallocation of staff. As time progressed, and elective surgeries and procedures increased, the availability of surge staffing diminished. Additional staffing from Le Bonheur and ambulatory sites was based on the Associate's willingness to work, which minimized the pool of resources system wide.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Visitation was the major complaint. As COVID numbers began to diminish, portions of units were established for co-horting of COVID+ patients. A few comments were made by visitors in non-COVID rooms when they saw the signs that they were concerned that they were near COVID patient rooms.

Provide THREE strengths related to INFECTION PREVENTION.

1. Evidence-based approach
2. Constantly reassessed
3. The "why" was communicated to stakeholders.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Could have leveraged more infectious disease MDs for feedback
2. As operations moved toward pre-COVID levels, maintaining entire units for co-horting was challenging.
3. Clear direction, based on the evidence, regarding HEPA filters and pseudo-negative pressure rooms was challenging.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Use of HEPA scrubbers to create a near negative pressure environment on units co-horting patients. Our ability to quickly implement and install window inserts with exhaust directed outside the building.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? The system has a presence in community groups. Our president (facility IC) communicated with physicians and community partners. Who were the responsible parties/job titles that were responsible for maintaining that communications? At the facility level, it was directed by the incident commander (president)

What were the topics of community meetings or work groups that your organization participated in? Status updated, importance of supporting infection control practices, testing and Memphis Mayor's update (through corporate representation).

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Calls, e-mails, GoToMeeting/Zoom sessions

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated/coordinated through the system Incident command structure, daily huddles, intranet link specific to COVID.

How did your organization address the distribution of federal, state, and local funding opportunities? finance team worked on these initiatives

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Yes – water tankers

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. This was mostly communicated with our System IC leaders. The meeting content was shared during IC system calls with the hospital.

METHODIST UNIVERSITY

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 3, 2020

How was your facility affected by the initial Safer at Home directives (i.e. canceled elective surgeries, visitation policies, or other closures)? Elective surgeries were cancelled, no visitation. Many policies developed strictly for COVID

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. There were daily IC calls and meetings for the first 7-8 months. They have scaled back to weekly.

Which components of incident were activated (i.e. which positions/groups were named)? What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Specialist – Infection Prevention

How was information disseminated throughout the facility to keep staff informed? Meetings, calls, established COVID specific link on our intranet home page

Provide THREE strengths related to INCIDENT COMMAND.

1. Ability to flex with the situation
2. Creativity
3. Experience from several different events throughout the county.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Lack of MOU for certain products.
2. Lack of clear direction.
3. More available staff.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Incident command did not have access to an up-to-date list of suppliers that could come to our aid. Currently that situation has changed considerably. New relationships were created with vendors and a strong sense of urgency has been communicated to them.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Almost immediately How long did this last? There are still some products on allocation or limited resources

What resources did you have difficulty procuring? N95, gowns, gloves How did you fulfill these needs? Sourced from different vendors and used supply from our disaster distribution center (DDC).

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? None

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. We did not change materials management policies, but we did share resources within the system

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Began a rotation plan for items we are keeping at the DDC to be able to keep in-date items for the next event

Provide THREE strengths related to RESOURCES. We were able to source many items

Provide THREE opportunities for improvement related to RESOURCES. We got items that we can't use after the pandemic or can't be rotated in our plan.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. DDC and rotation plan to keep items that will be needed in the future

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.)

- Health-grade surgical masks for associates, patients and visitors in hospital.
- Face shields or goggles for associates
- N95 for associates in hospital
- PAPR for associates and providers with facial hair
- Isolation gowns for associates caring for COVID PUI and COVID positive patients.
- Temporary walls for barriers to delineate hot, warm and cold zones.
- Hepa Filters for patients' rooms.
- Gloves for patient care

What new materials/PPE/resources did you utilize that you had not previous utilized?

- PAPR
- Temporary walls

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Unknown—will defer this to question to leadership team.

How did your facility address extended use and/or reuse guidance for PPE?

- N95 reuse via mask reprocessing – Instituted N95 mask reprocessing by vaporized hydrogen peroxide procedure.
- N95 reuse for limited number of times of donning/doffing. Mask could be reprocessed 20 times.
- Co-horted dedicated unit for COVID patients. N95, gown and face shield could be worn between patients without doffing unless soiled or exposed to AGP as defined by CDC.

How did your facility address COVID-19 patient and employee testing? All patients tested prior to admission. Pre-surgical testing. Associates tested based on exposure risk and if desired. Drive through testing available on site.

What standard or innovative infectious disease barrier control methods did you use, if any? Cold/warm/hot zones identified. Logs for sign in to manage distribution of limited PPE. Desk at entrance to COVID Unit to manage distribution of PPE.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Hospital morgue. Contingency plan to bring in refrigerated trucks if morgue exceeded capacity.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? Defining what patient number is considered a surge, renting ante rooms vs buying, short staffed with ICU nurses causes issues with flow and use of designated COVID ICU. If you had no plan, have you created a plan based on your COVID-19 response? We had a plan.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes. Staff did not always wear masks appropriately, did not social distance in break rooms or when eating, staff did not ensure patients wore masks when transported in hall.

Provide THREE strengths related to INFECTION PREVENTION.

1. IP team pulled call 24/7 to assist with COVID 19 issues/ concerns and questions for IOC hotline.
2. IP enforced CDC constantly changing recommendations daily and communicated to staff.
3. Rounded daily to ensure staff and patients were updated on policies and appropriately protected.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Better communication avenues to distribute information quickly.
2. Better timing of communication released from Incident Command Center to staff. IP team was caught off guard in morning safety huddles

3. Better system to pull location and numbers of COVID positive patients.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Flow and location of Potential and Confirmed COVID positive patients has become a refined process. IP now knows from current reports where patients are located throughout the facility. IP can ensure we are following CDC guidelines for removal of isolation or implementation of continued isolation.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Various vendors and manufacturers. Who were the responsible parties/job titles that were responsible for maintaining that communications? Materials Management Director and team.

What were the topics of community meetings or work groups that your organization participated in? Various city related calls.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Calls; email

How did your organization address the distribution of federal, state, and local guidance? Developed necessary policies and communicated them through Incident Command, daily huddles, intranet link specific to COVID

How did your organization address the distribution of federal, state, and local funding opportunities? This was done through our system Finance team

REGIONAL ONE HEALTH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 3/10/2020

How your facility was affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? We had a financial loss significant enough to hold PTO and stop retirement contributions. We have multiple off campus locations as well as a main campus outpatient clinic and surgery center that were totally shut down.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initially, the command team met twice a day/5 days a week with one call over the weekend. It varied over the summer and went up and down in frequency based on the number of patients and number of issues related to COVID. By September we were down to twice a week calls.

Which components of incident command were activated (i.e., which positions/groups were named)? All the command team, plus all chiefs and specialists. We teamed people into functional groups without using specific titles past chiefs.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Process architects. We added a person called a process architect that primarily helped teams and groups put process charts and flow diagrams into their plans. These architects came from project management positions across the organization and functioned only as an aid to the operations team.

How was information disseminated throughout the facility to keep staff informed?
We primarily used all user emails and print out posts across the facility and off-site clinics

Provide THREE strengths related to INCIDENT COMMAND.

1. Speed – groups were able to have turnaround times of less than 6 hours for most issues
2. Content creation – we had to make brand new policies and processes for COVID. Command team excelled in creating understandable and efficient answers and content.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Mass dissemination of incident command progress. It was not well known that the command team was working on this issue or that. We fixed this later with a command email, but this was not before September
2. Following the agenda was difficult at times once we started meeting virtually instead of in person. It took about a month to adjust. Strict scripts for agendas are needed to stay on track virtually.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Mass communication. We have since adopted a new mass communication system for calls and texts that runs organization wide as well as set up an incident command email so that staff can get updates straight from command team from command team title email. We used both during a 2021 activation and it made a great deal of difference.

Communication among team members. At first members hesitated to reach out to each other unless prescript, but by the summer most communication happened outside of meetings and was reported on during meetings. Creating speed and efficiency and most importantly trust.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? March. That lasted for about three months. We were forced to order extremely large amounts of PPE when they became available. The SNS and state supplies were grossly insufficient. We did re use n95s to help with PPE as well as employee use of half mask respirators that can be re used. Also, we had a large amount of emergency supplies of PPE that we utilized. Because of this we never fully ran out of basic supplies needed to function.

What resources did you have difficulty procuring? How did you fulfill these needs? Surgical caps and gowns as well as gloves became very scarce to find. Our supplies dwindled down into the 2-day or 3-day zone for gloves at one point, but we were able to procure enough every three days for about two weeks until the supply chain returned to normal.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? SNS, state and local MOUs were used, as well as some European vendors previously unknown to us but were referred to us by our local/common vendors.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. We had to centralize our masks and basic PPE procedures. We created a request process online for each department and area and we fulfilled based on need from a central location instead of the normal distribution from omni cells etc. to control and monitor the use and amount remaining (burn rate etc.)

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The type of PPE that we need in storage and the amount in storage will change. We needed larger quantities. Also, the use of half masks was so widely liked by staff, we procured enough to be able to outfit the entire ED if the need arises again.

Provide THREE strengths related to RESOURCES.

1. Command team was able to centralize the PPE procurement process in a rapid and efficient way
2. The use of half mask respirators instead of PAPRS and N95s saved time and money and staff felt safer.

Provide THREE opportunities for improvement related to RESOURCES.

1. Emergency storage numbers
2. Keeping more diverse vendors

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The awareness of staff that half masks exist, we have them, and that they are safe and easy to use when needed.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients. (i.e., masks, face shields, half masks, etc.) N95s, surgical masks, PAPRS, half mask respirators.

What new materials/PPE/resources did you utilize that you had not previous utilized?
Half mask respirators

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not that this time. Visitation policies are already reverting to normal. Screening is still in place but will not be long term. We have considered the use of the Moonbeam sterilization tool to be used for general room cleaning moving forward but not totally decided yet.

How did your facility address extended use and/or reuse guidance for PPE? Used half masks to save on masks and used a moonbeam sterilizer to re-use n95s for staff

How did your facility address COVID-19 patient and employee testing? We set up a testing team and gave them their own location within our outpatient center to test employees at an ongoing basis very early on, including outside testing in the parking lot. For patients we used rapid tests controlled by the lab.

What standard or innovative infectious disease barrier control methods did you use, if any?
The wide use of moonbeams, curb side procedures for our pharmacy so that they could stay highly functional and safe and half mask respirators

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do have a morgue. All morgue policies were essentially revisited as well as the installation of extra shelves, storage, and print/fax/phone to be

able to remain highly functional during a surge. As well as the training on bio seal bags and equipment held on campus.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We had a surge plan for mass fatality, but it was not infectious specific. We also had an influenza plan, but some surge elements were missing. We essentially joined elements of both plans to create a more rounded response.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? For the most part we didn't have any staff issues, but patient and visitor restrictions were difficult to maintain at first as it was a dramatic change and visitors were not pleased.

Provide THREE strengths related to INFECTION PREVENTION.

1. We had very limited staff cases of COVID related to a work exposure. Most cases were from outside of work exposures.
2. COVID units had almost no exposures to the rest of the hospital. Almost zero hospital acquired COVID for patients.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
More formal plans were needed for an infectious disease surge. We have an infectious disease plan and a surge plan, but we needed to combine in a formal way for this type of event specifically.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Awareness of PPE available, procedure related to PPE reuse and dissemination of protocols related to infectious disease

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications?

- Senior leaders were in communication with their counterparts at other hospitals, primarily CMOS and CEOs group calls
- City leadership led a surge call with hospital senior leaders and emergency managers to discuss daily surge numbers and plans
- We talked with our Regional Hospital Coordinator almost daily. Incident commander and chief integration officer were primary contacts
- Health department and EMS, incident commander and chief integration officer were primary contacts

What were the topics of community meetings or work groups that your organization participated in? The primary issue was surge and changing CDC guidance. There was a daily community surge call, as well as weekly coalition calls. All dealing with surge and incoming guidance from the CDC as it changed real time.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Primarily virtual meetings

How did your organization address the distribution of federal, state, and local guidance? Guidance came in to our COVID executive team and was disbursed to incident command team to deal with policy creation/reduction etc.

How did your organization address the distribution of federal, state, and local funding opportunities? Guidance came in to our COVID executive team and was distributed to the finance department with command team groups activated to create policy when needed.

What community partners did you work with during the pandemic that you had not previously worked with? We dealt with the health department at a much higher level than normal at the state level

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? We did not create any new MOUs before September.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. We were supported by local hospitals and EMS. Our local health department struggled to maintain consistency, our state partners were essentially useless as they provided no real resources or guidance other than the distribution of funds which we would have gotten regardless of the state. The state should re-vise their plans to state what they can and can't do as their current plans overstate their actual usefulness during a prolonged event.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We know understand that the federal SNS and the state stockpile are useless, and we can't depend on that for any real help. The entire organization also is now aware of the regional hospital coordinator/coalition benefits and how important communication is on that level.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Local hospitals were great.
2. We communicated and participated in community wide calls frequently and were able to maintain the same message / goals for the most part.
3. Our local vendors were helpful and referred us to resources and other vendors even if it didn't benefit them.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
The state health department needs to be clearer about what resources are readily available and how to access them at the state level.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Coalition involvement and regional hospital coordinator ability to provide guidance and resources

St. Francis Bartlett

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 12, 2020

How was your facility affected by the initial Safer at Home directives (i.e., cancelled elective surgeries, visitation policies, or other closures)? Our facility cancelled elective procedures and restricted visitation. School closures also
affected staff availability due to the lack of childcare

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. This group met 2 times daily, our incident command had a 24-hour monitor.

Which components of incident were activated (i.e., which positions/groups were named)? The Supply Chain/Materials, Executive, Security, Media Relations and Human Resources components were activated.

How was information disseminated throughout the facility to keep staff informed? Information was disseminated throughout the facility through emails, weekly CEO newsletters, and daily huddle calls.

Provide THREE strengths related to Incident Command

1. Visibility
2. Familiarity
3. Timeliness

Provide THREE opportunities for improvement related to Incident Command

1. Dissemination to off-shift frontline workers
2. Geographic location
3. Depth of leadership.

Narrative – What is at least ONE opportunity for improvement related to Incident Command that has become a strength (or close to) since the COVID-19 response began.
Situational pandemic preparedness.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? March 2020

How long did this last? Currently still have disruptions.

What resources did you have difficulty procuring? PPE supplies and needles/syringes

How did you fulfill these needs? We were able to pull supplies from the Tenet Centralized warehouse to help cover
backordered items and worked with vendors directly to get sub items needed.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Graham medical, A-1 Electrical, Cooper Glass, Extra Packaging LLC and going through the Tenet Command Center for centralized items for PPE and Lab products.

Did your normal materials management mechanisms/policies/procedures continue to work? No. If not, did your organization create new and/or temporary management plans? Please describe. We had to lock up all PPE so that we could control the usage for the different departments and keep a par level available. We also had to order new isolation carts for the floors to care for COVID Patients as well as longer extension tubing so that the Pumps could be in the hallway instead of in the patient room. We had to set up stations at all entry ways for temperature control and symptom checks for staff and visitors.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Currently we need to restock emergency supplies as they become available from the Distributors.

Provide THREE strengths related to RESOURCES

1. Tenet command center really came through with centralizing an area for all facilities to pull from and helped ensure we had the items needed to care for patients and staff.
2. The supply team worked every day to ensure that floors had PPE needed for all areas as well as House Supervisors at nighttime.
3. The Memphis Coalition also helped us secure much needed PPE items at the height of the pandemic.

Provide THREE opportunities for improvement related to resources.

1. We need a better storage place for the supplies. We had the bulk of the supplies across the street that we had to go to daily to pull supplies instead of having them in house.
2. We eventually moved supplies in house, but we do not have the storage space large enough to house what we truly need.
3. A better way for the PPE to be stored for the nurses on each floor. Better organization for PPE supplies for each nurse on floors.
4. Low staff in supply chain during pandemic caused additional strain on current duties.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The centralized location for supplies in Tenet was a huge help during this time.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? We used high protection gowns, gloves, masks, and face shields.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency? No, but we reserve the right to review the precautions or safety policies if necessary.

How did your facility address extended use and/or reuse guidance for PPE? In accordance with the CDC and manufacturer guidelines

How did your facility address COVID-19 patient and employee testing? In accordance with the CDC and state guidelines.

What standard or innovative infectious disease barrier control methods did you use, if any? We simply utilized standard airborne precautions.

What preparedness efforts did your on-site morgue engage to prepare for surge? If you have no morgue, how did you address this issue? We arranged for alternative on-site storage.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes, we did use an infectious disease surge plan, located in our Emergency Operations
Manual.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, we did not have any issues with staff and/or patient compliance, but we did have issues with visitation.

Provide THREE strengths related to INFECTION PREVENTION.

1. Malleability
2. Ability to cross multiple emergencies
3. Flexibility

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. More defined supply chain avenues

2. Direct tie into state/local government
3. The lack of alternatives

Narrative – What is at least ONE opportunity for improvement related to Infection Prevention that has become a strength (or close to) since the COVID-19 response began.
People are more educated, knowledgeable and understanding than in past times.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? The external partners that we communicated with the most were the Mid-south Emergency Preparedness Coalition, Respiratory Companies, Ventilation Company, and government leaders. The responsible parties were the Manager of Respiratory Therapy, Director of Facilities, Director of Facilities, the CFO, and the Finance CEO.

What were the topics of community meetings or work groups that your organization participated in? The cancellation of elective surgeries to minimize PPE usage, school closures, and visitation guidelines were often the topic of community meetings.

What were the primary ways in which you communicated with external partners (email, phone, virtual meetings)? We communicated with external partners via email, phone, and virtual meetings Equally.

How did your organization address the distribution of federal, state, and local guidance?
We addressed the distribution of federal, state and local guidance directly to staff and through the appropriate leaders.

How did your organization address the distribution of federal, state, and local funding opportunities? We addressed the distribution of federal, state, and local funding opportunities in accordance with the appropriate guidelines.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of the agreement? No.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. We were supported locally and by the state through consistent communication and Transparency.

How has your organization's emergency planning changed moving forward as it related to partners and on-going communication and planning after COVID-19 is no longer an emergency?
There was an added focus to the continuity of business operations and postponing.

Provide THREE strengths related to EXTERNAL PARTNERS

1. Familiarity
2. Team-Oriented
3. Community Focused

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Ability to diversify supplies
2. Lack of experience or different than expected situational resolution
3. Supply chain management

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Familiarity

ST. FRANCIS MEMPHIS

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 9, 2020

How was your facility affected by the initial Safer at Home Directives Visitation Policy Changed, Public Entrance was reduced to Front Door only, Employees were reduced to one entrance only, screened these entrances with questions and temperature taking. Outpatient procedures (Radiology, Physical Therapy, etc.) were closed, elective Surgeries were cancelled. Masks always worn by all employees. Patients and visitors issued masks to always wear in the facility. Many employees were furloughed for 90 days because of the low patient census.

How often did that group meet/engage? Weekly for two weeks then converted to our Daily Manager Huddle.

Which components of incident were activated? Admin (COO, CMO, CNO) Nursing, Infection Control, Engineering, Environmental Services, Laboratory, Employee Health, Human Resources, Public Relations, Pharmacy Respiratory Therapy, Security, Materials Management, Transportation.

How was information disseminated throughout the facility to keep staff informed? Departmental Meetings, CEO Email Alerts (Weekly or as needed) and COO Informational Email concerning Community stats, TN Dept. of Health Alerts, CDC Information, and Corporate Information (Daily or as needed)

Provide THREE strengths related to INCIDENT COMMAND.

1. Full involvement of administrative team.
2. Daily Management Huddles kept us current and on track.
3. Responsibilities were fully delineated and spelled out daily.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Twice-Monthly meetings to summarize existing status. (Because of the use of Daily Manager Huddles)
2. Trained backups for certain repetitive tasks and duties.
3. Documentarians to organize and summarize long term data.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Because of staff and manager turnover relying on more training for succession of certain tasks.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? After COVID patients began ramping up in April. How long did this last? Some shortages of PPE until July.

What resources did you have difficulty procuring? N95 masks, Face Shields. How did you fulfill these needs? Used corporate buying and participated in State and Local shipments when available.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Used local company to provide Acrylic Desk Shields to Public Areas desks and counters. Also, Local tent company for External Triage area. Corporate Buyers were procuring PPE from any sources available.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes. I did not have to create.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We increased PAR levels of supplies and literature such as CDC's "Optimizing Use of N95's", tested our expired PPEs to see if viable for use, which they were. (Gloves and Gowns) CDC's "Hospital Preparedness Checklist"

Provide THREE strengths related to RESOURCES.

1. Having a Corporate Material Management Department to procure and supply backups when needed.
2. Having existing Disaster supply of various PPE including PAPRs and other items not used in daily operations.
3. Facility has plenty of space for ample storage of supplies.

Provide THREE opportunities for improvement related to RESOURCES.

1. Turnover existing disaster supply more often so there will not be so many expired items when they are needed.
2. Ensure that the clinical staff are aware of the protocols for PPE use so there will not be substantial waste of products.
3. Inventory should be checked daily so that items that are low can be re-ordered and stay at par levels.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Have done a better job of maintaining supply levels based on census and acuity of patients for PPE.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Surgery Masks, N95's, PAPR's gloves, gowns, face shields, negative pressure rooms (64 total), portable HEPA exhaust units. To protect patients? Masks

What new materials/PPE/resources did you utilize that you had not previous utilized? Intubation boxes

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency? Employee masks are still required.

How did your facility address extended use and/or reuse guidance for PPE? Initially CDC's Optimizing N95 Use. When N95's supplies were low used reprocessed and sterilizing services for N95's.

How did your facility address COVID-19 patient and employee testing? Patients were screened and triaged for COVID in ER, tested if necessary. If symptoms developed during hospital stay patients were tested ad needed. (This was very infrequent). Employees were told Do Not Come to Work Sick, if testing was necessary, they were given options of where to be tested. If employees had symptoms that could be related to patient care they were tested in-house.

What standard or innovative infectious disease barrier control methods did you use, if any? Created COVID units that were basically isolation units with negative pressure patient rooms and nursing desk areas, PPE doffing and donning areas and closed doors for corridor entrance and exits.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Our Body Holding area will hold six bodies. Luckily very few times that we had to shuffle to get bodies picked up by Funeral Homes. We had a very low death rate at this hospital.

Did your facility have or use an infectious disease surge plan? Yes**.** What strengths and weaknesses have you since identified in that plan? The plan was reviewed and refreshed early in the COVID period when it looked like it would be needed. The strength of the plan was knowing how many beds we could use for surge and where they would come from. The biggest weakness was planning for nursing shortages.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Only situations where existing protocols had changed, and staff would continue to do things "the way we always have". These were limited.

Provide THREE strengths related to INFECTION PREVENTION.

1. There was a wealth of information and guidance available for COVID. These were from local, state and national sources.
2. General availability and stocking of the PPE that we did have and need.
3. Renewal of plans, processes, and policies for any future pandemics or surges.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. There was some much information and guidance for COVID that you had to check the sources of the information, staff would bring in what they saw on "Facebook" or other media.
2. Occasionally a few staff would let their fears of the pandemic or on the other hand their apathy about the pandemic rules their patient care.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. As stated in number three above, the renewal of plans, processes and policies regarding all issues of Infection Control for the protection of staff, patients and visitors.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Tenet Corporate Departments (Infection control, Facilities, security, Nursing, Material Management, Fiscal Control) Hospital Resource Tracking System, TN Health Alert Network, TN Department of Health, Shelby County Health Department, Emergency Preparedness Office of Memphis and Shelby County-Regional Hospital Coordinator, Mid-South Emergency Planning Coalition, Memphis Mayor's Office**.** Who were the responsible parties/job titles that were responsible for maintaining that communications? Chief Executive Officer, Chief Medical Officer, Chief Operations Officer, Emergency Preparedness Coordinator.

What were the topics of community meetings or work groups that your organization participated in? PPE and supplies including Clinical Equipment, Care of COVID Patients, COVID Patient Census, Surge Planning for COVID Patients, Protecting Patient Visitors from COVID, Protecting Staff personnel from COVID, and Employee staffing particularly Nurses.

What were the primary ways in which you communicated with external partners Phone, Texts, Email, Virtual meetings, group and Personal meetings.

How did your organization address the distribution of federal, state, and local guidance? Distributed during Staff Meetings, CEO, COO and Public Relations emails.

What community partners did you work with during the pandemic that you had not previously worked with? U.S. Health and Human Services, TN Department of Emergency Preparedness, Memphis Mayor's Office

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? None

Did you feel like your organization was supported by local community partners? Information, guidance and locating supplies**.** State partners? Federal partners? State and Federal provided invaluable information and guidance during the whole year.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Better understanding of what governmental agencies provide what services.
2. Having full contact information of agencies for future issues.
3. Previous relationships with local government agencies and partners helped during this stressful time.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Occasional government "red tape" in dealing with some agencies in the beginning. (Finding the right person or agency to help with a specific problem)
2. Being able to get messages through because of the sheer volume of requests. (Every hospital looking for or asking the same things)
3. Not knowing at times who instructions to follow. (Were we to follow the local health department rules, state health department, Governor, CDC who?)

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Having gained more knowledge about community partners and who and how to communicate with them about what they can provide.

ST. JUDE CHILDREN'S RESEARCH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/11/2020

How was your facility affected by the initial Safer at Home directives?
canceled elective surgeries, changed visitation policies, restricted travel, sent non-essential staff home

Which components of incident were activated? Incident Commander, PIO, Liaison Officer, Legal Affairs, Medical Care Section, Operations Section, Planning Section, Logistics Section, Finance Section, Research Section

How often did that group meet/engage? twice daily initially, then once daily later

How was information disseminated throughout the facility to keep staff informed? Frequent {daily} emails and numerous virtual "Town Hall' meetings.

Provide THREE strengths related to INCIDENT COMMAND.

1. The Medical Care Section Chief was an excellent Incident Commander in a clinical emergency such as this.
2. The Incident Command structure was well suited to effectively control the often overwhelming and frequently changing information being generated.
3. The Incident Command structure proved it was able to flex from a response to clinical emergency (pandemic) to other emergencies (local George Floyd protests, winter storm/low water pressure, etc.) and back to clinical with minimal disruption to operational effectiveness.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. The Incident Command Team had not contemplated nor been prepared for an Emergency Operations Plan activation that would last 12-18 months. Therefore, future exercises and training must include preparations for extended event such as this.
2. The "Bench Depth" of the individual team functions should be increased from 2 deep to 3 or more to effectively deal with extended activations of the Emergency Operations Plan.
3. Increase the number of trained individuals who can act as Incident Commander.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
Every member of the Executive Staff now has an improved working knowledge of how the Incident Command's structure functions as well as a greater awareness of the Incident Command Team's role in defined emergencies. Organizational preparedness, top to bottom, has never been greater.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? March 25, 2020. How long did this last? Until July 28, 2020.

What resources did you have difficulty procuring? Masks, gowns, gloves, N95 respirators, PAPR's, hand sanitizers, surface sanitizers, vaccines. How did you fulfill these needs? We asked our staff to conserve as much as possible and our Materials Management department worked continuously on resolving sourcing & supply chain issues.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Our Pharmaceutical Sciences department used bulk stocks of glycerin and alcohol to create replacement hand sanitizer. Preparations were made to use UV light to sanitize and reuse N95 respirators, but this was never necessary.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The definition of emergency assets has been expanded and the inventories of each of these assets has been increased.

Provide THREE strengths related to RESOURCES.
Materials Management leadership, the Incident Command Team, and the Executive Staff now have experience in weathering a supply chain crisis. This is not an experience that can be obtained through training or through exercises/drills.

Provide THREE opportunities for improvement related to RESOURCES.
Supply chain disruptions should be added to the HVA as a stand-alone emergency regardless of the trigger.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began? One take away from this pandemic is that supply chain disruptions while critical are not impossible to overcome with persistence and innovation.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? isolation gowns, bouffant caps, shoe covers, gloves, masks, N95 respirators, PAPR's, face shields, goggles, vaccines. To protect patients? masks, pediatric masks, vaccines.

What new materials/PPE/resources did you utilize that you had not previous utilized? Masks, gowns, gloves, and hand sanitizers.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Unknown.

How did your facility address extended use and/or reuse guidance for PPE? We asked our staff to conserve as much as possible. Preparations were made to use UV light to sanitize and reuse N95 respirators, but this was never necessary.

How did your facility address COVID-19 patient and employee testing? Everyone entering campus was screened for symptoms or contact with a known COVID positive person. Our Infectious Diseases department developed a COVID test before any other tests were commercially available. We screened and tested 100% of the staff, patients, and visitors coming on campus. Test results were turned around within 24 hours by our Pathology department and those testing positive were removed from campus for a 10–14-day quarantine period. At the end of the quarantine period, 2 consecutive negative tests were required prior to re-entry on campus.

What standard or innovative infectious disease barrier control methods did you use, if any? Information Services developed a self-screening app for cellphones with a color-coded screen that could be shown at Security check points around campus to indicate COVID testing or vaccination status.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes. 60+ staff members were designated as 'COVID Captains' and assigned to various areas of the organization to enforce masking, social distancing, hand sanitizing, and surface disinfection.

Provide THREE strengths related to INFECTION PREVENTION.

1. Screening, testing, and removal of COVID positive staff, patients, and families from campus was key in preventing disease outbreak and spread in the hospital.
2. Enforcement of mask wearing and social distancing of everyone on campus was also key in preventing disease outbreak and spread while awaiting test results.
3. Infectious Diseases expertise was vital in sourcing the contacts of staff, patients, and family members who tested positive.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The use of virtual meetings such as Web-ex and Zoom have proven to be effective when in person meetings are not possible or recommended.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? CDC, TN Dept of health, Memphis/Shelby County Health Dept. Who were the responsible parties/job titles that were responsible for maintaining that communications? PIO, Liaison Officer, Epidemiology physicians, Infectious Diseases physicians, Chief Legal Officer, Chief Government Affairs Officer, CEO.

What were the primary ways in which you communicated with external partners? email, phone, Web-ex and zoom virtual meetings

How did your organization address the distribution of federal, state, and local guidance? Discussed and passed along at the Incident Command Team's daily briefings

Has your organization created any new MOUs/agreement during this pandemic with external partners? No

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes, Federal partners? Yes

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Not yet known

ACUTE CARE REHABILITATION HOSPITALS

ENCOMPASS CENTRAL

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 13, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation restrictions to align with our Joint Venture Partner (Methodist University Hospital), school closures caused staffing challenges, screening procedures were implemented for all persons, PPE concerns with adequate masking and gloves for all persons, social distancing implanted.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Commander, Safety Officer, Public Information Officer, Liaison Officer, Medical Technical Officer, Finance added later

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily meetings. Additional meetings up 2 or 3 times daily initially to discuss changes.

How was information disseminated throughout the facility to keep staff informed? Daily HICS, daily huddles with staff, all staff emails, posted information, specific staff meetings, virtual staff meetings, company "HIVE" newsletter and daily management team meetings

Provide THREE strengths related to INCIDENT COMMAND.

1. Consistency
2. Transparency
3. Focus to meet objectives

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. More direct staff involvement in perceptions
2. Consistent rounding
3. Systems in place to track real time interaction or supply usage.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Supply chain disruption started in March 2020 and lasted until Sept. 2020.

What resources did you have difficulty procuring? How did you fulfill these needs?
We had supply issue with surgical masks, N95 masks, hand sanitizer and gloves. We used other vendors other than our regular suppliers. (Shelby county came through a couple of times for us – thanks)

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Amazon, Grainger for medical supplies and Mississippi Distillery for hand sanitizer

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
We instituted new policies for usage and took extra storage precautions with daily counts and security measures.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Our Supply Chain Officer created several centrally located depots of PPE and other critical supplies.

Provide THREE strengths related to RESOURCES.

1. We are better prepared for emergencies within the Encompass System
2. Encompass has 130+ hospitals that were able to share surplus.
3. SCO was able to use size of organization for procurement of supplies.
4. Home office created a unified and detailed plan for our company

Provide THREE opportunities for improvement related to RESOURCES.

1. Our facility did not have enough masks for a pandemic.
2. Hand sanitizer supplier was very slow to respond to a hospital.
3. Storage is limited at our facility.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. We were able to turn the mask supply around, get creative for hand sanitizer supplies and better utilize space for storage.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, N95masks, Face shields, goggles, gowns gloves

What new materials/PPE/resources did you utilize that you had not previous utilized?
Shelby County Coalition, Amazon, Grainger

How did your facility address extended use and/or reuse guidance for PPE? We re-used N95 and face shields only

How did your facility address COVID-19 patient and employee testing? Patient testing was completed through Methodist University Hospital

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do not have a Morgue. Space is designated if surge occurs.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We did not have a surge. We do have a surge plan in place.

Did you have any issues with staff and/or patient compliance with new infectious disease policies? Yes – Proper masking for use in a hospital

Provide THREE strengths related to INFECTION PREVENTION.

1. Effective screening process
2. Strong Home Office Support Team
3. PPE supply did not run out.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Staff trust (much misinformation was on information outlets)
2. Proper hand washing

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Staff trust that we are doing everything to protect them as front-line workers.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Shelby County Health – Medical Technical Officer, THANN –Safety Officer, Methodist University Hospital – Incident Commander, Public Information Officer

What were the topics of community meetings or work groups that your organization participated in? Disclose to staff any exposures, how to protect against COVID-19, screening guidelines, adherence to PPE, social distancing and regular updates as pandemic progressed

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, Phone and virtual meetings

How did your organization address the distribution of federal, state, and local guidance?
Policies and guidelines were updated as Shelby County, State of Tennessee, CDC and President of the United States

How did your organization address the distribution of federal, state, and local funding opportunities? None was needed or utilized. The home office did not feel our company needed it.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Shelby County provided PPE when asked

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
Much more aware of supply needs and visitor/ patient interaction i.e. phone, video

Provide THREE strengths related to EXTERNAL PARTNERS.
Shelby County was very supportive when needed.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. The health department was difficult to report to and seemed ever changing.
2. Supply partners prioritizing hospitals

ENCOMPASS NORTH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 5th, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?

- Terminate all outside visitors
- All essential personnel and vendors went through screening and PPE donning
- Non-essential personnel were granted work from home privileges
- Telehealth utilized when possible
- WebEx meetings replaced by in-person meetings
- Safe distancing implemented in all practices and areas

Which components of incident were activated (i.e., which positions/groups were named)?

- Incident commander
- Operations
- Planning
- Logistics
- Finance
- Safety officer
- Medical care branch director
- Infrastructure branch director
- Employee health and wellbeing leader
- HR & Infection Preventionist
- Supply unit leader
- Procurement unit leader
- Food services unit leader – (used all disposable until April 2021)

How often did that group meet/engage?

- Daily updates
- Transferred to weekly

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? COVID 19 Task Force

How was information disseminated throughout the facility to keep staff informed?
Staff notification of Company (FAQs) Frequently Asked Questions

Provide THREE strengths related to INCIDENT COMMAND.

1. Timely and ample procurement of supplies
2. Update testing capabilities

3. Review changes and updates in policy/practice

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Proficiency in cleaning/disinfecting practices
2. Communications
3. Lab Results

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources?
Mid-April 2020 How long did this last? 60-90 days before corporate organized and automatically shipped items out

What resources did you have difficulty procuring?

- Surgical & N 95 masks
- Gloves

How did you fulfill these needs? Ordered from Amazon, local department stores, etc.

Did your normal materials management mechanisms/policies/procedures continue to work?
Yes

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Increased PAR levels

Provide THREE strengths related to RESOURCES.

1. Vendor relationships
2. Automatic shipping of items from corporate

Provide THREE opportunities for improvement related to RESOURCES.

1. Tracking supplies
2. Storage space
3. Daily notifications to HIRTS

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Tracking supplies – we now have an automatic tracking system that allows us to always know what we have in house, how many days of supplies we have, and our burn rate

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Masks, face shields, goggles, shoe covers, hair nets, isolation gowns, gloves. To protect patients? Masks, face shields, goggles, shoe covers, hair nets, isolation gowns, gloves

What new materials/PPE/resources did you utilize that you had not previously utilized?
Face shields

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Will follow corporate guidelines

How did your facility address extended use and/or reuse guidance for PPE?

- Face shields cleaned daily or as needed
- N95 reused until designated time frame expired
- Provided storage container for face shields and N 95

How did your facility address COVID-19 patient and employee testing?

- Employees- referred to designated testing sites
- AEL for patient testing
- Corporate purchased machines for patient testing (in house)

What standard or innovative infectious disease barrier control methods did you use, if any?

- Negative air pressure rooms
- Droplet and contact precautions
- Limited staff interaction

Did your facility have or use an infectious disease surge plan? Policy in place, not specific to infectious surges. What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? A plan is in place pertaining to COVID Vaccinations

Did you have any issues with staff and/or patient compliance to new infectious disease policies?

- Patients did not want to wear masks
- Isolation patients did not want to always stay in the room
- Visitor restriction

Provide THREE strengths related to INFECTION PREVENTION.

1. Information dispersed in a timely manner from FAQs
2. Patients isolated at first sign/symptoms of respiratory issues, fever, etc.
3. Staff learned proper donning/doffing of PPE

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Fit testing
2. PAR levels
3. Disinfecting processes

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Knowledge gained pertaining to disinfecting.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Labs, joint venture partner Who were the responsible parties/job titles that were responsible for maintaining that communications? CNO, Quality Director, CEO, CFO

What were the topics of community meetings or work groups that your organization participated in? State guided process, MSEPC

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Phone, email, virtual meetings

How did your organization address the distribution of federal, state, and local guidance? Anything that came in from the state was forwarded to the corporate office; no decisions were made at this facility

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, if supplies were needed from the hospital coalition, we could have received them

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Maintain strong lines of communication

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Labs expedited test results upon request
2. Our Joint Venture was helpful with loaning supplies if needed

SELECT SPECIALTY

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/1/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? 1) Implemented a stricter visitation policy starting 3/9/2020 with health screening. Eventually transitioned to no visitation. Reopened to visitors on 4/12/2021, only allowing 2 visitors a day during certain hours (current process). 2) We implemented the cancellation of elective procedures

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We initially started meeting daily and transitioned to weekly. We also transitioned from in-person meetings to virtual meetings.

Which components of incident were activated (i.e., which positions/groups were named)? Activated the EOP on 3/1/2020; Implemented the Disaster Staffing Plan, Infectious Disease Plan

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Incident Command, Public Safety Officer-Address concerns patients and employees, Safety Officer-connect with the emergency planning agencies in the county, Operations Section-updating bed availability and type daily

How was information disseminated throughout the facility to keep staff informed? Through safety briefings, education/reiterating proper use of PPE, signage, mass text messaging, and emails**.**

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? About a month after the start of pandemic How long did this last? For months

What resources did you have difficulty procuring**?** PPE (gowns, gloves, masks), Cleaning supplies, Respiratory Supplies, Equipment (Ventilators, Bi-paps, Heated High Flow Units) How did you fulfill these needs? Worked with our corporate team to be able to procure the items needed

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Cardinal Health, Medline, & McKesson

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. We traditionally work with three primary vendors. We did work directly with some direct vendors to procure certain items.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We increased par levels on pertinent items.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Surgical masks, face shields, goggles, N-95 masks, when needed

What new materials/PPE/resources did you utilize that you had not previously utilized? Respirator masks

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, the current policy only allows patients to have 2 visitors a day. 1 visitor at a time who must stay inside that patient's room the entire visit. The visitor will also have to utilize a hospital approved mask during the visit.

How did your facility address extended use and/or reuse guidance for PPE? Initially, masks were issued 1 per week, and PRN if torn. We transitioned to replacing mask every three days or torn/soiled. We currently issue masks daily to staff

How did your facility address COVID-19 patient and employee testing? We screened each employee for symptoms via questionnaire, and checking temp, no employee testing done without symptoms. Our facility required the patients to be tested for COVID-19 prior to admission

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, we updated the staff as the CDC updates were made public

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The ability to build relationships with new vendors.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Mid-South Coalition Who were the responsible parties/job titles that were responsible for maintaining that communications? Safety Officer

What were the topics of community meetings or work groups that your organization participated in? PPE, guidance of community updates

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? email, virtual platforms

How did your organization address the distribution of federal, state, and local guidance? Followed the guidance of local guidance

DIALYSIS CENTERS

DaVita Downtown #02432

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 04/01/2020

How your facility was affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The Dialysis Clinic was not affective with any cancelation of in-center treatments, but outpatients' surgeries were re-scheduled, and electives postponed.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We met daily and adjusted and implemented new policies and procedures.

Which components of incident were activated (i.e., which positions/groups were named)? DaVita's COVID-19 Task Force. What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No new position was implemented at the local level of dialysis of clinics but adjustment to the Assessment and admissions of all patients and staff.

How was information disseminated throughout the facility to keep staff informed? All information was presented via emails, in-services, and written documentation.

Provide THREE strengths related to INCIDENT COMMAND.

1. Everyone received the same information,
2. Information was available with many resources and tools
3. All materials (supplies) were available.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The one area for improvement has been the constant changing of the policies and procedures related to the Entrance Evaluation Screening Tool. The process has improved the early identification of potentially positive patients that could have affected the entire clinical staff and patients.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? We did not experience a disruption in our supply chain.

What resources did you have difficulty procuring? We did not have any issues. How did you fulfill these needs? The clinic has a backup clinic for emergencies and if needed would be able to obtain resources from them.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes. How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? On a local level no changes.

Provide THREE strengths related to RESOURCES. Our Strengths r/t resources are

1. Relationship with our vendors
2. Inventory System on supplies constantly updated with shipments
3. The ability to utilities our sister clinic for resources.

Provide THREE opportunities for improvement related to RESOURCES.
No Improvements needed

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. I don't see any area for improvement r/t resources on a local or regional area, the processes that are in place work.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.). The PPE that is utilized to protect our staff is mandatory masks, face shields, gowns, gloves, and/or goggles.

What new materials/PPE/resources did you utilize that you had not previous utilized? No new PPE utilize, just all patients and staff required to wear mask at all times.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, I will continue pre-screening.

How did your facility address extended use and/or reuse guidance for PPE? We did not have to implement.

How did your facility address COVID-19 patient and employee testing? We can test patients and staff in house and send out results that are available within 48 hours.

What standard or innovative infectious disease barrier control methods did you use, if any? We utilize the 6 feet barrier and mask mandate.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? The strengths in using the assessment tool help to identify potentially infectious patients and was able to cohort from other patients.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes and No just a reminder for them to keep their mask pulled up at all times.

Provide THREE strengths related to INFECTION PREVENTION.

1. All patients pre-screened after arriving in lobby and new mask given
2. Pt are escalated to advanced screening
3. Pt are co-horted and treated in different clinics if infected or suspected.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Patient not to come to treatment if they suspect they are sick.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
The entrance evaluation and advanced screening tool has been a great opportunity for infection prevention and or spread. I would have liked to be able to utilize the tool before the patients entered the lobby, but the plus is it prevented patients that had symptoms from entering the treatment floor and to be co-horted to another facility if needed.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Mid-South Emergency Planning Coalition, and Network 8. Who were the responsible parties/job titles that were responsible for maintaining that communications? Barbara Jones, RN, FA

What were the topics of community meetings or work groups that your organization participated in? COVID 19 preparedness

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email and virtual meeting.

How did your organization address the distribution of federal, state, and local guidance? Email, web training and in-services with staff.

How did your organization address the distribution of federal, state, and local funding opportunities? This was not handled in a local or regional area.

What community partners did you work with during the pandemic that you had not previously worked with? State and local Health Department.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Distribution of COVID 19 vaccine

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes. Federal partners? Yes. If so, please provide examples. With the distribution of the COVID 19 vaccine. If not, please explain how you could have been better supported.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
No changes on the local level.

Provide THREE strengths related to EXTERNAL PARTNERS.
Upper management handles all external communication, so on our end from the local there are no issues or strengths to comment on.

DAVITA MIDTOWN #06841

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 04/01/2020

How your facility was affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The Dialysis Clinic was not affective with any cancelation of in-center treatments, but outpatients' surgeries were re-scheduled, and electives postponed.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We met daily and adjusted and implemented new policies and procedures.

Which components of incident were activated (i.e., which positions/groups were named)? DaVita's COVID-19 Task Force. What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No new position was implemented at the local level of dialysis of clinics but adjustment to the Assessment and admissions of all patients and staff.

How was information disseminated throughout the facility to keep staff informed? All information was presented via emails, in-services, and written documentation.

Provide THREE strengths related to INCIDENT COMMAND.

1. Everyone received the same information,
2. Information was available with many resources and tools
3. All materials (supplies) were available.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The one area for improvement has been the constant changing of the policies and procedures related to the Entrance Evaluation Screening Tool. The process has improved the early identification of potentially positive patients that could have affected the entire clinical staff and patients.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? We did not experience a disruption in our supply chain.

What resources did you have difficulty procuring? We did not have any issues. How did you fulfill these needs? The clinic has a backup clinic for emergencies and if needed would be able to obtain resources from them.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? On a local level no changes.

Provide THREE strengths related to RESOURCES. Our Strengths r/t resources are

1. Relationship with our vendors
2. Inventory System on supplies constantly updated with shipments
3. The ability to utilities our sister clinic for resources.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. I don't see any area for improvement r/t resources on a local or regional area, the processes that are in place work.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.). The PPE that is utilized to protect our staff is mandatory masks, face shields, gowns, gloves, and/or goggles.

What new materials/PPE/resources did you utilize that you had not previous utilized? No new PPE utilize, just all patients and staff required to wear mask at all times.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, I will continue pre-screening.

How did your facility address extended use and/or reuse guidance for PPE? We did not have to implement.

How did your facility address COVID-19 patient and employee testing? We are able to test patients and staff in house and send out results that are available within 48 hours.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? The strengths in using the assessment tool help to identify potentially infectious patients and was able to cohort from other patients.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes and No just a reminder for them to keep their mask pulled up at all times.

Provide THREE strengths related to INFECTION PREVENTION.

1. All patients pre-screened after arriving in lobby and new mask given
2. Pt are escalated to advanced screening
3. Pt are co-horted and treated in different clinics if they are infected or suspected.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Patient not to come to treatment if they suspect they are sick.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The entrance evaluation and advanced screening tool has been a great opportunity for infection prevention and or spread. I would have liked to be able to utilize the tool before the patients entered the lobby, but the plus is it prevented patients that had symptoms from entering the treatment floor and to be co-horted to another facility if needed.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Mid-South Emergency Planning Coalition, and Network 8. Who were the responsible parties/job titles that were responsible for maintaining that communications? Barbara Jones, RN, FA

What were the topics of community meetings or work groups that your organization participated in? COVID 19 preparedness

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email and virtual meeting.

How did your organization address the distribution of federal, state, and local guidance? Email, web training and in-services with staff.

How did your organization address the distribution of federal, state, and local funding opportunities? This was not handled in a local or regional area.

What community partners did you work with during the pandemic that you had not previously worked with? State and local Health Department.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Distribution of COVID 19 vaccine

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes. Federal partners? Yes. If so, please provide examples. With the distribution of the COVID 19 vaccine.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? No changes on the local level.

Provide THREE strengths related to EXTERNAL PARTNERS.

Upper management handles all external communication, so on our end from the local there are no issues or strengths to comment on.

DaVita Ripley

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? Activated on 3/13/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Facility was affected by restriction of visitors that were not considered essential to care team. Facility did not endure any closures. Facility was affected by access surgeries being cancelled and delayed for greater portion of 2020 due to being considered elective surgery but then these were later clarified to be life-sustaining surgery services.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Facility had daily virtual meetings/calls, and emails to discuss updates across the Village and as 2020 evolved and gained better understanding of pandemic the duration of calls and virtual meetings increased in between the timespan. Facility still receiving communications via emails, calls, newsletters, virtual meetings in 2021.

Which components of incident were activated (i.e., which positions/groups were named)? Infection control was the top priority of COVID19 pandemic. OCMO Medical Director provided guidance to Village on how to handle the COVID19 Infection Prevention policy and BDPs. Director of Clinical Services and Manager of Clinical Services also played vital roles in assisting facilities through the playbook processes. Public transportation companies, local hospitals, referring specialists, pharmacies, multi-level healthcare providers, health departments, nursing home facilities, etc.

How was information disseminated throughout the facility to keep staff informed? Posters, flyers, TM in-services, patient education handouts, TM computer training courses, TM emails, TM homeroom lessons/huddles, healthcare team verbally with patients, etc.

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication
2. Infection Prevention
3. Education

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Patient/Public Transportation
2. Treating Facilities locations for COVID positive patients
3. Facility vaccine availability arrival.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Facilities now have the option to treat their own COVID positive patients as opposed to having a

patient being treated upwards of 50 miles from their home. Facilities have adopted policies and procedures to allow for proper patient care environments where the COVID positive patient can be treated in their own home facility at a designated time away from general population and allow for proper clean time between shifts to allow for proper cleaning and prevention of virus contaminants.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Almost within the first few months of pandemic initiation there were issues with PPE supplies, hygiene/janitorial supplies, and medical supplies. Facility was never actually without any of these type supplies, but Inventory Clerk and FA had to work diligently to ensure that facility as properly stocked, and these stocked supplies were properly secured to prevent theft. How long did this last? Pandemic started March 2020 and supply issues began in April 2020 and lasted throughout the entire 2020. Facility is still tracking and securing PPE supplies such as masks and hand sanitizer weekly counts even in current day 2021.

What resources did you have difficulty procuring? PPE supplies, janitorial/hygiene supplies, normal saline, sol-carts, dialyzers, masks, hand sanitizers, etc. How did you fulfill these needs? Facility was able to receive items through DaVita vendors and was never without any of the supplies mentioned. DaVita vendors utilize major corporate accounts and at times different manufacturers were chosen by DaVita to ensure that the Village could maintain stock. Facilities would borrow supplies from each other if needed for patient care until deliveries could be received. DaVita Village utilizes PRISM – Procurement from Every Angle / PRISM (Procurement, Risk reduction, Innovation, and Supply Management).

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? DaVita utilizes corporate level vendor purchasing processes utilizing program PRISM – Procurement from Every Angle / PRISM (Procurement, Risk reduction, Innovation, and Supply Management).

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? DaVita utilizes corporate level vendor purchasing processes utilizing program PRISM – Procurement from Every Angle / PRISM (Procurement, Risk reduction, Innovation, and Supply Management).

Provide THREE strengths related to RESOURCES.

1. Corporate level ability to secure supplies worldwide
2. Corporate level ability to secure supplies from multiple vendors/manufacturers
3. Corporate level ability to secure supplies and ship/transport supplies via multiple avenues/vendors.

Provide THREE opportunities for improvement related to RESOURCES. DaVita did a very good job at ensuring facilities across the Village were not without supplies to perform everyday patient care tasks.

1. Facilities did have to change from some normal routine manufacturers' PPE, janitorial, hygiene, etc. but were provided with the same alternative that allowed for normal patient care functioning.
2. The vendors had delays on shipping due to weather, riots/domestic disturbances/lack of workers/COVID19 delayed processes and these were not a direct reflection of DaVita but those of the vendors themselves and DaVita remedied these situations via help desk tickets.
3. DaVita initially started COVID19 testing where the sample was sent out to 3rd party laboratory and then turned to where DaVita laboratory started running the test and had faster result turn around and easier method for result retrieval.
4. DaVita was encouraging patients to get the COVID vaccine where they could when they became eligible and did not readily have the vaccine for patients and/or teammates until months after health departments and pharmacies had secured the vaccine.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. DaVita now has process in place that facility has the capability to administer vaccine to patients and teammates. Data is monitored in Anaplan system and when patients become eligible and state desire to receive vaccine Anaplan will auto-send the vaccine to facility for licensed teammate to administer to patient.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Facility utilized: Gowns, masks, full face shields, gloves, goggles, yellow gowns. Facility utilized electronic devices to help monitor patients entering buildings for mask wearing doorbells, baby monitors, security cameras**.**

What new materials/PPE/resources did you utilize that you had not previous utilized? Facility had not previously used goggles prior to COVID19 pandemic. Facility did utilize full face shields. Facility utilized electronic devices to help monitor patients entering buildings for mask wearing doorbells, baby monitors, security cameras. Facility instituted the daily entrance evaluation screenings and advanced screening tools. Facility instituted increased wiping of touched surfaces for disinfecting prevention. DaVita Village put forth the BDPs and policy for these new changes and facilities adopted and followed as advised.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Facility is still under a limited visitation guidance of necessary medical personnel and visitors pertinent to patient care in the year 2021. Facility is still under daily entrance evaluation screenings and temperature checks in the year 2021. Facility is still under Advance Screening Tool based off answers given in the daily entrance evaluation screenings in year 2021. Facility is

still under weekly infection audit processes in the year 2021. Facility is still under increased cleaning of highly touched surfaces in the year 2021. Facility is still utilizing all PPE including masks and face shields while CDC has released leniency in community for those who are vaccinated in year 2021. It is hard to know at this point in the year 2021 as we have not been given any further guidance but to continue these current practices of infection prevention**.**

How did your facility address extended use and/or reuse guidance for PPE? Facility followed the BDP guidance from OCMO Medical Director regarding daily surgical blue mask guidance during breaks. Surgical blue masks were replaced every new workday for the teammates and every new treatment day for the patients. BDPs guidance was followed for N95 reuse, if applicable, for patient care treatments. BDP guidance for yellow isolation/contact precautions gowns, routine gowns, face shields, goggles were followed by teammates.

How did your facility address COVID-19 patient and employee testing? DaVita Village did have both patient and teammate testing multiple methods available for testing at facility and specimen sent off to DaVita lab for results. Sample method via nasal and sputum. Guidance of PPE to be utilized while collecting each sample type and how lab sample should be prepared. Guidance was given how patient should be co-horted on treatment shift while waiting for test results and then also timeline when patient could exit cohort shift. Guidance given for teammates on how they should be handled off work/return to work based off timeline exposure and symptoms improvements. Teammates could use the benefits of STD and work compensation. Testing for teammates was at no cost to teammates.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Facility does not have an on-site morgue. If a patient were to expire in the dialysis out-patient facility setting local EMS, 911 emergency services would be notified, emergency action plan set into motion, perform CPR, and patient would be transferred to higher level of care for further evaluation.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? DaVita Village and Southern Horizons Region (facility level) utilized the CDC COVID19 virus tracking information via website for specific county to know active count of infectious COVID19, deaths, recovered cases, etc.…

Did you have any issues with staff and/or patient compliance to new infectious disease policies? COVID19 pandemic was a new era for many of us in the healthcare field and the patients and we all had to learn new ways of living and how to wear masks and how not to touch each other. Restrictions for staying at home, social distance, not visiting family in nursing home settings or hospital settings, decreased physical human touching, decreased/halting traveling via plane or roads, cessation of public concerts and games, cessation of eating out in public restaurants, and contactless drive through methods, contactless methods for many things, increased hand hygiene, mask wearing out in public places, mask wearing inside public places, mask wearing inside home of suspected infectious persons, new vaccination policy, temperature screening

checks, entrance evaluations questionnaires, not eating on dialysis machines, wearing mask whole time on dialysis machine, come in dialysis clinic wearing a mask, etc.

Provide THREE strengths related to INFECTION PREVENTION.

1. Mitigation of infection spread by wearing a mask entering the building and changing that mask out for a new clean mask each treatment day.
2. Wearing masks entire treatment duration and/or work shift duration.
3. Wiping down frequently touched surfaces several times a day.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Teammates became familiar with routine as COVID pandemic has continued to last from 03/2020 until current year 07/2021 and dialysis facilities are still having to perform increased daily work tasks, and this might cause less of a focus on items.
2. Patients and teammates are becoming lax in practices of hand hygiene.
3. Patient and teammates are becoming lax in practices of mask wearing.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Facility is still in the active practice in current year 07/2021 of having patients enter building wearing a mask and then a new mask is provided to them each treatment shift and this mask must be worn the entire treatment duration and while inside the building. Patients cannot eat or drink on the machines to ensure that proper masking is enforced.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? DaVita Dialysis utilized internal OCMO Chief Medical Officer who gained knowledge from CDC during pandemic. Facility spoke with local hospitals, doctor offices, health departments, pharmacies, etc. Who were the responsible parties/job titles that were responsible for maintaining that communications? Facility administrator was the primary point of contact.

What were the topics of community meetings or work groups that your organization participated in? COVID pandemic related news topics and infection prevention and COVID vaccination.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Facility participated in email, phone, virtual meeting platforms, etc.
How did your organization address the distribution of federal, state, and local guidance? DaVita Dialysis is a corporate level business following CMS guidelines and national data reporting in the same manner guidelines.

How did your organization address the distribution of federal, state, and local funding opportunities? DaVita Dialysis is a corporate level business following CMS guidelines and national data reporting in the same manner guidelines.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency**?**
Facility is still acting under COVID19 restrictions and guidelines on the current day 07/2021. At this time, there are no plans to discontinue any of these practices.

FRESENIUS AIRWAYS

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) The incident command was activated around March 13, 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The facility was affected by the Initial Safer at Home Act by implementing a NO VISITATION/VISTITOR POLICY. No vendors or visitors were allowed in the facility. Patients and Staff were provided a letter of intent to travel to and from work/treatment

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The group met every day through daily huddles/briefings with staff and patients. Daily and weekly calls and teleconferences were conducted with upper management and Corporate Emergency Response Team.

Which components of incident were activated (i.e., which positions/groups were named)? The FKC Corporate Response Team communicated daily via email and or teleconference with RVP, Director of Operations, ATOM and Clinical Managers.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No additional positions were created. However, daily count of supplies and the number of positive patients/employees were reported daily.

How was information disseminated throughout the facility to keep staff informed? Information was disseminated throughout the facility to keep staff informed through daily huddles/debriefings, text messages, and writing updated information on hallway dry erase board near the employee time clock.

Provide THREE strengths related to INCIDENT COMMAND.

1. Accessibility
2. Delineation of roles and responsibilities
3. Implementation/development of new processes and policies.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Ensure that all parties know their duties/roles
2. Consistent and concise updated information
3. Accessibility to answer all questions and concerns

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began
One opportunity for improvement related to Incident Command is to ensure that all parties involved receive the same information and communicate to all necessary parties.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? The supply chain disruptions begin in June of 2020. Supplies were back in order due to high demand. We continue to have a supply disruption with gloves at this time.

What resources did you have difficulty procuring? How did you fulfill these needs? The company had difficulty procuring masks, gowns, hand sanitizer, and gloves. These needs were fulfilled by contacting the main vendor to seek other suppliers for needed supplies.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Some things were ordered through Amazon such as digital thermometers

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
Yes, normal materials management mechanisms/policies/procedures continue to work.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?
The pandemic changed preparedness as it relates to emergency procurement, emergency storage, and other supply chains and stored inventory by supplies secured in manager's office and daily count of PPE. Daily counts were incorporated to ensure which facilities had an abundance of certain supplies and could be transferred from facility to facility if needed.

Provide THREE strengths related to RESOURCES.
1. Available options to procure supplies
2. Daily count of on hand inventory
3. Networking with local vendors and community resources

Provide THREE opportunities for improvement related to RESOURCES.
1. Maintaining relationships with local vendors and community resources
2. Maintaining polices for supply chain disruptions
3. Always maintaining adequate supplies to avoid reuse of unsoiled supplies

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. One opportunity for improvement related to resources that has become a strength since the COVID-19 Response is functionality and the importance of not wasting supplies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, Gloves, Gowns, N95 Masks, and Face Shields were used to protect staff. Masks were used to protect patients.

What new materials/PPE/resources did you utilize that you had not previous utilized? Staff were allowed to use N95 masks.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? The facility will continue to have limited visitation policies and triage of visitors and patients.

How did your facility address extended use and/or reuse guidance for PPE?
The facility ensures that if PPE was reused, it was not physically soiled, and the same masks could be worn all day. Face shields were to be cleaned per policy.

How did your facility address COVID-19 patient and employee testing? Employees and patients were referred to local hospitals and testing centers for testing.

What standard or innovative infectious disease barrier control methods did you use, if any?
Universal PPE was utilized. N95 masks were provided for those working with patients with known exposure or tested positive for COVID-19. The disinfection of dialysis equipment and machines remained the same. Triage of all staff and patients. No staff or patients were admitted to the clinic with fever of 100.4 or known exposure to someone with COVID-19. Too, patients with known exposure or expected of having COVID-19 were isolated on COVID-19 isolation shifts.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? The facility does not have an on-site morgue. Pts were referred to the local hospital for symptoms and testing.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?
The facility maintained universal precautions when providing care. All staff and patients were to wear masks at all times. Patients and staff were triaged every day to identify exposure.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
The facility had issues with patients keeping their mask on throughout their entire treatment.

Provide THREE strengths related to INFECTION PREVENTION.

1. Triaging for known exposure or identifying symptoms
2. Availability of PPE
3. Proper disinfection

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Reuse of PPE
2. Proper handwashing
3. Ensuring that staff/patients were masks at all times.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The one opportunity for improvement related to Infection Prevention that has become a strength since COVID-19 is mask compliance.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? CM, CN, and SW communicated daily with local hospitals, transportation companies, access centers, and nursing homes. ATOMS communicated with designated vendors regarding supplies.

What were the topics of community meetings or work groups that your organization participated in? Topics of community meetings or work groups were Infection Control, Identification of Positive/Exposed Patients, and Procedures and Placements for Positive COVID patients.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? The primary ways that we communicated with external partners were through email, phone, and virtual meetings.

How did your organization address the distribution of federal, state, and local guidance? The distribution of federal, state, and local guidance was sent through emails and teleconferences.

How did your organization address the distribution of federal, state, and local funding opportunities? The distribution of federal, state, and local funding opportunities was discussed via email, virtual meetings, daily briefings/huddles and staff meetings.

What community partners did you work with during the pandemic that you had not previously worked with? We continued to work with local hospitals, pharmacies, access centers, and nursing homes. We did have to communicate with new COVID-19 testing sites for testing results/confirmation.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No new agreements have been established with external partners.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. I feel like the organization was supported by local community partners, state partners, and federal partners. Local partners provided supplies to the facility. State and federal partners provided childcare reimbursement for employees. Too, they assisted in vaccine procurement.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? The organization maintained frequent interaction with external partners before COVID-19. The organization will continue to maintain timely and effective communication with external partners after COVID-19 is no longer an emergency.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Available resources
2. Financial assistance for patients/staff
3. Vaccine procurement

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Collaboration of policies to accommodate patient needs
2. Hand/availability of resources
3. Delay in supplies or information

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. One opportunity for improvement related to External Partners that has become a strength since COVID-19 response began is maintaining communication without compromising patients' needs and safety.

FRESENIUS BARTLETT #6198

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date)
March 6th, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Initially vascular access placement surgeries were canceled because they were being considered elective surgeries. Our visitation policy changed where no family members or vendors were allowed in the building. No one was allowed to wait in the lobby, including private transportation services personnel.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initially daily calls, then transitioned to weekly calls, then to bi-weekly calls

Which components of incident were activated (i.e. which positions/groups were named)?
Clinical Services, Director of Operations, Regional Vice-President, President of the Company, Medical Director

How was information disseminated throughout the facility to keep staff informed?
Clinical in-services/ Posters

Provide THREE strengths related to INCIDENT COMMAND.

1. FKC's overall communication was great, our team was proactive vs reactive, in which we collaborated, coordinated, and communicated across all fields, developed and utilized available tools such as screening tools for patients and staff, supply and management of PPE, update calls from management (Clinical Services, Medical Staff Office, RVP team calls, and technical calls).
2. Facilities listed in our area were immediately identified as Isolation Clinics for placement of COVID19 patients. We were also flexible with transferring staff and shifting staff during the pandemic to fit the needs of the clinics in the area.
3. Education provided to the patients, staff, and business partners on COVID19 from FKC and the local Department of Health

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Policy Changes were made too frequent and it was difficult to keep up with the changes
2. Limited COVID19 testing abilities
3. Timely lab results (COVID19 results less than 72 hours turnaround time)

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Around April and May we were running low on gowns and gloves. It did not last long at all, maybe 2 weeks

What resources did you have difficulty procuring? How did you fulfill these needs? We had some difficulty with face shields, gloves, and gowns. The organization started to keep a count of supplies at all facilities and facilities began to share supplies. The organization also used outside vendors to ensure we did not run out of supplies.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Granger and Staple. Our organization's DPD warehouse also used other sources that we normally don't use.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
We would typically assess patient's vital signs on the treatment floor, but the policy was changed to check temperatures and screen patients for COVID19 prior to entering the treatment floor.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The organization will now have emergency storage for medical supplies.

Provide THREE strengths related to RESOURCES.

1. Our organization was creative and resourceful with obtaining medical supplies
2. My facility never ran out of any medical supplies
3. The facilities in the area were able to share inventory to ensure no one ran out of supplies

Provide THREE opportunities for improvement related to RESOURCES.
Better system to manage inventory counts

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The facilities communicating with each other to share inventory to ensure no one ran out of supplies

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.)
We used masks, face shields, barrier gowns, and gloves

What new materials/PPE/resources did you utilize that you had not previous utilized?
N95 masks

Does your organization have any plans of keeping any of your COVID-19 employees or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? The organization has not lifted any restrictions yet and no date has been given if the polices will change back to what they were before COVID19.

How did your facility address extended use and/or reuse guidance for PPE?
If the barrier gowns were not visibly soiled you were allowed to reuse them, face shields were not disposable, they were disinfected every day. Masks and gloves were not reused.

How did your facility address COVID-19 patient and employee testing? Patients who were symptomatic or had exposure were tested either at the hospital or in the isolation clinic. Same with employees. We did not do any testing in this facility

What standard or innovative infectious disease barrier control methods did you use, if any?
All staff were to wear masks and full PPE while on the treatment floor. In the break room employees were spread apart and a few employees were allowed in the breakroom at one time.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? There were some complaints from the patients about not being allowed to eat in the facility.

Provide THREE strengths related to INFECTION PREVENTION.

1. All staff and patients were compliant with always wearing a mask
2. The facility ensured all staff and patients were screened prior to entering the treatment floor
3. Hand Hygiene was heavily enforced and practiced

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. A better screening tool as the patients were not truthful sometimes on the screening tool
2. The ability to test in this facility

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Due to the clinical staff and patients always wearing masks contributed to decreased incidence of other infectious diseases such as the common cold and the Flu.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Transportation companies because we frequently had to coordinate transportation to isolation clinic for COVID19 positive patients. We also stayed in communication with Network 8

What were the topics of community meetings or work groups that your organization participated in? One of the major topics was medical supplies and working to ensure the facilities had everything they needed to properly care for the patients.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Virtual Meetings

How did your organization address the distribution of federal, state, and local guidance? The organization ensured our practices aligned with local guidance and above the guidance at the local and federal level.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. I feel like the organization was supported by community partners for example, there were so many local testing sites available in the community that made it easy for my patients and staff to quickly get tested.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. The transportation companies were accommodating in transporting COVID19 positive patients
2. Network 8 provided support to the facilities that included continuing education
3. Microsoft Teams was used for telehealth for the doctors to continue to see their patients

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Some of the transportation companies were not following our policies for wearing masks and we would often have to provide masks for the drivers.
2. Better communication between transportation companies and the facilities.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Better relationships with the transportation companies.

FRESENIUS GRACELAND

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) The incident command was activated around March 13, 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The facility was affected by the Initial Safer at Home Act by implementing a NO VISITATION/VISTITOR POLICY. No vendors or visitors were allowed in the facility. Patients and Staff were provided a letter of intent to travel to and from work/treatment.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The group met every day through daily huddles/briefings with staff and patients. Daily and weekly calls and teleconferences were conducted with upper management and Corporate Emergency Response Team.

Which components of incident were activated (i.e., which positions/groups were named)? What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No additional positions were created. However, daily count of supplies and the number of positive patients/employees were reported daily.

Provide THREE strengths related to INCIDENT COMMAND.

1. Accessibility
2. Delineation of roles and responsibilities
3. Implementation/development of new processes and policies

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Ensure that all parties know their duties/roles
2. Consistent and concise updated information
3. Accessibility to answer all questions and concerns

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began One opportunity for improvement related to Incident Command is to ensure that all involved parties receive the same information and communicated to all necessary parties.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? The supply chain disruptions begin in June of 2020. Supplies were on back order due to high demand. We continue to have a supply disruption with gloves at this time.

What resources did you have difficulty procuring? How did you fulfill these needs? The company had difficulty procuring masks, gowns, hand sanitizer, and gloves. These needs were fulfilled by contacting the main vendor to seek other suppliers for needed supplies.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Some things were ordered through Amazon such as digital thermometers.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes, normal materials management mechanisms/policies/procedures continue to work.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The pandemic changed preparedness as it relates to emergency procurement, emergency storage, and other supply chain and stored inventory by supplies secured in manager's office and daily count of PPE. Daily counts were incorporated to ensure which facilities had an abundance of certain supplies and could be transferred from facility to facility if needed.

Provide THREE strengths related to RESOURCES.

1. Available options to procure supplies
2. Daily count of on hand inventory
3. Networking with local vendors and community resources

Provide THREE opportunities for improvement related to RESOURCES.

1. Maintaining relationships with local vendors and community resources
2. Maintaining polices for supply chain disruptions
3. Maintaining adequate supplies at all times to avoid reuse of unsoiled supplies

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. One opportunity for improvement related to resources that has become a strength since the COVID-19 Response is functionality and the importance of not wasting supplies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, Gloves, Gowns, N95 Masks, and Face Shields were used to protect staff. Masks were used to protect patients.

What new materials/PPE/resources did you utilize that you had not previous utilized? Staff were allowed to use N95 masks.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? The facility will continue to have limited visitation policies and triage of visitors and patients.

How did your facility address extended use and/or reuse guidance for PPE? The facility ensures that if PPE was reused, if was not physically soiled and the same masks could be worn all day. Face shields were to be cleaned per policy.

How did your facility address COVID-19 patient and employee testing? Employees and patients were referred to local hospitals and testing centers for testing.

What standard or innovative infectious disease barrier control methods did you use, if any? Universal PPE was utilized. N95 masks were provided for those working with patients with known exposure or tested positive for COVID-19. The disinfection of dialysis equipment and machines remained the same. Triage of all staff and patients. No staff or patients were admitted to the clinic with fever of 100.4 or known exposure to someone with COVID-19. Too, patients with known exposure or expected of having COVID-19 were isolated on COVID-19 isolation shifts.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? The facility does not have an on-site morgue. Pts were referred to the local hospital for symptoms and testing.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? The facility maintained universal precautions when providing care. All staff and patients were to wear masks at all times. Patients and staff were triaged every day to identify exposure.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? The facility had issues with patients keeping their mask on throughout their entire treatment.

Provide THREE strengths related to INFECTION PREVENTION.

1. Triaging for known exposure or identifying symptoms
2. Availability of PPE
3. Proper disinfection

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Reuse of PPE
2. Proper handwashing
3. Ensuring that staff/patients were masks at all times.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The one opportunity for improvement related to Infection Prevention that has become a strength since COVID-19 is mask compliance.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? CM, CN, and SW communicated daily with local hospitals, transportation companies, access centers, and nursing homes. ATOMS communicated with designated vendors regarding supplies.

What were the topics of community meetings or work groups that your organization participated in? Topics of community meetings or work groups were Infection Control, Identification of Positive/Exposed Patients, and Procedures and Placements for Positive COVID patients.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? The primary ways that we communicated with external partners were through email, phone, and virtual meetings.

How did your organization address the distribution of federal, state, and local guidance? The distribution of federal, state, and local guidance was sent through emails and teleconferences.

FRESENIUS MIDTOWN #4000

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 03/11/2020

How was your facility affected by the initial Safer at Home directives? no visitors no venders allowed on site where patients were treating – all staff and patients must wear masks and have temps check prior to going on treatment floor, as well as answer short health care questionnaire

How often did that group meet/engage? Daily texts with area team, daily calls for regional members Weekly national call for team.

Which components of incident were activated? RVP/DO along with Regional Medical Director had calls/texts ongoing throughout initial 90 days

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? From a national level work with procurement and IT to help with internet access and getting supplies were added to the team.

How was information disseminated throughout the facility to keep staff informed? Text, handouts, flyers, daily huddles and individual one on one conversations

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication
2. No limit mindset
3. Collaboration

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Supply Depot closer to clinics available.
2. Respiratory masks (N 95) to be stored at every clinic.
3. Looking for space for minimum 2 weeks of incenter supplies present on floor.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
Following no limit mindset – setting out to be lead vaccine provider for all the dialysis facilities in the nation opening doors to assist our biggest competitors for the benefit for our patients.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? First of April some items where already on back ordered   How long did this last? Shortages for almost 6 months total

What resources did you have difficulty procuring? N 95 masks, Gowns and Hand sanitizer. How did you fulfill these needs? Lots of calls, looking to local, private own business's as well as looking at resources worldwide.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Staples and Walmart were added. More were added on a global level as or transportation team True Blue took lead in a lot of the procurement process.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Limited number of masks given daily, having non-patient caring facing reusing supplies when appropriate. No N 95 unless isolation shifts or clinics. Reuse gowns when no visible blood is seen

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? I did not think it on a bigger scale. Now looking at vendors that can help in all directions for the clinic is super important not to be dependent only on one person to help.

Provide THREE strengths related to RESOURCES.

1. Worldwide Access
2. no limit mindset
3. Able to buy in very large bulk

Provide THREE opportunities for improvement related to RESOURCES.

1. Better ability to spread the supplies within the area
2. Hoarding becomes a problem.
3. More local vendors are available.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Atoms started double checking supplies and confirmed what was on hand and made sure things were divided evenly

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Face shields, masks, N 95 masks, gowns, gloves, and googles. To protect patients? Hand hygiene, masks, health questionnaires as well as temperature checks

What new materials/PPE/resources did you utilize that you had not previous utilized? Vendors from China

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Still up in air, following CDC guidelines at the moment

How did your facility address extended use and/or reuse guidance for PPE? Re used gowns on the treatment floor.

How did your facility address COVID-19 patient and employee testing? No incenter testing. Had lists of all close local places for treatment and referral needs.

Did your facility have or use an infectious disease surge plan? Specifically, for COVID we opened a dedicated clinic for COVID only- What strengths and weaknesses have you since identified in that plan? Logistics was harder getting the patients to and from the isolation clinic. Transportation is a problem in the dialysis world without COVID and during it has been even worse with the one exception of the EMS transport has been a great help in getting our patients to and from.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Initially a couple of patients would not where masks and had to be re – educated not only on the CDC's and company's (Fresenius) guidelines, but they also learned the only option of not wearing the masks was to convert to home dialysis which we offered to every patient.

Provide THREE strengths related to INFECTION PREVENTION.

1. MASKS worked
2. It is a team effort holding each other accountable it takes all of us to be successful.
3. Vaccine education and patient participation at all time high

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Having the right supplies on hand – breathable gowns
2. Hot water at all sinks to help patients enjoy the hand washing process.
3. Education on when to stay home and when to see a specialist.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Masks wearing is not up for debate, even our patients will ask staff and other patients to wear their mask correctly. It has become the new norm and not a hassle.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Midsouth Emergency Disaster Coalition Who were the responsible parties/job titles that were responsible for maintaining that communications? Bryan Harrison Clinic Manager / April Gentry Director of Operations

What were the topics of community meetings or work groups that your organization participated in? Resources, Problems, Solutions, Brain Storming ideas.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? email and phone

How did your organization address the distribution of federal, state, and local guidance? Used the most stringent of the 3 and followed that one throughout the process. Being stricter vs more lenient

How did your organization address the distribution of federal, state, and local funding opportunities? Done more on a national basis than I am privy too. None that I am aware of personally.

Has your organization created any new MOUs/agreement during this pandemic with external partners? None locally Who were those partners and what was the topic of agreement? N/A

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. Yes – gowns and gloves and masks were made on local level as well as from State supplies – offered to us. If not, please explain how you could have been better supported.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Supplies lines are still open. COVID calls are now made on biweekly basis looking to move to monthly for just general data updates.

Provide THREE strengths related to EXTERNAL PARTNERS.

1.Communication.
2.Willingness

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Known call list
2 contact active list

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.

Ongoing communication minimum monthly to help “check in”, meeting face to face has allowed better connection and ability to network other resources.

FRESENIUS MT. MORIAH #6843

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan?
We activated the facility incident emergency plan at the end of March 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Our clinic was affected by the safer at home directives. Our patients access appointments were cancelled. Visitations in the lobby area were discontinued, ambulance employees were no longer allowed in the clinic area. Staples, UPS, and Fed ex were not allowed in the lobby area without proper PPE.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Our group huddled three times a week to discuss changes, policies, and COVID protocols.

Which components of incident were activated (i.e., which positions/groups were named)? The facility used a tornado/ severe weather.

How was information disseminated throughout the facility to keep staff informed? Huddles in the morning.

Provide THREE strengths related to INCIDENT COMMAND.

1. Staff made sure that they checked to make sure each patient in their bay was accounted for.
2. Patients agreed to disconnect themselves as needed.
3. Staff worked as a team.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Patients with accessible needs were not identified quickly
2. Train new teammates.
3. Making sure all teammates understand the emergency procedures.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Patients with accessible needs were attentive first. We are making sure we identify those patients.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? June 2020, we begin to have disruption in the supply chain. Our resources are still limited.

What resources did you have difficulty procuring? How did you fulfill these needs? We had a decrease in PPE. Gloves and gowns. We were able to fulfill the needs by getting PPE from smaller clinics.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes, they continued to work then and also now.

Provide THREE strengths related to RESOURCES.

1. Resources were available in a timely matter
2. There was communication via emails, FMC home page, and updated information on resources daily.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Mask, face shields, gloves, and gowns.

What new materials/PPE/resources did you utilize that you had not previous utilized? Hair nets, and shoe covers and also paper gowns.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, as of right now.

How did your facility address extended use and/or reuse guidance for PPE? We do not reuse. We did give out cloth masks for patients and employees.

How did your facility address COVID-19 patient and employee testing? Patients and employees that had COVID symptoms were sent for testing outside of Fresenius.

What standard or innovative infectious disease barrier control methods did you use, if any? Staff at front door to screen every patient and employee. No eating in the clinic area. Cleaning logs were initiated to make sure the lobby was disinfected. Only staff in the clinic area. PPE worn by patients that were COVID positive.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? No morgue. We did not have any surge.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, the staff was compliant.

Provide THREE strengths related to INFECTION PREVENTION.

1. PPE provided to staff and mask to all patients
2. Advanced nursing assessments for all patients
3. Screening each patient
4. Increasing the seconds on hand washing.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Making sure screening patients are correct
2. Follow FMC/ State protocols for COVID related infections
3. Making sure all PPE is worn at all times on the clinic floor.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. We are making sure the nurse is assessing the patients for symptoms of infection according to FMC standards/ and state protocol for screening for COVID.

*Facility did not submit evaluation documentation for the EXTERNAL PARTNERS section.

Fresenius Summer

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 6, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Dialysis clinic was moderately impacted. We were not able to allow visitors into the facility or allow family members to wait in the lobby. Any facility physical plant maintenance or repair required to be completed after hours.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Weekly

Which components of incident were activated (i.e., which positions/groups were named)? Medical Services, Nursing/Clinical Services, Technical Services, Clinical Technology Services, and Regulatory Services were all represented within incident command.

How was information disseminated throughout the facility to keep staff informed? Email, huddles, staff meetings and postings.

Provide THREE strengths related to INCIDENT COMMAND.

1. FKC's overall communication was great, our team was proactive vs reactive, in which we collaborated, coordinated, and communicated across all fields, developed and utilized available tools i.e., screening tool for patients and staff, supply and management of PPE, update calls from management (Clinical Services, Medical Staff Office, RVP team calls, and technical calls).
2. Unique questions, concerns or situations were addressed through open forum calls held weekly and then bi-weekly.
3. 22 Facilities listed in our area, immediate identification of Isolation Clinic for placement of COVID19 positive patients. Isolation clinic named (FKC Community 100271). Collaborated with the local transportation departments to ensure schedule changes were relayed.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Policies change weekly, it is difficult to manage such frequent policy changes
2. Experienced challenges in staffing the Isolation Clinic during high census times
3. COVID19 testing abilities, (who will test, screener, Educators, ICH staff), Timely labs results (COVID19 results less than 72 hours turnaround time)

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.

Frequency of P&P updates: FKC created a COVID19 resource page on the FKC home page. All policies and procedures, education materials, forms, resource documents and links contained in one area for quick reference. One staff member assigned in each clinic to ensure all P&Ps are reviewed and communicated to all staff.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Approximately a couple of months into the pandemic. Numerous resources have become limited at times throughout this pandemic.

What resources did you have difficulty procuring? How did you fulfill these needs? Hand sanitizer, gowns, and gloves. Our supply management team sought out and secured multiple procurement sources/vendors while also revising policy and procedure on PPE usage.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Numerous P&P were revised to preserve our resources. For example: limiting 1 mask/day for Indirect Patient Care staff, 2 masks/day for Direct Patient Care staff, and gowns discarded only when soiled. Only PPE supplies needed for the current day are stocked on the treatment floor. All remaining supplies secured until needed. Technical department began daily inventory counts in each clinic.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? FKC sought out and secured procurement contracts with local and international vendors including potential storage space/containers

.

Provide THREE strengths related to RESOURCES.

1. Supply management and distribution was much better than that of other locations and/or dialysis providers based on procurement efforts and policy revisions. FKC was also able to provide masks to other providers and hospitals.
2. Local daily inventory assessment provided quick insight into available resources and their locations that could be moved around the city as needed.
3. Worked with local healthcare coalition in locating or obtaining additional resources.

Provide THREE opportunities for improvement related to RESOURCES.

1. Better communication related to resource needs and availability
2. Consistent practices in resource usage and storage
3. Expand local vendor list

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Policies revised to create consistent practice in PPE usage. Inventory assessment increased to daily and reported to a shared file for all to view.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) All staff were required to wear a mask at all times while at work except while eating or drinking. All people entering the facility were screened, provided a mask and kept socially distanced. Staff screening were required to wear full PPE: gown, mask, shield and gloves. All staff providing patient facing activities were required to wear a mask and shield.

What new materials/PPE/resources did you utilize that you had not previous utilized? Infrared thermometers, various hand sanitizer options, various surface disinfectants

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? At this time, all COVID19 policies remain in place.

How did your facility address extended use and/or reuse guidance for PPE? Indirect patient care staff were allowed one mask per day, Direct patient care staff were allowed 2 masks per day, gowns were worn until soiled.

How did your facility address COVID-19 patient and employee testing? Staff were trained to provide onsite COVID19 testing to staff and patients

What standard or innovative infectious disease barrier control methods did you use, if any? Double masking: all staff/visitors and patients were masked at all times upon entering the facility. Social distancing of 6 feet maintained in lobby by removing chairs, asking patients/family members with transportation to remain in vehicles until called. Any symptomatic patients/staff/visitors were immediately separated from others. Quarantine policies in place for staff and patients. Symptomatic or positive patients dialyzed on ISO shifts or at an ISO clinic.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Not applicable

Did your facility have or use an infectious disease surge plan? Identified symptomatic/positive shifts and clinics for these patients. What strengths and weaknesses have you since identified in that plan? Strengths: these ISO shifts/clinics provided multiple locations and times for identified patients to be dialyzed around the city. Weaknesses: challenges in staffing these shifts/clinics adequately. If you had no plan, have you created a plan based on your COVID-19 response?

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Experienced challenges with patients wearing masks appropriately and not eating while in the clinic.

Provide THREE strengths related to INFECTION PREVENTION.

1. Swift response in implementing screening and double masking policy may have reduced/slowed spread.

2. Disinfection of routinely touched surfaces throughout the facility after each shift of patients may have reduced/slowed spread.
3. COVID19 testing and vaccine administration provided for staff and patients

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Staffing of ISO shifts/clinics and the screener position at each clinic
2. Improved compliance of consistent proper PPE use
3. Improved COVID19 testing abilities and result turnaround times

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Per Diem Screener positions approved for posting and hiring in clinics as needed to prevent pulling from already strained staff.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? The Mid-South Emergency Planning Coalition, and facility Clinical Managers were responsible for maintaining communication

What were the topics of community meetings or work groups that your organization participated in? Budgets, Resources and Equipment, COVID updates and variants, Public PODs, and other vaccine offerings

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? email, phone and virtual meetings

How did your organization address the distribution of federal, state, and local guidance? Weekly calls and the COVID19 resource page on the FKC intranet

How did your organization address the distribution of federal, state, and local funding opportunities? Weekly calls and the COVID19 resource page on the FKC intranet

What community partners did you work with during the pandemic that you had not previously worked with? Other local dialysis providers, local Fire Departments

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Formed new janitorial contracts for ISO shift/clinic cleaning, contracts for supplies and storage space

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, received ongoing guidance and updates from the Midsouth Emergency

Planning Coalition as well as assistance with vaccine distribution and administration; utilized Network 8/CDC resources for education and guidance

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
More frequent AARs to assess current plans/communications with partners

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Utilized Network 8/CDC resources for education and guidance to staff, patients and partners
2. Closely worked with Midsouth Emergency Planning Coalition in successful vaccine distribution and administration
3. External partners assisted in obtaining needed resources

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Need better streamlined approach in obtaining, reviewing, and communicating information from all external partners
2. An earlier and more efficient process in obtaining and distributing vaccines amongst dialysis clinics
3. Share one consolidated list of all external partners and available resources

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
One staff member in each clinic identified to obtain, review, and communicate updated information, guidance from all external partners.

FRESENIUS TIPTON #1541

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date)
Fresenius Corporate Emergency Response Team activated 3/13/21 when the President declared COVID 19 a national emergency. FMC-Tipton did not have any interruption of services or any alteration in opening or closing schedule.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?
The clinic altered its visitor policy and did not allow anyone inside the facility except staff and patients. Lobby chairs were moved 6 feet apart so patients would not be sitting beside each other. Patients were instructed not to arrive before their scheduled treatment time. Outside vendors had to leave deliveries outside the clinic front door.

Which components of incident were activated (i.e., which positions/groups were named)?
FMC corporate emergency response team communicated almost daily with management re: policy and education changes and updates. Clinic manager (CM) was then able to educate staff through daily morning huddles and in-services. Patients were educated by distributing and explaining handouts and with wall postings.

How was information disseminated throughout the facility to keep staff informed?
The CM or RN communicated with local nursing home daily about mutual patients re: COVID statuses and testing at their facility to see if our patients had been exposed or tested for COVID.

Provide THREE strengths related to INCIDENT COMMAND.

1. FMC Corporate Emergency Response Team kept CMs up to date with policy and education changes and updates which could be relayed to staff and patients.
2. CM and staff were able to communicate clearly with patients using verbal education, handouts, and wall postings re: COVID updates and policies.
3. Staff had daily huddles every morning to discuss policy changes and updates and patient statuses and frequent in-services.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Needed 1 or 2 contact people only at nursing home to communicate COVID status and information instead of multiple.
2. Not all outside vendors would notify clinic when deliveries were made outside facility door
3. Hospital case managers would not always communicate COVID status with facility on our patients prior to DC without clinic having to contact them

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last?
FMC-Tipton had no interruption in dialysis related supplies and PPE delivery. Clinic was unable to obtain some custodial related supplies such as toilet paper, paper towels, Lysol, and some cleaning supplies from regular vendor Staples due to shortage. Clinic manager was able to obtain these items online from other vendors such as Wal-Mart and Amazon using company credit card. Extra supplies were ordered as available to have extra on hand and clinic did not run out of these supplies.

What resources did you have difficulty procuring? How did you fulfill these needs?
Dialysis supplies delivered by the company continued to be brought inside the facility after the driver was screened and given a mask. All outside vendors were required to leave deliveries outside the clinic door so they would not have to enter the building.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
FedEx who picks up clinic lab work changed their pickup days from 5 days a week to 3 days a week on Tuesday, Wednesday, and Thursday only, so lab draw days had to be adjusted according to schedule.

Provide THREE strengths related to RESOURCES.

1. Facility had no interruption of delivery of dialysis related supplies or PPE.
2. Non-FMC vendors were instructed to leave deliveries outside of the clinic for staff to bring inside and all complied.
3. Clinic manager was able to obtain custodial supplies not available from normal vendor (Staples) such as toilet paper, paper towels, Lysol and some cleaning supplies from online sources such as Wal-Mart and Amazon using company credit card and clinic did not run out.

Provide THREE opportunities for improvement related to RESOURCES.

1. Not able to obtain some custodial supplies from the usual vendor
2. Clinic may need to always try to keep extra supplies of essential products such as toilet paper, paper towels, Lysol, and cleaning supplies in case of shortage
3. FedEx altered pick up days, so clinic had to adjust lab draw days

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
The facilities communicating with each other to share inventory to ensure no one ran out of supplies

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.)
Staff and patients were given face masks upon arrival at the clinic and were screened every morning for temperature >100.0 degrees and for signs and symptoms of COVID and if they had been in contact with anyone that had COVID. This was documented daily on a new form that was developed by FMC. If any staff member had any of the above, they had to leave the facility and go have a negative COVID test before returning to work. If any patient had any of the above the MD had to be notified and the patient also had to be tested for COVID outside of the facility.

What new materials/PPE/resources did you utilize that you had not previous utilized?
No patient or staff member refused to wear the face mask at all times during the day. Staff continued to wear all other PPE (gown, face shield, gloves) for patient care as well. FMC will continue to require screening of patients and staff and face masks will continue to be used indefinitely. Direct patient care staff are allowed 2 face masks per day, indirect patient care staff 1 mask per day and patients 1 mask per day.

How did your facility address COVID-19 patient and employee testing?
Our facility was required to dialyze our own patients who were COVID positive. This was done by adjusting patient schedules allowing the COVID positive patient to be on a special shift by themselves. These patients would dialyze on Tuesdays, Thursdays, and Saturdays on a second shift after all the other patients had vacated the building. The COVID positive patient was given a specific treatment time and was instructed to park in the back of the building and to call when they arrived. When the building was empty staff would go to the back door and get the patient. Follow up COVID testing was done by the CM outside prior to the patient entering. The patient was given a N 95 mask and gown to wear and was escorted through the back entrance into the treatment area. Patients then received their treatment without coming into contact with other patients. Staff also had N 95 masks to wear as well. Extra cleaning measures were implemented after the patient vacated the building and a new check-off sheet was utilized. This included wiping with 1:100 bleach/water disposable rags the patient chair and machine, doorknobs, light switches, counter tops, desks, phones, computers and keyboards, toilets, sinks, faucets and cabinet knobs.

Provide THREE strengths related to INFECTION PREVENTION.

1. No refusals from staff or patients re: screening methods and wearing of masks at all times.
2. No shortage of PPE supplies
3. Staff quickly developed a plan and schedule for dialyzing COVID positive patients in the facility and it was carried out safely and effectively and no staff became COVID positive.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Back up thermometer needed
2. COVID testing for positive patients originally done with patients in a chair outside. It was found to be easier and less likely to spread infection if the test was done while the patient was still in their vehicle.
3. Some regular patient transportation would not transport COVID positive patients and staff, and patients were left to find alternative transportation often last minute.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Due to the clinical staff and patients always wearing mask contributed to decreased incidence of other infectious diseases such as the common cold and the Flu.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? FMC-Tipton kept in communication with external partners such as Delta transportation, Med-Care ambulance, Staples, FedEx and UPS re: when clinic was dialyzing COVID positive patients so they would make sure not to enter the building. This was usually done by the clinic manager or RN via telephone.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? FMC Corporate Emergency Response team kept us informed by sending almost daily communication re: state and federal news and guidelines. MSPEC also kept us informed of new information with frequent emails.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Our facility was also able to administer the Moderna vaccine to our staff and patients in March and April. The CM and RN had to apply and get access to the Tennessee immunization system (TennIIS) to be able to log in the vaccinations. CM had ongoing communication and assistance via phone and email with vpdip.pandemic@TN.gov and Tennessee Dept of Health representative to assure CM and RN were properly trained in how to receive, store, administer and record the vaccinations correctly. The CM and RN were also required to do online classes and testing for this also. There was ongoing communication re: delivery dates and expiration dates of the vaccine as well as how to store and administer the vaccine.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. CM and RN received assistance in obtaining access to TennIIS site to record Moderna vaccinations.
2. CM and RN received helpful education opportunities on how to receive, store and administer vaccines.

3. CM received assistance from TN department of health in how to transfer extra vaccines to the local health department for them to use and not be wasted.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Clinic received too many doses of Moderna vaccine to utilize and it took numerous phone calls and emails to make arrangements to transfer vaccine.
2. Some local transportation services would not transport COVID positive patients so it was sometimes difficult to arrange transportation
3. FedEx altered lab pick up days making some lab redraws more difficult to obtain.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Better relationships with the transportation companies.

FRESENIUS WHITEHAVEN #4001

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date)
March 6th, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Initially vascular access placement surgeries were canceled because they were being considered elective surgeries. Our visitation policy changed where no family members or vendors were allowed in the building. No one was allowed to wait in the lobby, including private transportation services personnel.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initially daily calls, then transitioned to weekly calls, then to bi-weekly calls

Which components of incident were activated (i.e., which positions/groups were named)?
Clinical Services, Director of Operations, Regional Vice-President, President of the Company, Medical Director

How was information disseminated throughout the facility to keep staff informed?
Clinical in-services/ Posters

Provide THREE strengths related to INCIDENT COMMAND.

1. FKC's overall communication was great, our team was proactive vs reactive, in which we collaborated, coordinated, and communicated across all fields, developed and utilized available tools such as screening tools for patients and staff, supply and management of PPE, update calls from management (Clinical Services, Medical Staff Office, RVP team calls, and technical calls).
2. 8 Facilities listed in our area were immediately identified as Isolation Clinics for placement of COVID19 patients. We were also flexible with transferring staff and shifting staff during the pandemic to fit the needs of the clinics in the area.
3. Education provided to the patients, staff, and business partners on COVID19 from FKC and the local Department of Health

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Policy Changes were made to frequent, and it was difficult to keep up with the changes
2. Limited COVID19 testing abilities
3. Timely lab results (COVID19 results less than 72 hours turnaround time)

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Around April and May we were running low on gowns and gloves. It did not last long at all maybe 2 weeks

What resources did you have difficulty procuring? How did you fulfill these needs?
We had some difficulty with face shields, gloves, and gowns. The organization started to keep a count of supplies at all facilities and facilities began to share supplies. The organization also used outside vendors to ensure we did not run out of supplies.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Granger and Staple. Our organization's DPD warehouse also used other sources that we normally don't use.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
The organization created the position for a full-time screener. The screener checks the temperature of every patient and screens all patients and visitors for s/s of COVID19.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The organization will now have emergency storage for medical supplies.

Provide THREE strengths related to RESOURCES.

1. Our organization was creative and resourceful with obtaining medical supplies
2. My facility never ran out of any medical supplies
3. The facilities in the area were able to share inventory to ensure no one ran out of supplies

Provide THREE opportunities for improvement related to RESOURCES.
Better system to manage inventory counts

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
The facilities communicating with each other to share inventory to ensure no one ran out of supplies

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) We used masks, face shields, barrier gowns, and gloves

What new materials/PPE/resources did you utilize that you had not previous utilized?
N95 masks

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? The organization has not lifted any restrictions yet and no date has been given if the polices will change back to what they were before COVID19

How did your facility address extended use and/or reuse guidance for PPE? If the barrier gowns were not visibly soiled you were allowed to reuse them, face shields were not disposable they were disinfected every day. Masks and gloves were not reused.

How did your facility address COVID-19 patient and employee testing? Patients who were symptomatic or had exposure were tested either at the hospital or in the isolation clinic. Same with employees. We did not do any testing in this facility

What standard or innovative infectious disease barrier control methods did you use, if any?
All staff were to wear masks and full PPE while on the treatment floor. In the break room employees were spread apart and a few employees were allowed in the breakroom at one time.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
There were some complaints from the patients about not being allowed to eat in the facility.

Provide THREE strengths related to INFECTION PREVENTION.

1. All staff and patients were compliant with always wearing a mask
2. The facility ensured all staff and patients were screened prior to entering the treatment floor
3. Hand Hygiene was heavily enforced and practiced

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. A better screening tool as the patients were not truthful sometimes on the screening tool
2. The ability to test in this facility

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Due to the clinical staff and patients always wearing mask contributed to decreased incidence of other infectious diseases such as the common cold and the Flu.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Transportation companies because we frequently had to coordinate

transportation to isolation clinic for COVID19 positive patients. We also stayed in communication with Network 8

What were the topics of community meetings or work groups that your organization participated in? One of the major topics was medical supplies and working to ensure the facilities had everything they needed to properly care for the patients.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Virtual Meetings

How did your organization address the distribution of federal, state, and local guidance? The organization ensured our practices aligned with local guidance and above the guidance at the local and federal level.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. I feel like the organization was supported by community partners for example, there were so many local testing sites available in the community that made it easy for my patients and staff to quickly get tested.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. The transportation companies were accommodating in transporting COVID19 positive patients
2. Network 8 provided support to the facilities that included continuing education
3. Microsoft Teams was used for telehealth for the doctors to continue to see their patients

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Some of the transportation companies were not following our policies for wearing masks and we would often have to provide masks for the drivers.
2. Better communication between transportation companies and the facilities.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Better relationships with the transportation companies.

SKILLED NURSING AND ASSISTED LIVING FACILITIES

Applegrove Living

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 03/2020

How was your facility affected by the initial Safer at Home directives (i.e., cancelled elective surgeries, visitation policies, or other closures)?

- Eliminated our family's ability to see their loved one's face to faces (visitation)
- Began testing staff and residents weekly for COVID
- Incurred significant costs to create and maintain a COVID PPE supply
- Eliminated our Day Care program and Respite Stay program
- Continued on-site weekly MD visits, initiated telehealth calls
- Able to operate effectively, while still maintaining health/wellness of residents

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Weekly and as needed regarding CDC updates/changes

Which components of incident were activated (i.e., which positions/groups were named)?
Enhanced IPC- Infection Prevention and Control Program

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command?

- Additional Housekeeping staff were hired
- Housekeeping schedules were tiered to ensure round the clock cleaning
- Weekly anti-bacterial spraying done throughout the facility

How was information disseminated throughout the facility to keep staff informed?
Staff meetings, informational Binders, handouts, flyers posted, specific education

Provide THREE strengths related to INCIDENT COMMAND.

1. Consistent experienced staff
2. Organization/ Leadership
3. Smaller community

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. PPE usage control
2. Education/ Knowledge of use of PPE
3. Education/Knowledge of COVID-19

Narrative- What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
PPE Control/ Management

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last?

- Almost immediately gloves became limited/hard to find, Lysol spray became impossible to get and Clorox wipes impossible
- This difficulty lasted until June of 2021

What resources did you have difficulty procuring? How did you fulfill these needs?

- PPE supplies (hand sanitizer, N95 masks, gloves, disposable gowns)
- Cleaning supplies (Lysol spray, Clorox wipes)
- We began to use new suppliers including Amazon

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Amazon

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.

- Much higher shrinkage rate of PPE supplies than normal supplies
- PPE had to be locked away and carefully managed

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?

- We have converted a less used office into PPE storage
- At first hint of emergency situation or supply chain interruption, we will over order
- Increased minimum supply kept on hand

Provide THREE strengths related to RESOURCES

1. Larger on hand reserve of PPE supplies
2. Enhanced relationships with long-term vendors
3. Created new relationships with previously unused vendors

Provide THREE opportunities for improvement related to RESOURCES.

1. Could have ordered more stock earlier
2. Improve backup stock
3. Better storage/dispersal options

Narrative- What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
We now have a much larger on hand supply of PPE equipment and understand the need to over order at the very onset of any new threat to ensure coverage

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients (i.e., masks, face shields, half masks, etc.) Masks, face shields, gowns, gloves, hair covers, shoe covers, goggles, sanitizer, fogging

What new materials/PPE/resources did you utilize that you had not previously utilized?
N95 masks, face shields, hair and shoe coverings, gowns, fogging

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Screening visitors for temps

How did your facility address extended use and/or reuse guidance for PPE?

- Education/training on Face shield disinfection/ reuse/ storage
- Laundry- washable gowns

How did your facility address COVID-19 patient and employee testing? COVID-19 Rapid testing 2 to 3x weekly, residents and staff

What standard or innovative infectious disease barrier control methods did you use, if any?
Barrier/ curtains

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? No on-site morgue, Hospice services, local police/ fire dept. if needed

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?

- Will create
- Increased rapid screening/testing
- PPE education/handwashing

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
No, compliant

Provide THREE strengths related to INFECTION PREVENTION.

1. Disinfection/ Environmental infection control

2. Hand Hygiene
3. Isolations precautions

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
1. Education of proper removal/disposal of PPE
2. Dangers of cross contamination
3. Disposal of infectious waste

Narrative- What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began/
Mask wearing as a standard and hand hygiene are keeping general virus numbers low as compared to years past

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Shelby county health dept., State of TN dept of health, Dr. Nidal Rahal our visiting physician to the community Who were the responsible parties/job titles that were responsible for maintaining that communication? Executive Director/Managing Partner, Kimily Taylor

What were the topics of community meetings or work groups that your organization participated in? COVID-19 safety protocols, weekly discussions on cross contamination, PPE, Handwashing procedures

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)?
Email, phone, conference calls initiated by the dept of health

How did your organization address the distribution of federal, state, and local guidance?
Any material we received from them we distributed to staff, also created a COVID-19 binder that staff had to review and sign off on

How did your organization address the distribution of federal, state, and local funding opportunities?
Applied for and received PPP loan

What community partners did you work with during this pandemic that you had not previously worked with?
Shelby County health dept

Has your organization created any new MOUs/agreements during this pandemic with external partners? Who were those partners and what was the topic of agreement?
None

Did you feel like your organization was supported by local community partners? State partners? Federal?

- Local, yes
- State, no
- Federal, no

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
Established closer relationships with the Dept of health and Shelby county and know more where to go for the support we need if there is another situation such as this in future

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Created new relationships
2. Re-established past relationships
3. Became more comfortable with communications with outside agencies

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Requested PPE equipment that was never received from TEMA (no response at all from them)
2. Receipts and documentation were sent to the State of TN Dept of health for reimbursement for COVID testing, yet have not received any reimbursement for that expense
3. Questions were submitted to the DOH that were to be answered on conference calls or via email, never received answers to the questions. We realize it was a difficult time and there were staffing shortages, however, also believe there are opportunities for better response and follow up

Narrative- What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
The whole situation supported a greater understanding by our team of how important it is to follow established safety standards and protocols while also making us more self-sufficient and able to look within for support during a global pandemic.

ALLENBROOKE NURSING AND REHAB

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 4-14-20

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Caused significant drop in census due to reduced referrals.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily during the week and as needed on the weekends.

Which components of incident were activated (i.e., which positions/groups were named)? All departments were impacted.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? NHSN (Federal), TN Dept of Health (State), Shelby Co Health Department (County), City of Memphis (City) all requiring reports that had the same information, but each one had a different format.

How was information disseminated throughout the facility to keep staff informed? Bulletin boards, meetings, supervisor interactions.

Provide THREE strengths related to INCIDENT COMMAND.

1. Experience
2. Organization
3. Teamwork

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Reliance on computers (ours went down during this time for an extended time)
2. Emergency supply of infection control supplies.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Centralized procurement at the support (corporate) level. Centralized procurement allowed us to quickly obtain needed emergency supplies of PPE.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Immediately. How long did this last? At least 6 months.

What resources did you have difficulty procuring? PPE How did you fulfill these needs? Local purchasing and centralized procurement through the corporate office.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Varied.

Did your normal materials management mechanisms/policies/procedures continue to work? At a limited level. If not, did your organization create new and/or temporary management plans? Tara Cares developed a 'push' model for PPE supplies where orders were placed at the corporate level and pushed down to facilities through 'supplies hubs' at certain facilities.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Increase emergency supply of PPE.

Provide THREE strengths related to RESOURCES.

1. Procurement
2. Storage
3. Proper usage

Provide THREE opportunities for improvement related to RESOURCES.

1. Emergency PPE levels
2. Backorders from established suppliers

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The centralized procurement system with facility hubs.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) All PPE

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not determined at this time.

How did your facility address extended use and/or reuse guidance for PPE? Per CDC guidance.

How did your facility address COVID-19 patient and employee testing? Per CDC guidance.

What standard or innovative infectious disease barrier control methods did you use, if any? Creating Designated Units for infection Control.

Did your facility have or use an infectious disease surge plan? We created one. What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes. We have a very strong Infection Control Plan.

Provide THREE strengths related to INFECTION PREVENTION.

1. Infection Prevention Nurse
2. Staff compliance

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Emergency PPE Supply

*Facility did not submit evaluation documentation for the EXTERNAL PARTNERS section.

AVE MARIE

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan (date)?
March 11,2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Closed facility to visitors, vendors and other outside individuals, residents did not leave facility except for hospital visits, workers were given form to put in vehicles to show they were essential workers.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Met at least a couple times a week and at times daily based on number of active facilities COVID cases.

Which components of incident were activated (i.e., which positions/groups were named)?
All members worked collectively. The infection preventionist and Administrator led the team.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Additional help from the business office.

How was information disseminated throughout the facility to keep staff informed? Call Multiplier and Constant Contact Email, signs by time clocks, during staff meetings, multiple in-services.

Provide THREE strengths related to INCIDENT COMMAND.

1. Collaboration
2. Adapted to frequent change in guidelines
3. Cooperative as a team

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Communication at times
2. Fatigue and burnout related constant demands
3. Having adequate time

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
The way we now communicate with staff with today’s technology. Ave Maria Home uses Call Multiplier and Constant Contact Email on a more regular basis as it has proven to be more of a consistent and effective method in communicating with staff.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? The disruption started in May 2020 and it lasted several months

What resources did you have difficulty procuring? How did you fulfill these needs?

- I had difficulty getting gloves, masks, cleaning products, gowns and hand sanitizer.
- Bought masks from a different vendor but had to pay significantly more for them.
- Had cloth masks made and donated in the event staff needed them but were not used.
- Bought hand sanitizer locally.
- Bought cleaning supplies locally as well.
- Got washable gowns
- Used the Emergency Coalition to obtain supplies as well.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? The Emergency Coalition

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.

- Took inventory of supplies more often – weekly
- Stored all COVID supplies in a locked area
- Staff were required to fill out a form for all COVID supplies needed before they could be obtained.
- A locked storage space had to be identified for COVID supplies.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?

- Par levels of specific supplies have been increased
- Have an identified space to store extra supplies

Provide THREE strengths related to RESOURCES.

1. Had multiple vendors supplies could be ordered from
2. Had appropriate space and locked area for storage of supplies
3. Resourceful in obtaining supplies to prevent ever running out of them.

Provide THREE opportunities for improvement related to RESOURCES.

1. Ensuring additional supplies are obtained early
2. Ensuring more than one person knows how to order supplies

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Increased our weekly par levels

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, gowns, shoe protectors, face shields, gloves

What new materials/PPE/resources did you utilize that you had not previous utilized?
Shoe protectors, face shields, masks

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? No

How did your facility address extended use and/or reuse guidance for PPE? The facility followed the State of TN guidance

How did your facility address COVID-19 patient and employee testing? The facility followed the State of TN guidance

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? The facility did not have many COVID deaths and did not have any issues with the morgue.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? No, and we have not completed a plan.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
No

Provide THREE strengths related to INFECTION PREVENTION.

1. Having a designated full-time infection preventionist on staff
2. Frequent in servicing and keeping staff informed of frequent changes policies and processes
3. Participated in state and local calls related COVID

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Additional surveillance

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
More surveillance

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining those communications?

- The Health Department on a state and local level
- The Office of Health Care Facilities
- The Infection Preventionist and Administrator were responsible for the communication.
- QIO

What were the topics of community meetings or work groups that your organization participated in?

- Lack of supplies
- Processes related to screening, COVID testing, and infection control

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, phone, zoom meetings and WebEx

How did your organization address the distribution of federal, state, and local guidance?
Had frequent staff in-services

How did your organization address the distribution of federal, state, and local funding opportunities? The director of finance and the administrator handled all distributions

What community partners did you work with during the pandemic that you had not previously worked with? The local health department

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement?

- A new lab company was obtained to be able to do COVID testing
- A new staffing agency for supplemental staff

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported.

- The state health department was most informative and helpful
- The local health department was requiring the same information that was required by the test, creating more work and use of time.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? The facility knows who to reach out to in the future in the event of an emergency.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Through the contact with the State of TN the facility was able to have an infection preventionist come to the facility and do an assessment of the infection control program and processes.
2. Got to network with LTC facilities
3. Received guidance and support from outside sources

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
Having the local health department be more helpful and supportive to the long-term care facilities.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Networking with other facilities

GRACELAND REHAB

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 10th, 2019

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Not being able to Visit was difficult for residents and family. Facility was able to work around other closures and elective surgeries.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Our COVID team met twice weekly and extra as changes were made by CMS.

Which components of incident were activated (i.e., which positions/groups were named)? COVID team and Infection control

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? We added an additional Infection Control nurse and additional responsibilities to all departments pertaining to COVID-19.

How was information disseminated throughout the facility to keep staff informed? Mandatory Meetings, In-services, Flyers and Signage and emails.

Provide THREE strengths related to INCIDENT COMMAND

1. The COVID team was very proactive, putting things in place before guidelines were ever handed down.
2. Enforced strict PPE
3. Educating staff, residents and family proactively.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Having emergency PPE supplies in stock.
2. Communication between administration, management and staff,
3. Improvement on COVID-19 vaccine recipients for staff and residents.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Continuing proper PPE use above and beyond CMS guidelines and recommendations.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? We did not experience any supply chain disruptions, although we were limited to certain items on the amount or quantity, we could purchase at one time.

What resources did you have difficulty procuring? How did you fulfill these needs? PPE especially the N95 mask, we were able to fulfill our needs through other vendors and utilizing the mask reuse policy and through our local coalition.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? It has caused our facility to be more proactive in making sure we have good communication with our supply chains and keep emergency supplies on hand.

Provide THREE strengths related to RESOURCES.

1. The facility was able to acquire PPE to keep staff and residents safe.
2. Communication with vendors.
3. PPE Burn Calculator.

Provide THREE opportunities for improvement related to RESOURCES.

1. Partnering with more vendors to acquire resources.
2. Being more conservative with PPE to limit waste.
3. Education with staff regarding PPE and being conservative to reduce waste of PPE.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Education with staff regarding PPE.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients. (i.e., masks, face shields, half masks, etc.) surgical mask, N95 mask, face shields, goggles, and gowns.

What new materials/PPE/resources did you utilize that you had not previous utilized? Surgical masks, N95 mask, face-shields and goggles.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Our facility will continue to follow CMS guidelines.

How did your facility address extended use and/or reuse guidance for PPE? Contingency plan

How did your facility address COVID-19 patient and employee testing? Followed CMS guidelines and community prevalence rates.

What standard or innovative infectious disease barrier control methods did you use, if any? Plastic barriers with zippers.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? All residents had a funeral home on file in the event of a death.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? The COVID Unit and observation Unit.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes, in the beginning due to lack of knowledge of COVID-19.

Provide THREE strengths related to INFECTION PREVENTION.

1. Early detection of signs and symptoms of COVID-19.
2. Testing
3. COVID Unit and Observation Unit.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Education to reduce risk of spreading germs and infections with staff and residents.
2. Keeping proper PPE on at all times while in the facility.
3. Social distancing among staff and residents.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. These areas of improvements have become strengths due to proper education with staff and residents.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? PPE vendors, coalition for emergency preparedness state and local, who were the responsible parties/job titles that were responsible for maintaining those communications? Administrator and Director of Nursing and Infection Preventionist

What were the topics of community meetings or work groups that your organization participated in? COVID-19

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? webinars, emails, phone, virtual meetings.

How did your organization address the distribution of federal, state, and local guidance? Meetings, in-services, signage, and phone calls.

What community partners did you work with during the pandemic that you had not previously worked with? We have previously been in contact with local community partners ex. Local health dept, coalition.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Yes, who were those partners and what was the topic of agreement? Vendors for emergency supplies.

Did you feel like your organization was supported by local community partners? Yes, State partners? Yes, Federal partners? Yes. If so, please provide examples.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We will keep communication on-going and continue to plan for any future emergency that we may be faced with.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Communication
2. Education and knowledge shared between any external partner
3. Teamwork with our local health department.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Although education was a strength it can always be improved especially if the information is relayed in a timelier manner.
2. More involvement from all external partners especially in participation with meetings, webinars, etc.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. More external partner involvement.

KIRBY PINES SENIOR LIVING

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) We did a modified version starting March 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Office visits were cancelled by outside doctors requiring the attending physician here at the facility to address more medical concerns. Residents and family members expressed concern regarding not being allowed to visit. We noted increased behaviors.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We had a COVID meeting 3 times a week for 1 hour that included directors and managers from the various departments in the facility. Additionally, we met separately with the staff on the unit twice a week for 30-45 minutes to cover any updates.

Which components of incident were activated (i.e., which positions/groups were named)? The medical director, nurse practitioner, director of nursing, administrator, unit managers, executive director, culinary service director and CDM, environmental service director and the maintenance director.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Charge nurses and certified nurse's aides

How was information disseminated throughout the facility to keep staff informed? Frequent rounding by the management team. 1:1 meeting with the various groups, flyers were posted, updates sent via computer system and text messaging.

Provide THREE strengths related to INCIDENT COMMAND.

1. Consistent review of the plan
2. Ongoing staff education
3. With us being part of a CCRC we have access to a variety of staff, not just the medical area

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Timeliness of information getting transmitted to the various employees
2. Accurate information being communicated due to frequency in changes of the information from various sources.
3. Family members require a lot of time and effort to keep them updated

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. We have incorporated a method of getting information out to many individuals at one time.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Very early in the pandemic our facility started purchasing supplies and storing them; therefore, supplies were available most of the time during the pandemic.

What resources did you have difficulty procuring? How did you fulfill these needs? Initially we did have some difficulty obtaining hand sanitizer and N95 masks. We had purchased a large order but there was a delay in shipment; however, it finally came before we ran out.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? We eventually purchased some hand sanitizer, gloves and masks from a beauty supply store.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. We did have to modify components of our material management mechanism temporarily. We had an increase in waste disposal due to increased use of PPE and paper products.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We have increased our par levels of PPE and disinfectants.

Provide THREE strengths related to RESOURCES.

1. Early preparation
2. Team collaboration
3. Team education

Provide THREE opportunities for improvement related to RESOURCES.

1. Being better equipped to deal with the fear factor, staff were afraid to come to work and this impacted the staffing
2. Improved communication in a timely manner
3. Emotional support for residents, staff and family members on a large-scale level.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. We have increased our par level tremendously to be better prepared for future incidents.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Gowns, masks, gloves, bonnets for the hair and face shields. We also gave each employee a small bottle of hand sanitizer to keep in their pockets and we placed extra sanitizer on stands throughout the facility.

What new materials/PPE/resources did you utilize that you had not previous utilized? We had face shields and N95 masks but had used them on limited occasions in the past.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? We currently screen all entrances to the facility at the guard house and we plan to keep that practice. We plan to keep the increased disinfecting protocol on the medical units.

How did your facility address extended use and/or reuse guidance for PPE? We gave our staff a weekly supply of PPE and placed them in a plastic storage bag and educated the staff on cleaning PPE.

How did your facility address COVID-19 patient and employee testing? We performed weekly mandatory testing. We had a standing order from our physician to test any residents that exhibited symptoms related to COVID 19.

What standard or innovative infectious disease barrier control methods did you use, if any?

- We established a designated area with designated staff for the COVID area
- Any staff exhibiting any symptoms prior to coming into the building after being screened at the guard house were not allowed to enter the building. They had to notify their supervisor and get tested prior to returning to work.
- New admissions to the facility were placed in isolation initially.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We contacted the local morgue in the surrounding area and they agreed to address our needs.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?
Getting information out to the staff timely have been addressed, we did purchase a texting method to get information out to many individuals at one time, we interviewed staff to better understand their concerns to provide a support system and we had to consistently document interventions timely.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Some staff initially did not want to wear masks daily and residents (especially with dementia) did not want to remain in their rooms during the isolation periods.
Provide THREE strengths related to INFECTION PREVENTION.

1. Early preparation
2. team collaboration
3. Team education (including the families)

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Emotional support
2. Improved communication
3. Staff feeling empowered to take a decision-making role

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Educating the staff throughout the facility regarding the importance of infection control protocol. Monitoring the protocols frequently.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? The Administrator and the Director of Nursing communicated with the health department in our area.

What were the topics of community meetings or work groups that your organization participated in? Topics discussed regularly were PPE usage, infection control protocols, social distancing as much as possible, hand hygiene, disinfecting high usage areas, emotional support (residents, staff and family members) and the benefits of obtaining the vaccine.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Combination virtual meeting, emails and phone

How did your organization address the distribution of federal, state, and local guidance? Virtual meeting, email, phone and in person meeting maintaining social distancing.

What community partners did you work with during the pandemic that you had not previously worked with? Church organizations, police and fire department

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No new signed agreement but have established a close working relationship with the police and fire department.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. We did not request much assistance from local partners. During the pandemic a lot of reporting has been required which can be very time-consuming with limited staff.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
We will maintain our relationship with the local police and fire department.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. We invite our external partners to events held at our facility on an ongoing basis
2. We communicate with our external partners on a weekly basis
3. They are located close to our facility

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Increase our relationship with additional external partners
2. Inform our external partners of information on our web site in case they haven't read it
3. Ensure that accurate information reaches our external partners.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Ensuring they receive timely accurate information regarding our facility.

MAJESTIC GARDENS

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 18, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Canceled elective surgeries, doctor's appointments, family visitation

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Met daily Monday- Friday, sometimes multiple times a day depending on info received from CDC

Which components of incident were activated (i.e., which positions/groups were named)? Clinical team, dietary, maintenance, and housekeeping

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Position of Infection Control Nurse (certified)

How was information disseminated throughout the facility to keep staff informed? Via text, Smartlinx, and postings

Provide THREE strengths related to INCIDENT COMMAND.

1. Teamwork
2. Ability to understand and implement new CDC guidelines
3. Quick implementation of new policy and procedure

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Implementing new policies and procedures daily
2. Daily tracking and monitoring
3. Adherence to new policy and procedures

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The actual treating of COVID. When the pandemic initially hit and a brief explanation of what COVID is, was released to the public, panic ensued. Our first outbreak happened in July and it was mass panic in the facility, simply from the fear of the unknown. We had employees that quit as soon as they got word that we had positive residents and we had some that truly steeped up to the plate and saved lives. After treating numerous residents in our 1st outbreak with no deaths we had a sigh of relief. With being responsible for the population that basically if they contracted COVID it was a death sentence to not losing any residents we now gained both knowledge and confidence. Several fights with COVID later we now treat it like any other infectious disease.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Disruptions began around the end of March. How long did this last? Issues persist to this day.

What resources did you have difficulty procuring? It was difficult and still is difficult getting everything that must be ordered and can't be simply picked up from the store. How did you fulfill these needs? Corporate was very vigilant and took the threat of a global pandemic seriously. When the discussion of the pandemic started overseas our company started ordering PPE. So, by getting ahead of everyone else we were able to stockpile early and it has carried us through.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? When the pandemic hit, we had to get creative with vendors. It was no longer we have this one set vendor for each individual supply need. It turned into whatever company has it in stock order it.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Materials management had to be changed and the mindset shifted from budgeting to stockpiling. Inventory and forecasting became critical.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The old rule of thumb of a 3-day emergency supply goes completely out of the window. We know stock for a minimum of 30 days.

Provide THREE strengths related to RESOURCES.

1. PPE inventory was ordered a month before the panic ensued
2. An excellent central supply director
3. Properly securing inventory

Provide THREE opportunities for improvement related to RESOURCES.
Set up accounts with multiple back up vendors

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Established new contracts and relationships with companies we never knew existed prior to COVID. With an expanded network of vendors, it allows us to have all the supplies we need at all times.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Masks (surgical/N95), gloves, face shields, gowns. To protect patients? (i.e., masks, face shields, half masks, etc.) Masks (surgical/N95), gloves, face shields, gowns

What new materials/PPE/resources did you utilize that you had not previous utilized? Amazon and Wal-Mart medical surprisingly had a lot of supplies to help keep us stocked along with various overseas vendors. Face shields were new to being used on a regular basis. All other PPE was commonplace when dealing with infectious diseases.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? We will keep some of the infection control policies in place, but screening and visitation will eventually go back to normal.

How did your facility address extended use and/or reuse guidance for PPE? We only used the extended use guidelines sporadically for N95s but with no other PPE.

How did your facility address COVID-19 patient and employee testing? Initially the facility handled all the testing for months until we found a lab that was willing to come in house to conduct testing for us. Now that the testing has decreased some, we are now back handling testing in-house.

What standard or innovative infectious disease barrier control methods did you use, if any? We had to use clear painting plastic/tarps to secure PUI and COVID areas to reduce the spread.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? No onsite morgue, however, we did verify that all residents had actual burial plans in place.

Did your facility have or use an infectious disease surge plan? No What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes, a plan was created with a focus on prevention, containment, and effective treating/monitoring of the disease process.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? With the residents it was quite difficult to get them to wear masks consistently and with the memory care population very difficult to enforce 6ft apart.

Provide THREE strengths related to INFECTION PREVENTION.

1. Policies and procedures
2. PPE inventory

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Tracking
2. Monitoring
3. Screening

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Employee screening was one of the most difficult but important aspects of infection prevention. With over 200 employees on payroll and over a 100 each day clocking in and out it was extremely difficult to ensure each, and every employee was properly screened prior to each shift. We have now figured out how to properly split up the monitoring and have installed a new timeclock that takes temps and asks screening questions.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? CCS (food and general supplies), Phoenix chemicals, Home Depot, Amazon, McKesson, Twin Med, random overseas vendors for PPE, and TN Health Department. Who were the responsible parties/job titles that were responsible for maintaining that communications? Infection control nurse communicated with TN Health department, central supply director communicated with supply vendors, corporate ordered supplies from overseas vendors, dietary communicated with CCS, housekeeping with Phoenix chemicals, maintenance with Home Depot.

What were the topics of community meetings or work groups that your organization participated in? Prevention, policy and procedure, screening, and PPE inventory

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email and Zoom

How did your organization address the distribution of federal, state, and local guidance? Via company website and internal messaging system (Smartlinx)

How did your organization address the distribution of federal, state, and local funding opportunities? Via company website and internal postings

What community partners did you work with during the pandemic that you had not previously worked with? Local health department from a consulting point of view instead of surveying

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No

Did you feel like your organization was supported by local community partners? yes State partners? Yes. Federal partners? No federal involvement If so, please provide examples. If not, please explain how you could have been better supported.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Our network of partners when it comes to supplies and various services has increased to ensure we have backups for the backups.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Availability
2. Flexibility
3. Promptness

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
Communication

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Improved communication whether it was due to implementing a new system, email, direct contact for sales rep etc.…

MEMPHIS JEWISH HOME

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/9/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures***)?*** We closed our facility to outings and visitors on 3/9/2020. We cancelled group activities and communal dining. On 3/12/2020, we began screening all staff. Some of the implementations created a potential for isolation and depression for the patients and residents.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. In the beginning with the first 6 months of COVID, we were meeting daily, then that went to weekly and as needed. This occurred up Late October and November through January.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Commander, Safety Liaison, Documentation Recorder, Operations Section Chief, Finance Section Chief, Public Information Officer.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Triage Unit Leader, Holding Area Unit Leader, COVID Coordinator

How was information disseminated throughout the facility to keep staff informed? Information was shared through social media at minimum weekly and as needed. The facility used its internal messaging platforms, Makeshift and Tiger Text to remain in close contact.

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication was very quick and thorough causing low numbers in COVID Spread compared to other like facilities
2. Strong Information Sharing amongst the group
3. Ability to create cohesiveness and buy in from front line staff through Incident Command members

Provide THREE opportunities for improvement related to INCIDENT COMMAND.
Being a stand-alone facility, we sometimes had less support and access to the most current information

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Incident Command were all in constant communication, but how that communication was done could have been better organized. This taught us a lot for the future.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? We began really utilizing and stockpiling in April of 2020, but saw real limitations during the summer through fall, causing us to have to enact conservation methods and protocols. The supply chain saw less strain in the last winter of 2020

What resources did you have difficulty procuring? How did you fulfill these needs? Gowns and goggles. We used our state, national and local resources to help us secure additional items.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Being part of a national Jewish Organization, in the summer of 2020 that were able to secure additional items to fill the gap in our need.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. No, they did not work. We created an emergency supply room and our Director of Purchasing and Supply began stockpiling and utilizing conservation methods to help preserve the materials needed for safe patient care. Procedures were developed to encourage Staff to keep up with assigned reusable PPE (i.e., Safety glasses)

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? This Pandemic and caused us to always have emergency supplies for patient care on hand at all times.

Provide THREE strengths related to RESOURCES.

1. Being part of a Larger Jewish Organization afforded us additional connections that other stand-alone non-religious based organizations did not have
2. The local Jewish Community assisted in procuring additional supplies
3. Strong leadership in the supply and procurement departments

Provide THREE opportunities for improvement related to RESOURCES.

1. Stand-alone facility was also a negative-We didn't have the larger resources that others that were part of a chain had
2. Could have started stockpiling and conserving earlier
3. Could have started finding other resources earlier

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
We may have done better early in the obtaining and securing of PPE and supplies

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, N-95's, goggles, face shields, gowns, shoe covers

What new materials/PPE/resources did you utilize that you had not previous utilized? Goggles and N-95's

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes

How did your facility address extended use and/or reuse guidance for PPE? Face shields, N-95's and gowns were re-used following the CDC conservation of supplies suggestions.

How did your facility address COVID-19 patient and employee testing? MJH followed the CMS/CDC suggestions for outbreak testing and routine surveillance.

What standard or innovative infectious disease barrier control methods did you use, if any? Plexiglass petitions were used for visitation. Visitation areas were set up to allow for social distancing in conjunction with Plexiglass partitions. Call ahead scheduling was also implemented to help control the volume of visitors.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? MJH has a morgue and is planned to utilize it if needed in accordance with our current policy.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? MJH used one of its units with the furthest distance from all the other units for COVID residents. The unit was accessible to staff without entering the interior of the building.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No but education was provided consistently to staff, residents and families.

Provide THREE strengths related to INFECTION PREVENTION.

1. Education,
2. Surveillance and
3. Supplies.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Continuing Education,
2. Return demonstrations with PPE donning and doffing and

3. Early identification of potential infections.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Early identification of signs and symptoms of a potential infection not only with assessment of residents but also in staff identification of their own or a close contact.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining 5those communications? Shelby County Department of Health, State Department of Health, CDC, Local Emergency Coalition and other like agencies. The Incident Commander and the Operations Section Chief were the primary points of contact and information flow. The Public Information officer was also very involved.

What were the topics of community meetings or work groups that your organization participated in?
COVID Prevention, PPE procurement and conservation, Policy and Procedure best practices

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, Phone and Zoom Meetings

How did your organization address the distribution of federal, state, and local guidance? This communication and guidance were done through email, usually in the form of a memo or updated policy.

How did your organization address the distribution of federal, state, and local funding opportunities? The Finance Section Chief along with oversite by the board of directors, executive director, and auditors

What community partners did you work with during the pandemic that you had not previously worked with? We had not formally worked with any of these agencies for assistance.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Very much so…. We shared supplies and best practices.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We have continued those relationships we have built over the last year and 1/2

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Ability for a small stand alone to utilize bigger organizations with bigger resources

2. Ability to obtain PPE when needed

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Ability for a small stand alone to utilize bigger organizations with bigger resources
2. Ability to obtain PPE when needed

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
We could have started earlier, learning and sharing resources with external partners

MID-SOUTH REHAB

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 8, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Initially, we were unable to provide therapy services in some of our communities (Brookdale Dogwood Creek, Village of Primacy Place, Town Village at Audubon Park) or were limited in our ability to provide therapy in our certified space. In response, we developed broad, all-encompassing COVID protocols as a company to include appropriate COVID capacity levels (initially down to 25% of normal capacity with increase to current level of 50% capacity in our certified therapy space) and delivery of telehealth services when appropriate based on the current COVID status of the time. All the communities where we have leased space to deliver therapy services to residents limited all visitors for a significant period with steadily increased ability for family/visitor interaction over the last year based on the COVID status in the community.

How often did that group meet/engage? Weekly? Daily? We met multiple times per week with the leadership of each community that we have certified therapy space. As a company we talked daily during the initial stages, currently we maintain at minimum a weekly meeting about the status of COVID in Shelby County to help guide our continued response.

Which components of incident were activated (i.e., which positions/groups were named)? The emergency response plan was activated. No new positions were named, the current emergency response team was utilized.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? We did not need to add any positions in response to the pandemic. However, as the Agency Administrator for TN, I needed to add a robust reporting system for both staff and patients regarding COVID, develop appropriate and upgraded infection control measures/checks (daily temperature/symptom checks for the clinic along with the facility as an example), develop policy on masking that met or exceeded each facility protocol, develop policy adjustments for vaccinated residents, etc.

How was information disseminated throughout the facility to keep staff informed? I met regularly as noted with our facility partners to make sure our certified therapy place met all their standards and guidelines. I would then disseminate that information along with own company policies verbally in meetings, via email or zoom meetings, and at times via phone conversations. We also completed full tabletop exercises regarding all emergency management, COVID protocols, Infection Control policies, etc. in June 2020.

Provide THREE strengths related to INCIDENT COMMAND.

1. Effective Communication
2. Emergency Operations Plan in place
3. Team effort to research updates and edit response accordingly

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. No experience with emergency response for pandemic
2. State communication regarding staff vaccination was confusing initially
3. CDC information was changing often with difficulty implementing plan initially

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Our understanding of optimal communication and ability to implement our communication plan to evaluate and address any situation timelier has dramatically improved during this episode.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? For the most part, we were able to attain all needed PPE, cleaning supplies, and other necessary supplies to handle the changes brought on by COVID. We did experience some delays in acquiring products from May-July of 2020 but were able to improvise at the local level in finding needed supplies if our regular supplier was unable to provide needed resources.

What resources did you have difficulty procuring? How did you fulfill these needs? Primarily, our only issues were providing some cleaning supplies (Disinfectant wipes, disinfectant sprays, etc.). Our suppliers were able to provide those needs on most occasions, but if not, we were able to go out to local stores (Target, Wal Mart, etc.) and get needed supplies. We had no shortage of masks or N95/surgical masks (our corporate team had a good supply on hand throughout the pandemic after seeing some of the possible signs early in the national response)

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Local retailers when needed along with Geiger and SME.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. As noted, our materials management mechanism worked for the most part.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We have made decisions to keep a reserve supply of products on hand (N95 masks, gloves, cleaning supplies, etc.) in case a similar situation arises to be more well prepared.

Provide THREE strengths related to RESOURCES.
Several facilities are close in proximity and able to share resources if needed.

Provide THREE opportunities for improvement related to RESOURCES.

1. Par levels were increased for PPE and disinfection supplies due to the pandemic
2. Limited availability for resources.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Continue to refine and determine the appropriate amount of all supplies that are needed for each facility at any given time and be able to efficiently understand that best times to re-order supplies proactively instead of in reaction to decreased supplies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.): Masks, N95 masks, gloves, gowns, face shields/goggles

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? We are still evaluating the situation to make final determinations for after the PHE ends.

How did your facility address extended use and/or reuse guidance for PPE? We implemented to use of cloth masks that must be laundered daily

How did your facility address COVID-19 patient and employee testing? Our company consistently followed CDC guidelines regarding employee testing. We also communicated with the facility regarding time off work waiting on testing to make sure we had a policy that met or exceeded each facility partner requirement for our certified therapy space. Additionally, notices were issued to anyone who had close contact with someone within the suggested timeframes confirmed as COVID positive.

What standard or innovative infectious disease barrier control methods did you use, if any? Social distancing and PPE, no additional barriers were used

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Yes, we have now created a plan for pandemic response

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No. Everyone was very understanding of the difficulty of the situation once expectations and clear guidelines were communicated.

Provide THREE strengths related to INFECTION PREVENTION.

1. Existing infection control committee
2. Availability of PPE and staff cooperation

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Maintaining the appropriate level of cleaning supplies at all times to proactively limit any issues with acquisition in the future.
2. Communication with our partner facilities, where each clinic is located, on their current infection control protocols to make sure we are in line with our standards along with their standards.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Our staff education and monitoring of appropriate infection control practices. We now have weekly forms that all employees must sign off on tracking appropriate infection control measures, current levels of all PPE, and other tracking mechanisms.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining those communications? TN Department of Health and CDC

What were the topics of community meetings or work groups that your organization participated in? Optimal infection control protocols

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, Zoom calls, phone calls

How did your organization address the distribution of federal, state, and local guidance? We would monitor all new guidance from the federal (CDC, Government, etc.), state (Governor Bill Lee's announcements, guidance, policy changes, etc.), and Shelby Co/City of Memphis policy (Shelby Co Health Department guidance, institution of mask mandates, etc.). That information would then be discussed with our facility partner and at our corporate level via in person meetings when able, zoom meetings, emails, and phone calls. All guidance and information would then be passed on to the employees as appropriate through similar channels.

How did your organization address the distribution of federal, state, and local funding opportunities? This was addressed by the executive leadership team

What community partners did you work with during the pandemic that you had not previously worked with? Mid-South Emergency Planning Coalition

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes. We registered our facilities with the Mid South Emergency Planning Coalition and followed guidance via emails, zoom meetings, educational zoom meetings, etc. The information was reported regularly by all major news sources, so we were able to find all guidelines/policy changes, announcements from government officials, and other communication timely and as needed.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We have made and continue to make continual updates to our emergency plan with the evolution of the pandemic to ensure we use best practice.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Responsive
2. Knowledgeable
3. Available

MILLINGTON HEALTHCARE

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/17/20

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Yes. We restricted in-door visitations; cancelled group activities and communal dining; social distancing, cancelled appointments-surgeries, implemented use of PPE and other supplies, testing and employees missing work related to COVID exposure.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We met daily in large dining rooms with social distancing and mask and hand sanitizing in place.

Which components of incident were activated (i.e., which positions/groups were named)? Administration, All Managers and Nurses and Environment Services.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Environment Services: Disinfecting, cleaning and washing per CDC guidelines.

How was information disseminated throughout the facility to keep staff informed? Small groups with social distancing, handouts, emails, group texting, Relias, signs, and PCC.

Provide THREE strengths related to INCIDENT COMMAND.

1. Leaders fostered engagement
2. Organizing and distributing information

Provide THREE opportunities for improvement related to INCIDENT COMMAND.
So much COVID 19 information came out initially: too much and overwhelming with a wide range of different scientific opinions.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. One improvement area is ensuring that healthcare providers acquire needed PPE and vaccination first.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Millington Healthcare began to have supply chain disruptions of resources by 4/1/20. We began to continue to place bulk orders for storage from our main vendor but were fortunate

to receive supplies from outside resources such as corporate, Mid-South Health Coalition, TEMA, and private businesses.

What resources did you have difficulty procuring? PPE resources. How did you fulfill these needs? Utilized bulk orders, TEMA, Mid-South Healthcare Coalition and securing PPE supplies from private businesses.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? TEMA, Mid-South Health Coalition, Kroger, Wal-Mart, Sav A Lot, McKesson Supplies

Did your normal materials management mechanisms/policies/procedures continue to work? No. If not, did your organization create new and/or temporary management plans? Please describe. We implement Emergency Pandemic and Disaster policies; bulk purchasing and established new contracts.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? This pandemic change was unique. It affected our emergency storage and let us to rent out storage bins in the community to house extra supplies; affected our staffing patterns that required us to reach out to agency staffing and changed our structural planning interior to designate an area for isolation and COVID 19 positive.

Provide THREE strengths related to RESOURCES.

1. Established relationships with other entities such as the Shelby County Health Department COVID 19.
2. Fostered our knowledge with CDC and CMS.
3. Gave the facility an opportunity to bond with residents as their family due to families not being able to visit.

Provide THREE opportunities for improvement related to RESOURCES.

1. Encouraging all to be vaccinated.
2. Education on ways to combat COVID 19 and eliminate the spread.
3. Make more USA PPE products.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Dissimulating relevant information to families by way of PCC-Clinoconex, electronic means to keep family members informed that sent messages to their email address, text and voice messages to their phone numbers. Keeping families connected through electronic devices with their loved ones.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Surgical masks, N95, KN95. Hand sanitizers, disinfection products approved by CDC; gowns, overalls, shoe covers, head covers,

gloves, social distancing, face shields, goggles, vaccination, testing, isolation and sanitizing equipment. To protect patients? (i.e., masks, face shields, half masks, etc.). Same as employees.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face Shields, foot and head covering, testing, vaccination, social distancing, quarantine, isolation barrels, sugar bags for laundry, biohazard pick up increased

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes. Screening, testing, wearing PPE and social distancing, disinfecting, sanitizing, communication mass by electronic, and inventory of PPE.

How did your facility address extended use and/or reuse guidance for PPE? Utilize paper bags to store N95 individual mask; stationed COVID 19 positive patients on a unit to allow straight flow of services.

How did your facility address COVID-19 patient and employee testing? Via way of education, written policies and procedures mandating testing for patient and employee; reporting positive results for isolation and employees staying at home when exposed or tested positive.

What standard or innovative infectious disease barrier control methods did you use, if any? COVID 19 Isolation Hall designated for new admits, and those with positive COVID 19.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Funeral Homes located within 2 blocks were ready and available.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? Testing and vaccinating residents and employees; utilizing other resources made available to us and creating electronic communication medical records mechanism to communicate with staff and employees were some of our strengths. Weakness included but not limited to providing visitation outdoor booths—we have no way of setting this up. If you had no plan, have you created a plan based on your COVID-19 response?

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No

Provide THREE strengths related to INFECTION PREVENTION.

1. Total buy in to preserve and protect us from getting COVID 19 as much as possible,
2. Environment Services constant disinfection and cleaning equipment and areas thoroughly
3. Proper wearing of appropriate PPE.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Enhance purchasing PPE supplies from USA vendors.

2. Communication with family members via means of zoom; and
3. Correlating resources inside the facility to provide on-going non-interruption of care.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Education. Dissimulating policies, procedures and requirements from CDC and CMS and local Shelby County Health Department and meeting with zoom calls weekly with other coalition to aid in receiving information was a drastic improvement related to infection prevention.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? State of Tennessee Health Department, Shelby County Health Department and Midsouth Coalition and Abiqias. Who were the responsible parties/job titles responsible for maintaining that communications? CEO, CDOC, Infection Prevention Control Nurse.

What were the topics of community meetings or work groups that your organization participated in? Weekly calls regarding CMS and CDC guidelines on visitation, testing, vaccination, PPE, COVID 19 disease, proper wear of PPE, communication techniques and devices for residents to maintain contacts with the community.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Zoom meetings, emails, phone calls, virtual meetings, faxes, letters, texts.

How did your organization address the distribution of federal, state, and local guidance? Small meetings with social distancing, emails, zoom meetings, mass group texts, and hand outs and signs posted in building.

How did your organization address the distribution of federal, state, and local funding opportunities? Made applications and sent to corporate office for funding processes.

What community partners did you work with during the pandemic that you had not previously worked with? Alliance Group, TEMA, Tennessee Health Department with Healthcare alliance entities.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Yes. Who were those partners and what was the topic of agreement? Stericycle—increase med waste pickups; Accountable Staffing and Maximum staffing dealing with agency staffing for Nurses and C N A s.

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes. Federal partners? Yes. If so, please provide examples. If not, please explain how you could have been better supported. Examples: interchanging of information on a weekly

zoom call from local, state and federal agencies, receiving PPE supplies, testing, vaccination with pharmacy and Shelby County Health Department.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
Yes.

Provide THREE strengths related to EXTERNAL PARTNERS.
1. Communication
2. Information
3. Resourceful

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
1. Continued alliances to boost relationships and planning
2. Encourage various ways to connect without meeting personally
3. PPE storage areas in the Mid-South

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Externa Partners need to provide a backup means to ensure healthcare provider miss opportunities to participate on zoom or virtual meetings. This will ensure providers are afforded ongoing information channels to keep abreast due to other internal responsibilities.

Parkway Health and Rehab

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 8th, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? -Resident appointments and surgeries took place on a need ONLY basis. Communal dining, group activities, and visitation was stopped. Vendors to include but is not limited to beauticians, barbers, podiatry, and dental visits stopped. Began telehealth visits for other services.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Conducted meetings as often as needed to keep all departments in their respective places informed and abreast to facility changes and updates. This includes twice daily once daily and weekly meetings.

Which components of incident were activated (i.e., which positions/groups were named)? - Nursing, Housekeeping, Dietary, Non-Clinical Staff,

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Screeners and testers

How was information disseminated throughout the facility to keep staff informed? -Facility conducted several meetings with social distancing, posted signs and information throughout the facility and utilized an On Shift automated messaging system to inform staff of any important information.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? At the very beginning of the pandemic. This lasted for a few short weeks.

What resources did you have difficulty procuring? How did you fulfill these needs? Gowns, gloves, sanitizer, goggles, N-95 masks. Needs were fulfilled by reaching out for help

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Local Health Department

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? New policies were

created to fit into the new normal during the pandemic. This held true to ALL areas of the organization.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? It taught us to OVER PREPARE and consider ALL possible scenarios

Provide THREE strengths related to RESOURCES.

1. Easily accessible for assistance
2. Timely responses

Provide THREE opportunities for improvement related to RESOURCES.
Having one person or department in place designated for assisting facilities with needed resources

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, face shields, goggles, N-95 respirators, gloves, gowns, shoe covers

What new materials/PPE/resources did you utilize that you had not previous utilized? Signage and face shields

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Screening

How did your facility address extended use and/or reuse guidance for PPE? Discouraged it unless there was a shortage. Provided education of proper storage and extended reuse of PPE

How did your facility address COVID-19 patient and employee testing? Mandated testing according to CMS guidelines and corporate policies about COVID-19

What standard or innovative infectious disease barrier control methods did you use, if any? - Vinyl barriers, plexi glass, social distancing markers in common areas

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Came to agreement with funeral home near the facility in case of a surge

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? No plan was in place prior to the pandemic. Once has since been put into place

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes. Social distancing was difficult to keep in compliance.

Provide THREE strengths related to INFECTION PREVENTION.

1. Overall compliance with basic practices
2. Willingness to adapt to new procedures
3. Safety

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Staff staying consistent after education
2. Staff practicing good infection control habits in ALL areas
3. Keeping core principles even when not providing direct care

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. - Staff willingness to stay incompliance with basic infection control practices

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Local and state health department, Center for Disease control. Infection Preventionist, Administrator and Director of Nursing

What were the topics of community meetings or work groups that your organization participated in? Emergency Preparedness

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Phone, email, zoom, webinars, virtual meetings, automated messaging

How did your organization address the distribution of federal, state, and local guidance? - Handled through corporate office

How did your organization address the distribution of federal, state, and local funding opportunities? Not able to effectively answer this

What community partners did you work with during the pandemic that you had not previously worked with? None

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? None

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. The support was minimal. It would have been nice for someone to reach out and be persistent in offering help and support.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Will continue to utilize systems put into place during the pandemic

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. The facility found innovative and creative ways to communicate pertinent information to its staff and vendors as a response to COVID-19 that will remain in place once the pandemic ends

Ripley Healthcare and Rehab

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3.11.2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation policies, in-house activities, staffing

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Directors meet every morning and afternoon.

Which components of incident were activated (i.e., which positions/groups were named)? Command, Operations, Logistics, and Finance.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Central supply manager became a vital part of our readiness team.

How was information disseminated throughout the facility to keep staff informed? Daily meetings and in-services.

Provide THREE strengths related to INCIDENT COMMAND.

1. Mitigation
2. Preparedness
3. Recovery

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Communications
2. Supply chain
3. Staff development.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Preparedness for future events.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Immediately and it lasted over a year.

What resources did you have difficulty procuring? How did you fulfill these needs? PPE and maintenance supplies. Used other sources to procure supplies.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? State and Federal agencies.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We recognized our weaknesses in these areas and planned for delays in procurement and ordered accordingly.

Provide THREE strengths related to RESOURCES.

1. TEMA
2. Usage plan
3. Tracking system

Provide THREE opportunities for improvement related to RESOURCES.

1. Importance of having multiple vendors and suppliers
2. Training and reeducation of use of PPE
3. Preparation for when your plan is not enough (preparing for unthinkable circumstances)

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. COVID has made us evaluate our plan even more closely and have a backup plan for the plan

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, shields, goggles, gloves, gowns, sanitizers and cleaning agents.

What new materials/PPE/resources did you utilize that you had not previous utilized? Goggles and shields and sprayers.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes

How did your facility address extended use and/or reuse guidance for PPE? In- service for all staff.

How did your facility address COVID-19 patient and employee testing? In-house lab.

What standard or innovative infectious disease barrier control methods did you use, if any? Isolation areas and physical barriers.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? M.O.U with refrigerated trucking company.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We did have a surge plan and we have tweaked it to be better prepared for the next event.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? We had some issues, but they were addressed in our daily meetings and in-service.

Provide THREE strengths related to INFECTION PREVENTION.

1. Designation of an Infection Control Leader
2. Re-education and training
3. Initial screening

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Continued focus on IC
2. Ongoing training and updates
3. Auditing of employees to assure proper compliance

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. COVID has made us realize the importance of Infection Control and Prevention. It has taught us to take no chances, screen everyone and often, ask questions, and treaty every symptom as if it was a COVID positive individual and act accordingly.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Local and state D.O.H. Lauderdale Emergency Management. CMS. Jennifer Pitts (Admin.) Vivian Bridges (D.O.N.) Libby Butterworth (A.D.O.N.)

What were the topics of community meetings or work groups that your organization participated in? PPE. Surge capacity, Testing

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? E-mail and Phone

How did your organization address the distribution of federal, state, and local guidance? Daily meetings

How did your organization address the distribution of federal, state, and local funding opportunities? We utilized TEMA and their supply of PPE.

What community partners did you work with during the pandemic that you had not previously worked with? None. We maintain communications with L.E.M.A. and local health dept.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? Yes. Pine Meadows and Huntingdon for transportation.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes. We received guidance from local health and emergency management officials. State D.O.H. and Federal agencies.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Ongoing communication is key. Know your local EMA personnel, have backup resources and vendors available for supplies, increase your emergency supply.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. They have a wider knowledge of resources
2. They see what is going on outside our immediate area and they can share ideas/experiences.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Stay up to date with contacts
2. Communicate more frequently
3. Participate in local planning

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Use them when you need to. COVID has taught us to be prepared to things you never expected and when you do experience what we have this past year, you need all the resources and support you can get.

St. Clare Health and Rehab

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 3/12/21

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation at the facility was cancelled and all residents and staff started the screening process. It seems to close off the world to nursing homes.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We started meeting daily about the changes in the CDC guidelines and learned the new reporting requirements with the health department if new cases emerged.

Which components of incident were activated (i.e., which positions/groups were named)? Administration and Nursing were educated daily on any updates that we were getting to implement. First wearing masks continuously, going through the screening process for all staff and residents. Meeting weekly with THCA and attending webinars to ensure the safety of our residents.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Making sure we had 100% compliance, it took all staff including the scheduler to send out blast to let staff know what was going on. We added a 24-hour screening process.

How was information disseminated throughout the facility to keep staff informed? Through email, in-person education, postings in different places throughout the facility. Mandatory in-services with all shifts.

Provide THREE strengths related to INCIDENT COMMAND.

1. It kept COVID out of the building
2. Staffing was not an issue
3. We had plenty of PPE

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. I had a hard time finding an area of isolation
2. Improving employee morale
3. Keeping the staff throughout the COVID year

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Family communication improved greatly, and they are still grateful for us taking care of the residents during this time of need.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Probably around May or June 2020. How long did it last? Not long, probably a few weeks.

What resources did you have difficulty procuring? The first item that we begin to have was gloves. How did you fulfil these needs? We were able to utilize the Dietary vendor to obtain what we needed.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Our dietary vendors and TEMA and the community.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes. If not, did your organization create new and/or temporary management plans? Please describe. We continued to evolve with the new CDC recommendations and our policies were continually updated throughout this process.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We learned that we now keep more PPE on hand to ensure the safety of our residents. We were able to procure an emergency storage of supplies and some emergency vendors to ensure the procurement of supplies continue.

Provide THREE strengths related to RESOURCES.

1. We were able to obtain PPE
2. Able to identify other sources to obtain PPE
3. Were able to conserve and use the PPE sparingly when need be

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. To maintain adequate PPE. We only had 1 outbreak with 2 Asymptomatic residents during this time.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Face masks, gloves, gowns, N95's, face shields. To protect patients? (i.e., masks, face shields, half masks, etc.) To protect the residents, we used masks.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields and N95's.
Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, we will continue to follow the CDC guidelines until they show that not screening is no longer a threat. We will continue to screen and take temperatures and wear masks at this

time. Not everyone is vaccinated so testing will still occur until CDC makes a final determination.

How did your facility address extended use and/or reuse guidance for PPE? Had all N95's put in a paper bag and reuse for 5 days. Once PPE procurement, the reuse of N95's decreased. Masks were replaced daily.

How did your facility address COVID-19 patient and employee testing? We are testing everyone at first and then tested by the CDC guidelines based on the positivity rate and an outbreak and communicated heavily with the Health Department on individual cases. Testing continues.

What standard or innovative infectious disease barrier control methods did you use, if any? We used masks, face shields, gloves and gowns and disposed of them properly. Had these items set up before you go into the observation areas.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do not have an on-site morgue. We did not have any deaths.

Did your facility have or use an infectious disease surge plan? Yes. We continued to take vitals and O2 stats to ensure infection was kept to a minimum and we could catch this early before infecting others. What strengths and weaknesses have you since identified in that plan? As previously stated, this practice has become a strength and we continue to use it to this day. and If you had no plan, have you created a plan based on your COVID-19 response?

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, everyone was on board. It was an adjustment, but LTC is always changing.

Provide THREE strengths related to INFECTION PREVENTION.

1. Keep the residents safe
2. Keeps from spreading the infection
3. Kept supplies on hand

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Continue to educate and emphasize the importance of infection prevention.
2. Ensure that everyone understands infection control and continues to maintain a good level of PPE.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Obtaining vitals and O2 stats has been maintained as a practice but ensuring good hygiene and wearing masks has been our strength.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? The Health Department, THCA and CDC as well as other facilities. Who were the responsible parties/job titles that were responsible for maintaining that communications? The Administrator, the Director of Nursing, Dietary Manager Therapy and the Social Worker. All departments were involved in communicating to their departments and we would ensure that the safe practices were maintained. The Administrator and DON communicated with the external partners and communicated the information to various departments and all staff.

What were the topics of community meetings or work groups that your organization participated in? Rules for admissions, rules for the screening process, procurement of PPE, family notifications and resident notifications, infection control, guidelines for testing for both residents and staff. Proper way to wear PPE, donning and doffing, alternatives to masks during shortages, Reporting requirements to the CDC, communication between residents and family members.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? We used teams, zoom, phone calls, emails and webinars.

How did your organization address the distribution of federal, state, and local guidance? We used what they said as our protocol.

How did your organization address the distribution of federal, state, and local funding opportunities? We are such a small facility that we did not procure any communication devices but utilized our personal devices for communication between residents and families. I am sure we did receive other funding that was used for staffing.

What community partners did you work with during the pandemic that you had not previously worked with? THCA, CDC, Health Department, and another facility.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Yes. Who were those partners and what was the topic of agreement? Methodist Hospital and another nursing home to admit to for positive residents.

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes. Federal partners? Yes. If so, please provide examples. If not, please explain how you could have been better supported. They provided much needed education to be able to handle the pandemic.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We are still testing, still screening, still wearing masks and providing any updated communication with our staff. We are still reporting to the CDC.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Provided us with good protocols
2. Gave us effective communication with our residents and staff and improved our quality of care

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Reach out and partner with new external partners
2. Seek new partners in learning
3. Make attendance mandatory for our staff to learn

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. By partnering with the community, family members, and hospice; it has allowed us to make a difference in the lives of our residents.

THE KINGS DAUGHTERS AND SONS HOME

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 11, 2021

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation policies changed (no visitors allowed), communal dining and group activities stopped.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily

Which components of incident were activated (i.e., which positions/groups were named)? Facility Incident Commander, Safety Officer, Logistics Chief, Finance/Administration Chief

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? None

How was information disseminated throughout the facility to keep staff informed? Flyers, posters, text messages, calling tree messages

Provide THREE strengths related to INCIDENT COMMAND.

1. Enhanced communications
2. Community partnerships strengthened
3. Interagency coordination

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Internal communications needed with families and staff
2. Incident Commands defined roles was not understood by many facility staff
3. Increased options for staffing needed to increase long term response sustainability

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The ability to develop, coordinate, and disseminate information and notifications to the family members and staff becomes critical in a pandemic. This presented an opportunity for us to expand our internal communications strategy. The creation of a calling tree and weekly update calls helped do this by ensuring employees were aware of the situation and felt engaged. We will continue these methods going forward as an increased and improved communication method between our Home and our families and staff.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Our suppliers were limited on what was available and when shipments would arrive beginning March 20, 2021. This lasted approximately 6 months.

What resources did you have difficulty procuring? How did you fulfill these needs?
We had difficulty procuring gowns. We were able to receive a weekly supply through the Mid-South Emergency Planning Coalition.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? The Mid-South Planning Coalition and Amazon

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
We were able to continue with regular material management mechanisms.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We began a second supply room for emergency supplies and monitor this inventory very closely.

Provide THREE strengths related to RESOURCES.

1. High stock of emergency resources
2. Multiple procurement sources
3. Excellent materials management policies and procedures.

Provide THREE opportunities for improvement related to RESOURCES.

1. We could have stronger relationships with vendors
2. Improved organization system for our inventory needed
3. Ensure employees have a better understanding of how they obtain needed resources

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Since COVID 19 began we have started a second room designed for strictly emergency PPE such as gowns, gloves, masks, disinfectant, etc. There is an employee assigned to monitor the inventory of this room and ensure that stock does not fall below a certain level so we will be prepared in an emergency. We have also improved the system for employees obtaining resources and ensuring they are educated in the process.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, face shields, goggles, gowns, foot coverings

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields, goggles

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, we plan to enhance screenings and limit visitation

How did your facility address extended use and/or reuse guidance for PPE? We were lucky enough to not have to use reuse PPE

How did your facility address COVID-19 patient and employee testing? The facility contracted with a lab to receive testing materials and two of our nurses were appointed to do all testing. Administrative staff volunteered to assist with the paperwork portion.

What standard or innovative infectious disease barrier control methods did you use, if any? We built temporary walls using lumber and flame retardant polyethylene film to incorporate two partitions to maintain barrier protection between residents and workers on the COVID-19 unit from the general population.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do not have a morgue and all our residents have private rooms.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We did not have a surge plan but are creating one based on our COVID-19 response.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, we did not have any problems.

Provide THREE strengths related to INFECTION PREVENTION.

1. Good practices observed daily
2. Effective control of spread of COVID 19 and routine action taken (education, supervising and monitoring).

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Lack of practical knowledge of some staff on transmission between staff
2. Some attitudes limited to fulfilling only bare minimum requirements
3. Could use increase offerings of education programs and training

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Practical forms of local training were adapted specific for COVID 19 and our facility; the staff was interested, and feedback was excellent.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Shelby County Health Department, State of TN HAI Department and Mid-South Emergency Coalition communicated most with our Administrator and Infection Preventionist.

What were the topics of community meetings or work groups that your organization participated in? Weekly COVID-19 updates on changes/updates to rules and regulations.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Phone calls, webinars, conference calls

How did your organization address the distribution of federal, state, and local guidance? Updated policies and procedures as necessary and used calling tree to get out the information as quickly as possible.

How did your organization address the distribution of federal, state, and local funding opportunities? Applied for PPP Loan

What community partners did you work with during the pandemic that you had not previously worked with? Shelby County Health Department

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, Mid-South Emergency Coalition supplied us PPE during COVID outbreak weekly.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
All staff, individuals providing services under arrangement, and volunteers will continue to be trained on the facility's emergency preparedness plan and procedures, consistent with their expected roles.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Trust among partners
2. People who are committed to work
3. History of collaboration

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Improve technology
2. Strengthen partnerships
3. Improved communication

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
We were able to strengthen partnerships with our local County Health Department and State of TN HAI Department, as well as other nursing homes, to ensure we all stay up to date and educated.

TREZEVANT EPISCOPAL HOME (ALLEN MORGAN)

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 03/09/2020

How was your facility affected by the initial Safer at Home directives?

- Modified visitation policy
- Staff were tested prior to mandatory testing requirements
- Elimination of agency and non-essential personnel

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We met daily starting 3/9/2020 through the end of the year

Which components of incident were activated? Incident Commander, Safety Officer, Public Information, Medical Specialist, Equipment/Supply Lead, Dining Lead, Security Branch, Access Control, Hazmat, Family Assistance Branch, Social Services Lead

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? We added staffing to do screening at all entrances, added staff to conduct mandatory testing.

How was information disseminated throughout the facility to keep staff informed? We posted information in the employee breakroom and by email, announcements made in department head meetings.

Provide THREE strengths related to INCIDENT COMMAND.

1. Gave structure to the process
2. Gave accountability to the process
3. Gave leadership to the process

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. When staff leads changed bringing in somebody new and getting them up to speed
2. Educating all staff on the various components of incident command
3. More effective communication strategies are needed

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. We used email and website to communicate to our families since so much was changing rapidly early on. This gave us an opportunity to identify and refine our email addresses and to work with our EMR to find an easier way to retrieve them when mass communication became essential. We also identified multiple individuals who could update the website so that it didn't fall on one person to be available 24/7 when something needed to be communicated.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? Approximately 3-4 weeks into the pandemic we had shortages of mask and gloves. How long did this last? Approximately 9 months (all of 2020)

What resources did you have difficulty procuring? PPE became the most difficult to procure (mask, gloves, gowns).

How did you fulfill these needs? We had to identify new vendors who could provide PPE that was approved by the appropriate agency.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? EDEXDEALS, Coalition, Zoro Tools, and MedEx Supply for PPE

Did your normal materials management mechanisms/policies/procedures continue to work? Our normal plan worked most of the time. If not, did your organization create new and/or temporary management plans? When it did not work, we collaborated with other facilities to find vendors and develop purchasing power to obtain discounted pricing (bulk purchase of mask split between Ave Maria, King's Daughters and Trezevant).

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We created a new storage space to ensure adequate supply of non-perishable PPE such as mask, gowns, and gloves. We are now working to build a 90 supply to ensure that we have enough if another supply shortage occurs.

Provide THREE strengths related to RESOURCES.

1. Develop a new network of vendors for specific needs (mask, gowns, gloves, etc.).
2. Collaborated with other facilities for bulk purchasing power
3. Identified weakness in existing supply chain and developed backup vendors

Provide THREE opportunities for improvement related to RESOURCES.

1. Need to extend our network to include different vendors that normal (i.e. – getting some non-tradition items from vendors like US Foods for PPE).
2. Need to repurpose some staff so need to know credentials even if they are not working in that role (are they a nurse aide or LPN).
3. Need to develop better tracking of burn rate for PPE

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. We had a limited number of vendors that we used for medical supplies which turned out to be a detriment when faced with supply shortages from our tradition network (TwinMed, Medline, McKesson). We had to become astute at finding new vendors that could supply products that were appropriate (medical

grade gloves, NIOSH approved mask, etc.). This resulted in developing closer collaborations with other non-profit nursing homes so that we could leverage some bulk purchasing and then splitting the cost (example – buying 10,000 N95 at a discounted price and splitting the expense between 3 facilities).

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) We purchased infrared thermometers, procedural mask, KN95 mask, N95 mask, disposable gowns, reusable gowns, face shields, goggles, fit testing equipment, changed out our cleaning/disinfecting solutions, changed out mop heads to a different style.

What new materials/PPE/resources did you utilize that you had not previous utilized? New cleaning/disinfecting solutions, different style of mops that are easier to use/clean, KN95 mask, N95 mask, face shields.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? We anticipate continuing to screen all staff prior to starting work and having a 90-day supply of PPE available.

How did your facility address extended use and/or reuse guidance for PPE? We use the washable gowns and put the start date when we bring them out of storage and laundry then marks them each time they are washed, early on we issued a procedural mask and fabric mask to try and keep the procedural mask from being contaminated against the skin, we disinfected KN95 mask and N95 mask per CDC protocols until enough were available.

How did your facility address COVID-19 patient and employee testing? We started testing staff in April before mandatory testing was required and continue to test at a higher than mandatory frequency based on CMS guidelines. We continue to test CMS policy with every outbreak all residents and staff, not just those who were potentially infected.

What standard or innovative infectious disease barrier control methods did you use, if any? We created a separate unit using a temporary wall/door barrier where all new admissions were sent. All staff are in full PPE for any resident that has not been fully vaccinated.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do not have a morgue so when a resident passed who was COVID+ we informed the funeral home and provided full PPE. We then disinfected the room and hallway where the resident was removed from the facility.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We had a generic plan for “Emergent Infectious Disease” but modified it as we went through COVID. It has been adapted to ensure that we can isolate residents, screen

staff/visitors, lock down the campus if necessary, and repurpose staff across campus and how to feed staff if dining venues become closed.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes, and we terminated individual staff members who violated the established procedures.

Provide THREE strengths related to INFECTION PREVENTION.

1. It created a centralized entrance for all employees, vendors, and contractors to be screened and vetted.
2. It created a cross sectional team that normally doesn't work on projects together.
3. It helped create a cohesive plan for the campus to deal with infectious threats.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Better education with all departments involved in cleaning/disinfecting
2. Better education of all staff about the effective use of vaccines
3. Better education of all staff on the proper use of PPE

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Trezevant did not have a strong plan to ensure that the campus could operate in an emergent infectious disease environment. As the pandemic unfolded and new information was coming in daily at the onset, Trezevant had to learn to change course quickly and effectively. It caused the senior leaders to work on projects together that they typically don't get involved together. The senior leaders became aligned behind one guiding principle which was to ensure the health and safety of all the residents and staff. This shift in how we operate allowed us to be creative in our way of handling deliveries, entrances to the campus, screening of staff/vendors/contractors and visitors. We had to find new vendors for products that we do not typically utilize on a large-scale basis (disinfectant fogging machines as an example). We had to develop new policies and procedures and communicate this out to all staff and residents on a timely fashion. This caused us to evaluate our communication processes and implement a system to notify all staff through a product called Alert Media.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? We communicated routine with the TN Department of Health, Shelby County Health Department, medical supply vendors, THCA and LeadingAgeTN.
Main contact for TDH and SCHD was Paul Martin, VP-Health & Wellness
Main contact for THCA and LeadingAgeTN was Julie Repking, Asst. Director Healthcare
Main contact for medical supply vendors was Chris Walker, Central Supply/Purchasing

What were the topics of community meetings or work groups that your organization participated in? Infection Prevention, testing of staff, availability of testing supplies, PPE supplies, and then vaccine education at the end of 2020.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, phone, virtual meetings, limited in person meetings

How did your organization address the distribution of federal, state, and local guidance? Through participation in weekly calls with various regulatory agencies and through updates from our trade associations (THCA and LeadingAgeTN)

How did your organization address the distribution of federal, state, and local funding opportunities? We provided the CMP funding opportunities to our Foundation Director which the fund-raising arm of Trezevant, PPP was sent to our CFO

What community partners did you work with during the pandemic that you had not previously worked with? Shelby County Health Department

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Shelby County Health Department did not understand their role vs. our regulatory agency role from the TDH. This caused tension and confusion for Trezevant. The Coalition was extremely helpful in obtaining PPE when it was available. Our state agencies were supportive by providing weekly calls and information. CMS and CDC were hit and miss; information was good when you could get connected. They were not equipped to handle the demands of the webinars. If feels like CDC and CMS want SNF to be reporting like ACH through NHSN which we do not have the reporting capabilities or staffing to do so at that level.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Trezevant is constantly evaluating our emergency plan to ensure that we are better prepared for any emergency that would impact access to essential equipment and/or supplies. We are stocking piling essentials so that we can continue to operate efficiently while trying to obtain new vendors if needed. We have developed additional contacts at various agencies that we can contact to provide us with information.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Willing to partner on education for staff
2. Provide expertise in areas that we don't have at our fingertips
3. Provide additional funding opportunities for equipment to enhance residents' lives

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Better understanding of how each agency interacts and works with others.
2. More consistent communication between agencies so end users do not get conflicting information.

3. More planning across agencies so multiple ones is not doing presentations at the same time. This resulted in the splitting of staff to be on multiple webinars at the same time.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Trezevant's connection to the local health department has increased due to the pandemic. SCHD now understands its role better and how they relate to other licensed healthcare entities and where regulatory authority resides.

HOME HEALTH/HOSPICE

BAPTIST REYNOLDS HOSPICE HOUSE

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 21, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation policy was changed to include no visitors for stable patients, no volunteers, and closing of areas where staff/visitors could congregate.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The incident command group met each morning and talked through any changes several times per day. Some days there were changes that needed to be discussed several times. Our Medical Director was instrumental in all changes.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Commander 2(Executive Director), Clinical Manager (Charge Nurse/Patient Care Manager), Business Manager/Office Assistant-assist with PPE ordering/counting/organizing, Facility Foreman- assist with air flow in rooms and closing section of hall for possible COVID19 positive patient influx.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Incident Commander 1 (Medical Director)- Gave valuable input on COVID19 precautions as far as visitation, accepting new patients, rapid testing of staff, etc.

How was information disseminated throughout the facility to keep staff informed? Information was disseminated via email, daily huddle with clinical staff, staff meetings, postings at each Nurse's Station and Aide Station, postings by assignment schedule, and COVID19 information binders at each Nurse's Station and in Director's office.

Provide THREE strengths related to INCIDENT COMMAND:

1. Incident Command 1 (Medical Director) was a wealth of knowledge of all things COVID19. He worked in two COVID19 units during the pandemic. He assisted with visitation policies, criteria for accepting new patients, rapid testing of staff, etc.
2. Dissemination of Information: Information was disseminated throughout the facility via Incident Commander 2, Clinical Manager, and Business Manager via email, daily huddle with clinical staff, postings at each Nurse's Station and Aide Station, postings by assignment schedule, and COVID19 information binders at each Nurse's Station and in Director's office
3. Ordering of PPE, organizing of PPE, counting of PPE: Business Manager was instrumental in making sure all PPE was ordered, organized, and counted daily.

Provide THREE opportunities for improvement related to INCIDENT COMMAND:

1. Original dissemination of Visitation changes was disorganized. It occurred so quickly that we had to call in extra staff to make calls to families.
2. Needed better information on air flow exchanges in patient rooms prior to COVID19 pandemic.
3. Needed template to determine PPE needs for COVID19 precautions, as well as PPE needs for COVID19 positive patients.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Facility Foreman assisted in having our facility tested regarding air exchanges in patient rooms. We now have detailed information on air flow exchanges and the effect that a COVID19 positive patient may have on our facility. This led to us closing six rooms at the end of a hall in preparation for any COVID19 positive patients. We also are in the process of getting those six rooms able to be turned into negative pressure rooms.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Late March 2020

What resources did you have difficulty procuring? N95 masks. How did you fulfill these needs? Memphis Mission of Mercy donated 600 N95 masks to us.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? None, all procurement was completed though our company, LHC Healthcare.

Did your normal materials management mechanisms/policies/procedures continue to work? No. If not, did your organization create new and/or temporary management plans? Yes. Please describe. We developed new procedures on soiled linens for suspected and positive COVID19 patients and soiled utility bins (outside facility) for suspected and positive COVID19 patients.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We did not have enough storage space for all PPE related to COVID19. Much of it was stored in front offices at first. We then purchased shelving and some items were stored in our attic.

Provide THREE strengths related to RESOURCES.

1. We had little difficulty with obtaining resources. Our company, LHC Healthcare stream-lined distribution of resources to all agencies.
2. Donation of 600 N95 masks from Memphis Mission of Mercy in late March 2020.

3. All PPE was stored in front offices to prevent possible theft of items. This also allowed us to do a daily count of PPE items on hand.

Provide THREE opportunities for improvement related to RESOURCES.

1. We had some difficulty initially with communicating new procedures for soiled linen of suspected and positive COVID19 patients.
2. We had some difficulty initially with communicating new procedures of utilizing soiled utility bins (outside facility) for suspected and positive COVID19 patients.
3. We had a lack of storage space for PPE.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
One opportunity for improvement related to resources that has become a strength is the storage of PPE. We originally stored all PPE in the front offices. We purchased shelving and placed all PPE that was not being routinely used in our attic. This has freed up space in our front offices.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? N95 masks, surgical masks, isolation gowns, face shields, goggles, shoe covers, hair covers, gloves, PPE kits for admission and subsequent visits of suspected or positive COVID19 patients. To protect patients? (i.e., masks, face shields, half masks, etc.) Surgical masks, gloves, face shields, goggles.

What new materials/PPE/resources did you utilize that you had not previous utilized? None

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes. We are continuing to assess visitation policy, rapid testing weekly for all staff who are not vaccinated, daily COVID19 screening of unvaccinated staff, visitors, and volunteers, continued use of surgical mask for all when in the facility, temperature screening for all when entering facility.

How did your facility address extended use and/or reuse guidance for PPE? We had to reuse N95 masks at the start of pandemic. Each staff member was issued a mask and paper bag to keep it in. A new mask would be given if their mask became soiled or loose fitting.

How did your facility address COVID-19 patient and employee testing? New patients are required to have a negative COVID19 test within 48 hours of admission if coming from home or hospital. If coming from a nursing facility, they are required to have 2 negative COVID19 tests. All staff members were initially required to have a rapid test completed the first shift of each week. We now require the rapid test to be completed weekly by all unvaccinated staff.

What standard or innovative infectious disease barrier control methods did you use, if any? Due to air flow exchanges in our facility, we blocked off 6 patient rooms at the end of a hall. This block of rooms was to be used for any suspected or confirmed COVID19 patients.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We have no morgue. Any surge issues were to be coordinated with Baptist Memorial-Collierville hospital.

Did your facility have or use an infectious disease surge plan? Yes. What strengths and weaknesses have you since identified in that plan? We are unable to identify strengths and weaknesses as we only had one COVID19 positive patient. If you had no plan, have you created a plan based on your COVID-19 response?

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No

Provide THREE strengths related to INFECTION PREVENTION.

1. All staff were very mindful about Infection Prevention policies and correct usage of PPE.
2. All staff were complaint with weekly rapid COVID19 testing.
3. Requiring all admissions to have a negative COVID19 result prior to admission has helped keep our patients, staff, and families safe.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. We had some difficulty communicating changes in the Visitation Policy to all 65 staff members.
2. Not having negative pressure rooms in the facility.
3. Ensuring all visitors keep a surgical mask on at all times in the facility.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. One item that has become a strength in relation to Infection Prevention is working on having at least six negative pressure rooms due to the air flow exchanges in our facility. We are currently in the process of making six rooms at the end of one hall into negative pressure rooms.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Shelby County Health Department, State of TN Department of Health, and Shelby County, TN Environmental Health & Food Safety. Who were the responsible parties/job titles that were responsible for maintaining that communications? Rebecca Weishaupt, BSN, RN Executive Director

What were the topics of community meetings or work groups that your organization participated in? COVID19 Infection Control in IPU

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? email and phone

How did your organization address the distribution of federal, state, and local guidance? All federal, state, and local guidance was communicated to all staff via email and COVID19 education binders.

What community partners did you work with during the pandemic that you had not previously worked with? Memphis Mission of Mercy

Has your organization created any new MOUs/agreement during this pandemic with external partners? No.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? No. If so, please provide examples. If not, please explain how you could have been better supported. At one point we thought we may have a PPE need. We communicated that PPE needed via form but had no reply.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? No change currently.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Great support from Memphis Mission of Mercy.
2. Shelby County Health Department was extremely helpful during the pandemic regarding facility questions.
3. Great communication from federal, state, and local levels.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Communication if PPE request was not able to be met.
2. Initially had some difficulty finding who to speak with at Shelby County, TN Environmental Health & Food Safety.
3. Difficulty disseminating all information from federal, state, and local entities to 65 staff members.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. One opportunity for improvement related to external partners that has become a strength is the way we disseminate information from federal, state, and local entities. Since the COVID19 pandemic began we now use email, daily huddle with clinical staff, education binders at each Nurse's stations, Aide stations, and in Director's office, staff meetings, and postings by assignment schedule.

Crossroads Hospice

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 12, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Crossroads Hospice (Memphis Site) was affected in the following ways: Staff could not make routine visits to our patients who were in nursing homes that were on "lock down". Those nursing homes only let us see our patients once every twenty-one days per Medicare guidelines. Our expectation is that nurses make two routine visits a week per patient and CNA's make three routine visits a week per patient. Our visit frequencies dropped to one routine visit a week per patient for nurses and two times a week per patient for CNA's. Social Workers, Chaplains, Bereavement councilors, and volunteers were not allowed to visit unless it was emergent. The emotional support staff had to work from home for a few months to make phone calls to our patients since they were not allowed to visit to decrease the risk of exposure.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. For the weeks of March 12-14 and 16-21 we met daily. For the month of April, we met twice a week. The rest of the year we met weekly and as needed.

Which components of incident were activated (i.e., which positions/groups were named)? Executive Director- Samantha Jefferson, Clinical Director- Vicki Noble RN, Human Resources- Joycelyn Robinson, Site Educator/Staff Development- Samantha Hartsfield RN, MSN, Assistant Clinical Directors: Rhonda Garner RN, Susan Campbell RN, Colleen Casta RN, Violet Gohil RN, Patricia Ward RN, and Social Services Director- April Leary.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Developing a COVID Clinic to test employees weekly and a temperature screening station.

How was information disseminated throughout the facility to keep staff informed? Email, Virtual Meetings, and Conference Calls.

Provide THREE strengths related to INCIDENT COMMAND.

1. Plenty of PPE for staff.
2. Developing a system for effective COVID testing.
3. Effective communication with staff.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Communication with local facilities could improve.
2. A better way to utilize the ESS staff that were awaiting dispatch from home.
3. Early on- getting employees to stop congregating at the office.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
At the beginning of the pandemic, we had a large amount of field staff employees coming into the office unnecessarily. We quickly realized this problem when we started with temperature screenings. To improve the traffic in and out of the office we implemented the following: conference calls with the clinical teams every morning at 0830 to talk about report, emergent needs, critical patients etc. We assigned pick up days for patient supplies to the CNA's and Nurses to control the amount of people in central supply. These expectations are still practiced today.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last?
We began to struggle with supplies in April 2020. This lasted a couple of months. We started with Turenne early to mitigate supplies.

What resources did you have difficulty procuring? Hand Sanitizer, Clorox Wipes, Lysol, and gloves. How did you fulfill these needs? We made our own hand sanitizer using aloe vera, 90% rubbing alcohol, and essential oil. Chlorohexidine concentrate was purchased, and disinfectant was made by using a 15:1 ratio with water. The solution was put into spray bottles and empty Clorox wipe containers with paper towels. Gloves were bought from a new supply company, Turenne, because they make their gloves in house.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Turenne PharMedCo was utilized for supplies. This was a supply company that we started doing business with at that time. Additional vendors included Sam's Club, Amazon, Restaurant Supply Companies.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. No, this was disrupted as well. Corporate was able to procure supplies and send to the eleven different sites. Sister sites shared supplies with each other. Turenne also procured items.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Our EPP was changed by the pandemic. Corporate office added several new policies in correlation with the COVID 19 outbreak.

Provide THREE strengths related to RESOURCES.
1. We had plenty of surgical masks to offer to our employees from our Influenza emergency supply.
2. Our partnership with vendors such as medical supply companies and the pharmacy.
3. We were able to adapt to situations when specific supplies were not available.

Provide THREE opportunities for improvement related to RESOURCES.

1. Inconsistent facility usage
2. Storage space
3. Strategic plan from corporate

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Our partnership with Turenne has been very beneficial to our company to procure supplies. They have gone above and beyond to help us cover our needs for patients during the pandemic. We still do business with this company to this day.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Surgical Masks, N95's, KN95's, Face Shields, Isolation Gowns (washable and disposable), gloves, hand sanitizer, hair bonnets, and shoe coverings for our staff were provided. COVID testing was performed weekly on Monday mornings to clinical staff. Supplies for patients- surgical masks and gloves.

What new materials/PPE/resources did you utilize that you had not previous utilized? Chlorohexidine Solution, infrared thermometers, and face shields.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, all patients are screened with a COVID questionnaire prior to visits.

How did your facility address extended use and/or reuse guidance for PPE? The CDC guidelines were followed for use and reuse of PPE.

How did your facility address COVID-19 patient and employee testing? Employee testing occurred every Monday morning weekly to test clinical staff. Patients were tested upon facility placement, or if infection was suspected.

What standard or innovative infectious disease barrier control methods did you use, if any? Standard universal precautions have always been used with our patients and will continue to be used in our practice.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? Since we are a hospice company, we do business with multiple funeral homes in the area daily. There were challenges due to the funeral homes being so full. There were instances when the funeral home had to refuse body pick up because they did not have any room at their facility. We addressed this issue by finding a funeral home that did have space for our deceased patients.

Did your facility have or use an infectious disease surge plan? We already had infectious disease policies in place when the pandemic occurred. What strengths and weaknesses have you since identified in that plan? Additional information from the CDC was provided to our employees and displayed in common areas. A strength was that our company already followed infection control precautions. Our office is cleaned nightly by a company called Zoom and Broom which is another strength. A weakness that our staff realized is that we could do a better job of cleaning our personal areas. Therefore, cleaning materials were placed in the common areas such as the nursing offices, kitchen, conference room etc.

Provide THREE strengths related to INFECTION PREVENTION.

1. An infection control policy was already in place and was followed by our staff.
2. Universal precautions and bag technique are a part of daily practice.
3. The company Zoom and Broom were contracted pre-pandemic, and our offices are cleaned nightly.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Staff could improve cleanliness of their personal areas such as workstations.
2. Limiting staff time in the office.
3. Kitchen usage for employees (social distancing).

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Cleaning supplies have been left out in common areas and the staff continue to wipe down counter tops, pens, and keyboards at workstations daily. This is a way that we can improve our infection control practices. We have become more aware of infection control in our shared spaces, and shared equipment such as computers and copy machines.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Corporate office, Turenne PharmMedCo, Bartlett Prescription Shop, NHME, Shelby County Health Department, and Compass Laboratories.

Who were the responsible parties/job titles that were responsible for maintaining those communications? Patricia Ward oversaw communicating with Turenne and NHME. Violet Gohil oversaw speaking with Bartlett Prescription Shop. Samantha Jefferson and Vicki Noble were communicating with the corporate office, Shelby County Health Department and Compass Labs.

What were the topics of community meetings or work groups that your organization participated in? We have a manager's meeting every Tuesday afternoon and discuss all the topics that involve our company. For example, safety meetings, budget meetings, staffing issues etc.
What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email is our primary communication at CRH. We also utilize the telephone, fax, and virtual meetings.

How did your organization address the distribution of federal, state, and local guidance? CRH continued to follow these guidelines as they were communicated. The leaders at our office watched the news, CDC guidelines, and Medicare guidelines closely.

How did your organization address the distribution of federal, state, and local funding opportunities? We were unaware of those opportunities; therefore, we did not utilize them.

What community partners did you work with during the pandemic that you had not previously worked with? Turenne PharmCo, the Shelby County Health Department, and Compass Labs.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Yes. Who were those partners and what was the topic of agreement? Compass Labs were contracted to run our COVID tests weekly and to provide testing supplies. Turenne also provided testing supplies for rapid tests.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. We were supported by the Shelby County Health Department, Compass Labs, Turenne, and Nursing Facilities.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? The effects of the pandemic have taught us a valuable lesson in preparedness. We still have relationships with vendors that started at the beginning of the pandemic that we still do business with today such as Turenne. It is important to have multiple resources when procurement of supplies is a challenge. You never rely on just one resource.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. We obtained a contract early with Turenne.
2. Our corporate office partnered with Turenne to obtain supplies on a corporate level.
3. The longevity of the Memphis site was a strength to implement changes on a rapid basis related to the local long-term nursing facilities.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Corporate could improve our EPP by having more resources listed for each site, instead of each individual site having to find their own.
2. There is not a standardized plan across all the sites when it comes to external partners.
3. Communicating with external partners such as nursing homes, there was not a centralized base or people to communicate with. Our staff relied on word of mouth from what a facility was doing from one day to the next.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Our corporate office has a continued contract with Turenne to obtain supplies on a corporate level for all eleven Crossroads Hospice (CRH) sites across the country. Through Turenne, the

corporation ordered COVID testing supplies to be sent to all the CRH sites. PPE supplies have been ordered on a corporate level as well to share with the sister sites through Turenne. Doing business with Turenne has become a strength for CRH on a local site level and corporate level.

NO PLACE LIKE HOME

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 12, 2020

How was your facility affected by the initial Safer at Home directives? Loss of revenue due to families canceling (not able to work so they were able to provide care, fear of nurses bringing the virus into the home), nurses not able to work (kids out of school, no childcare), PPE shortages.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. We met as often as updates and/or changes were received from the CDC and Shelby County Health Dept.

Which components of incident were activated (i.e., which positions/groups were named)? Clinical supervisors contacted all patient families, Jesse Barnes handled all email/website updates, office staff contacted all personnel

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? A log was initiated to track all COVID testing (negative / positive), quarantine dates, and clearance to return to work.

How was information disseminated throughout the facility to keep staff informed? Email, text, website, In-service education

Provide THREE strengths related to INCIDENT COMMAND.

1. Staff Communication
2. Quick delivery of PPE when available
3. Additional infection control measures provided (soap, paper towels)

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Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Other communication options to contact patient families, such as website up or patient portal.
2. Plan to keep family contact and emergency information up to date.
3. Ability for office staff to work remotely.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Ability for office staff to work at home. Since the beginning of COVID all office personnel have been equipped with laptops and have the capability to work remotely. The website has been updated and contains a direct link to our operating system, outlook, and any other necessary software programs.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? 3/25/20 How long did this last? 4/27/20 after about this time we might not receive our 'normal 'order but the supplier was able to substitute, and staff were beginning to use cloth masks.

What resources did you have difficulty procuring? Gloves, masks, sanitizer, soap, paper towels, sanitizing wipes How did you fulfill these needs? MSEPC assisted, donated reusable masks, staff made their own, purchasing from retail outlets.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Retail outlets, Amazon, MSEPC

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Did not change

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Masks and face shields are now a part of inventory.

Provide THREE strengths related to RESOURCES.

1. Capability to deliver to staff as needed
2. Supplier was able to substitute our normal order with comparable items.
3. MSEPC was able to assist

Provide THREE opportunities for improvement related to RESOURCES.

1. Need a better knowledge of how to navigate locating additional supplies when needed.
2. Better relationship with suppliers.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. We have developed better relationships with our current supplier and have had the opportunity to try new brands etc., due to substitutions.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Masks, gloves, face shields, sanitizer, paper towels, soap. To protect patients? Same as staff

What new materials/PPE/resources did you utilize that you had not previous utilized? Masks and face shields, paper towels, soap

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not as far as screening and visitation did not affect us.

How did your facility address extended use and/or reuse guidance for PPE? Instructions for cleaning face shields and storage; instructions for reuse of masks and storage; cleaning of reusable masks

How did your facility address COVID-19 patient and employee testing? We gave locations for testing when needed. Followed up after testing for results, logged return to work time and communicated with staff/families

What standard or innovative infectious disease barrier control methods did you use, if any? PPE, telehealth supervisory visits

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Yes, reports of staff not wearing mask appropriately, addressed situation directly with staff, education provided.

Provide THREE strengths related to INFECTION PREVENTION.

1. No cross infections from patient to staff, staff to patient.
2. Staff infection was relatively low.
3. Staff were more aware of themselves and symptoms.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Better tracking of daily screening results.
2. Knowledge of additional suppliers

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Staff seemed to be more aware of their health and symptoms of illness. Staff have been very responsible to call and report possible illnesses prior to going to work.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communication? Jesse – vendors; Kim – MSEPC; Ashley – Shelby County Health Dept./TAHC, MCOs

What were the topics of community meetings or work groups that your organization participated in? COVID updates

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Virtual, broadcast, email, phone

How did your organization address the distribution of federal, state, and local guidance?
Website, email

What community partners did you work with during the pandemic that you had not previously worked with? MSEPC, Shelby County Health Dept.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. TAHC was able to provide valuable information and assist with dissecting State and Federal information for home care. They also offered insight in how other home care agencies were responding to the PHE. MSEPC provided emergency PPE.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
No change

Provide THREE strengths related to EXTERNAL PARTNERS. TAHC's knowledge of home care!

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS. Develop a relationship with other local home health agencies.

AMBULATORY SURGERY CENTERS

CAMPBELL CLINIC SURGERY

MIDTOWN AND GERMANTOWN LOCATIONS

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? On March 3, 2020, Campbell Clinic distributed a Coronavirus hand out to its employee's that provided information on what coronavirus was, how it was spread, and the symptoms, that was provided by the CDC. This was followed by a screening toll to be used by the employees on March 13, 2020. On March 16, 2020, all employee's, physicians, residents, and patients were screened with a questionnaire and a temperature check. Coronavirus Task Force activated on March 13, 2020.

How was your facility affected by the initial Safer at Home directives? Elective surgeries were cancelled. A panel of surgeons was formed to approve those cases that were considered emergent or urgent. All cases were presented to this panel for approval before they were scheduled. Our Midtown location was closed and all resources were moved to the Germantown location. All people who accompanied patients to the surgery center were asked to wait in their cars until the procedure was completed.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The Task Force met daily at the beginning to help keep updated with the latest information. As the pandemic continued, the meetings were spaced out to weekly.

Which components of incident were activated (i.e., which positions/groups were named)? Additional cleaning protocols were initiated using approved cleaning products. Special attention was given to door handles and flat surfaces. Social distancing was put in place and one-half of the chairs were removed from the break area. Social distancing reminders placed in all high traffic locations. Policy put in place for facemask use. Administrator and CEO began tracking daily and weekly PPE inventory.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? FNP to monitor and help further screen possible positive patients.

How was information disseminated throughout the facility to keep staff informed? Information provided in weekly e-mails to all staff members by Chief of Staff and CEO. Memos posted in all high-traffic locations.

Provide THREE strengths related to INCIDENT COMMAND.

1. Quick response to getting possible positive individuals isolated and tested.
2. Obtaining and providing the most up to date information to staff and patients.

3. Developing protocols and treatment plans that allow patients to be treated with minimal risk of exposure as well as protecting staff and reducing their exposure level.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.
We covered everything else well I thought.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
Better communication to the entire clinic using e-mails and staff meetings.

RESOURCES

How long did this last? Supply chain disruptions began for us 2-3 weeks into the pandemic and have continued to present time.

What resources did you have difficulty procuring? The first items we began to have issues with was PPE. We began to look at other sources for non-sterile gloves, shoe covers, and hair covers. Some of these were obtained from online sources. Many sterile gowns and gloves were put on allocation. Since some of these items are included in our custom surgical packs, we were able to obtain these through our pack supplier. Our purchasing person spent multiple hours on the phone and internet tracking available supplies and kept a spread sheet updated with what items we had on hand and what items were in short supply or backordered.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? We used internet searches to try and secure non-sterile items such as hair covers, shoe covers, non-sterile exam gloves, and non-sterile gowns. Cardinal, Medline, and McKesson were able to keep us supplied with what we needed for the most part. Their sales reps also helped us source product that they were having difficulty getting themselves. PPEs were available from our local emergency coalition from time to time, but we were able to maintain our levels without their help.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. For the most part our normal purchasing protocols worked. We did add a daily assessment of PPE's that were reported to the Administration team. Our O.R. teams were very vigilant in opening only needed supplies for any given case. Purchasing maintained daily contact with our vendors for any information on items that were about to be placed on allocation. Our vendors were also proactive in warning us of possible shortages on our needed supplies. We were able to order extra supplies in the very beginning that helped us maintain adequate supply levels to do the cases that we were allowed to do.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We will maintain close contact with our suppliers and have asked for their plans on how they plan to handle any future emergencies. We set a protocol for purchasing extra supplies, as well as policies on storage of these supplies. We will also work on a spreadsheet of available vendors that were utilized during the pandemic.

Provide THREE strengths related to RESOURCES.

1. Strong relations with our vendors
2. Strong commitment from our vendors to make sure that we maintained adequate product levels to provide the needed care to our patients.
3. Working relationship with our local emergency coalition.

Provide THREE opportunities for improvement related to RESOURCES.

1. More organized storage for supplies
2. More research into other suppliers that might have the supplies that we need.
3. Establish relationship with other purchasing departments in our area in order to source supplies.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The one opportunity for improvement related to resources that has become a strength is better contact with our vendors about possible shortages and resourcing possible replacement product that can be used until the desired product is obtained. Also, maintaining a spreadsheet of possible vendors that have product available that we can source in the event of a shortage.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? Gowns, non-sterile gloves, facemasks, face shields, non-sterile gowns, and N95 mask were all utilized to protect staff and patients.

What new materials/PPE/resources did you utilize that you had not previous utilized? In the surgery center, we do not use N95 masks routinely in-patient care, but they are utilized anytime a patient required a general anesthetic in both the surgery area as well as the post-op area. We also installed clear Plexiglas screens at the reception and check in area as well as markers on the floor every six foot at the reception area to remind patients to social distance.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Now, we still require wearing mask by staff and visitors in the clinic area. Use of N95's during procedures requiring general anesthesia is highly recommended. All patients will continue

to be screened, and employees are required to self-monitor and report any symptoms to their manager before reporting to work.

How did your facility address extended use and/or reuse guidance for PPE? N95 mask were labeled with the employee's name and the date that they were first used. These masks were stored in designated blanket warmers at 130 degrees Fahrenheit in paper bags with the employee's name and date of first use on the bag. Mask and bag were discarded, and new N95's issued after 30 days. If masked were compromised during the case, they were replaced immediately.

How did your facility address COVID-19 patient and employee testing? Any patient that tested positive for COVID were rescheduled 14 days after their test if there were no continued symptoms. Employees who exhibited signs and symptoms of COVID were sent to one of multiple test sites for testing and were instructed to quarantine until test results were obtained. Those testing positive were reported to HR, and HR notified them with the date that they could return to work.

What standard or innovative infectious disease barrier control methods did you use, if any? Signs were placed in every other chair in the waiting room to promote social distancing. Signs were placed on the floor to maintain six feet of separation between patients waiting to check in. In the early stages, visitors were not allowed in the waiting area's and were instructed to remain in their cars in the parking lot. All patients, vendors, and staff were screened for temperature, recent travel, and any possible contacts before being allowed to enter the building. Housekeeping staff increased the number of times that door handles were being wiped down, and stations were placed at all entrances that contained mask, gloves, and hand sanitizer. Clear Plexiglas shields were placed at the reception and check in desk.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? We had several employees in the early stages of the pandemic that were reluctant to come to work and take care of any patients. They were very upset when they found out that they might have been exposed to a positive patient. Some were reluctant to social distance and some did not want to wear a mask the whole time they were at work.

Provide THREE strengths related to INFECTION PREVENTION.

1. Very dedicated infection control team
2. Timely communication with staff as new information came available.
3. Through monitoring of staff and patients for temperature, signs and symptoms of COVID, and monitoring of staff that had tested positive for COVID.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. More education of staff.
2. Additional Infection Control nurse.

3. Additional instruction and monitoring of housekeeping staff regarding COVID and proper cleaning protocols.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Housekeeping is paying more attention to door handles and other high touch surfaces throughout the facility that were often overlooked. These areas are now wiped down multiple times per day.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communication? There were three to four times weekly conservations with our McKesson and Cardinal reps and our purchasing department as we tried to stay ahead of the shortages and find possible substitutes for products that were hard to find.

What were the topics of community meetings or work groups that your organization participated in? We attended virtual meetings with TASCA and our local emergency coalition, as they were available. Discussions were had between other outpatient type centers and our emergency coalition as to current recommendations from the CDC and our local health department as to best practices regarding safe patient treatment and care, and how best to protect our employees at this time. We also made room and ventilator data available to our local coalition in the case that our facility was needed to provide care for COVID victims.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Primary communication with external partners was primarily by phone and e-mail. Zoom meetings were held by TASCA and the local emergency coalition.

How did your organization address the distribution of federal, state, and local guidance? All federal, state, and local guidelines were followed by the COVID task force as well as the surgery center administrator and clinic managers. All Guidelines and correspondence from these agencies, as well as clinic guidelines, were placed in a COVID binder and made available to the staff. Updated guidelines were placed in all high traffic areas, break room doors, at time clocks, and at entrances to the building.

What community partners did you work with during the pandemic that you had not previously worked with? Our local emergency coalition. They were very consistent with offering PPE’s when they were available to them. Our administrator also worked through the local Mayor’s office as well as through the OrthoForum.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. I feel that we were well supported and informed by all levels, especially the

local and state level. We were able to obtain N95 mask through these contacts that were not available through our suppliers. We were also questioned about our need for supplies frequently by our local emergency coalition and was kept updated when critical supplies were available.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
We will continue to be an active part of the Shelby County Emergency Coalition and will work closely with them. In addition, as a part of the Non-Hospital group, we will continue to work closely with these centers to develop an emergency plan. We did share information about where we were able to find supplies with other ASCs in our area.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Timely updates about possible shortages or hard to get supplies.
2. Product reps were able to provide alternate products until requested products were available.
3. Good communication with the local emergency coalition.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Continue to develop relationships with non-hospital partners.
2. Explore other vendor relationships.
3. Maintain constant inventory of PPE's, and possible substitutes.

EAST MEMPHIS SURGERY CENTER

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 4/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Elective surgeries were cancelled, patient's surgeries delayed, employees unable to work and obtain their full salary.

How often did that group meet/engage? Weekly- The center operated 2-3 days per week for emergent procedures during this time.

Which components of incident were activated (i.e., which positions/groups were named)? Call tree was used to notify employees of schedule, communication with vendors regarding supplies needed and when center would be open for deliveries, telephones were forwarded. Communication was important between vendors, physicians, clinics, staff, and patients

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No additional positions noted

How was information disseminated throughout the facility to keep staff informed? By phone calls and text messages

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication
2. flexibility with schedule
3. Surgeons being flexible

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Earlier pre- op testing available for patients
2. Did not experience lack of PPE in our organization but still limited to surgeries performed by governor
3. Better assessment of current situation.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. We were required within our organization to do weekly PPE inventory; we are now much more aware of PPE stocked within our facility. Our company set up a warehouse for PPE, to compile PPE available but not needed, we could ship PPE not needed and could order PPE unavailable in our market. We are stronger logistically than we were before.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? June 2020 How long did this last? In a few situations this still exists, due to staffing and resources, most of issues resolved Jan 2021

What resources did you have difficulty procuring? It varied, PPE and assorted supplies and implants How did you fulfill these needs? Corporate supply chain and utilizing various vendors, some implants were purchased from a different vendor than usual.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Did not have vendors unfamiliar, just not the typical vendor, did order from corporate warehouse which was created due to COVID-19

Did your normal materials management mechanisms/policies/procedures continue to work? Yes. these continued to work

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We are better prepared supply chain

Provide THREE strengths related to RESOURCES.

1. Corporate supply chain
2. How to manage PPE inventory
3. Materials management

Provide THREE opportunities for improvement related to RESOURCES.

1. The biggest opportunity is to stay calm, do not panic, order accordingly.
2. The biggest pitfall was companies who created panic and sold goods marked up 5-10 times

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Managing PPE, what is used daily, weekly, how to order, and thinking outside the box.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Face shields, eye wear, and masks

What new materials/PPE/resources did you utilize that you had not previous utilized? Full face shields

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not sure at this moment, we follow CDC guidelines and will continue to follow

How did your facility address extended use and/or reuse guidance for PPE? We used CDC guidance for reuse of N-95 masks and wearing surgical mask per day unless soiled.

How did your facility address COVID-19 patient and employee testing? We required pre-op PCR test

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? This was included in our Infection Control Plan, we are outpatient surgery with pre- op testing, do not fall into Surge incident

Did you have any issues with staff and/or patient compliance to new infectious disease policies? as time went on reminding staff to keep their mask over the nose and mouth

Provide THREE strengths related to INFECTION PREVENTION.

1. Hand washing
2. Masking
3. Patient assessment

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Social distancing

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Hand hygiene has increased amongst all center staff

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Shelby County Health Department, Baptist Hospital, Surgery Partners Who were the responsible parties/job titles that were responsible for maintaining that communications? Medical Director, Chief Clinical Officer

What were the topics of community meetings or work groups that your organization participated in? Infection Control, PPE, Testing

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, ZOOM, TEAMS

How did your organization address the distribution of federal, state, and local guidance? Local team worked with TN and MS

How did your organization address the distribution of federal, state, and local funding opportunities? Local team

What community partners did you work with during the pandemic that you had not previously worked with? Shelby County Health Dept.

Did you feel like your organization was supported by local community partners? Yes, State partners? Yes. Federal partners? Yes. If so, please provide examples. If not, please explain how you could have been better supported. Shelby County Health Dept., Baptist, TASCA, CDC

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Communication
2. Knowledge

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
To share information more quickly

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
External partners have learned to communicate more effectively and give directions.

EYE CARE SURGERY CENTER

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Cancelled Elective Surgeries. Only performed Urgent/Emergent cases at one location. Visitors had to remain in their cars. They could not accompany the patient inside.

How often did that group meet/engage? Weekly? Daily? Weekly and sometimes Biweekly

Which components of incident were activated (i.e., which positions/groups were named)? Emergency Preparedness team, Infection control, Safety, Risk Management, Barbara Overbey ASC Administrator, Thomas Brown, JD, Practice CEO, Dr. Andrew Crothers, Medical Director, Dr. Subba Gollamudi, Senior Partner, Haley Armstrong, ASC Nurse Manager, Heather Southerland, Charge Nurse/Infection Control, Karley Seranno, Charge nurse, Infection control/Risk Management. Orval Fessenden, Inventory coordinator, William Sanvee, ASC Purchasing Director, Mike Slavsky, CFO

How was information disseminated throughout the facility to keep staff informed? Via e mail, teleconferences, phone calls and texts.

Provide THREE strengths related to INCIDENT COMMAND.

1. Strong Communication
2. Supportive physicians
3. Dedicated employees

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. The ability to carry out a plan efficiently and quickly
2. Minimize staff
3. Provide more up to date information to employees

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. With the unexpected closing of elective surgeries and the pandemic our center was prepared to and did utilize our Emergency management plan. We had multiple issues with Shelby County being unable to give us accurate and complete data so we could better manage our practice. I feel that for practices throughout this city to have success in any emergency the government officials should have the same. The public does not know what is going on behind the scenes to make them safe. It is our responsibility to ensure that. Much improvement could be done on communication from city and county officials to businesses and medical practices within their jurisdiction. Once we were a few months in it became more organized and communication

continued to improve which in turn helped our practice make better decisions for our patients, employees and physicians

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Supply chain disruption began in March of 2020. It lasted more than nine months with it being allocated.

What resources did you have difficulty procuring? How did you fulfill these needs? Mainly PPEs. PPEs were being allocated by suppliers and we had to sign up for a PPE assurance program with some venders.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Other online medical supply sources were used including amazon.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Our organization implemented new management plans to closely monitor inventory of PPE and procurement of PPE.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Yes, we increased our par levels for PPEs and sign on to PPE assurance programs.

Provide THREE strengths related to RESOURCES.

1. Monitoring
2. Effect distribution & usage
3. Procurement

Provide THREE opportunities for improvement related to RESOURCES.

1. Avoiding waste or miss use of resources
2. Finding more sources to procure resources
3. Keep informed with pandemics & resource availability

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began.
Keeping up with resource availability and updates on pandemics and other health emergencies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) We provided surgical masks to all patient who arrived at the clinic

without one. All staff had N95 fit Test and were assigned N95 masks. We also provided face shields, goggles, and gloves.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face Shields and goggles

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes

How did your facility address extended use and/or reuse guidance for PPE? We held in services on Donning and Doffing. Continuing education regarding the use of N95 respirators and when to discard. We have a policy regarding storage and usage of N95 masks

How did your facility address COVID-19 patient and employee testing? Developed our own testing department and policy that if any employee or family member was symptomatic or had a direct exposure we would test them. The specimen was obtained outside of the building while utilizing proper PPE and then shipped to an out of state lab. The employee was placed in quarantine until the results of the test was known. If the employee had been at work while having symptoms, special cleaning was performed on that workstation.

What standard or innovative infectious disease barrier control methods did you use, if any? Mask and gloves

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? This does not apply to any of our facilities. We are an ambulatory surgery Center where elective procedures were performed.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We did not have a surge plan but developed one as the pandemic progressed and new data was received.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No

Provide THREE strengths related to INFECTION PREVENTION.

1. Education
2. Communication
3. Available Resources

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Processes for check in while maintaining social distancing
2. Communication with the patients
3. Educating the patients

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. As COVID-19 evolved the staff and patients became more aware of their surroundings and how often people touch things. Our cleaning staff quickly stepped up to the high demand of cleaning throughout the day that was required with the new standards. This will continue once COVID is non- emergent since disinfecting has proven to be invaluable in preventing the spread of any disease, not just COVID 19.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Shelby County Health Department, CDC, Tennessee Department of Health. Barbara Overbey, MSN, FNP-BC, ASC Administrator, Kim Monaco, Human Resources Director and Thomas Brown CEO of the practice.

What were the topics of community meetings or work groups that your organization participated in? Infection Control, Communication, Emerging Infectious Disease Management, Policies and Procedure changes related to the Pandemic, Screening and maintaining employee, patients and surgeon's safety during an appointment to our clinics and surgery centers.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Phone, Virtual Meetings, and Minimal e mails.

How did your organization address the distribution of federal, state, and local guidance? We organized committees and outlined policies to ensure the safety of our staff and patients.

How did your organization address the distribution of federal, state, and local funding opportunities? PRF funds were included as misc. income for the organizations.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? We had an agreement with a lab in Birmingham due to the turnaround time for lab results in Memphis and Shelby County.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. It appeared that our resources in Shelby county and West Tennessee were restricted making it nearly impossible for small businesses to make educated decisions on policies related to COVID-19

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We began attending our local community emergency management coalition meetings.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Community support. We had to use an out of state lab because our local community could not help their businesses
2. Communication – we received conflicting information consistently even through the HOTLINE
3. Federal agencies should have been called in to assist with the high demand. Our population and community were at higher risk than most.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. As an organization have secured external relationships with vendors and emergency management organizations in preparation should we need to activate the Emergency Management Plan again.

GASTRO ONE

WOLF RIVER, WOLF PARK, AND DESOTO LOCATIONS

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 01/31/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures? 03/23/20 Elective procedures cancelled, remaining patients risk stratified for procedure urgency. Drivers restricted and required to wait in car. ASC Schedules reduced and revised. Staff reduced.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Frequency weekly initially. Daily updates regarding par levels of stock and critical shortage

Which components of incident were activated (i.e. which positions/groups were named)? Purchasing Control, Infection Control, Scheduling Restrictions

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Global purchasing, Inventory control counting daily/weekly

How was information disseminated throughout the facility to keep staff informed? Weekly emails and prn from Safety MD Chair and IC RN.

Provide THREE strengths related to INCIDENT COMMAND.

1. Good communication from leadership,
2. Staff Education
3. Delegation of teams to work on projects and responsibilities

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Staff Education when changes are made to ensure that all staff are brought up to date prior to starting work.
2. Detailed change documentation of the multiple schedule restrictions and changes whenever a new guideline was rolled out.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Documentation of change processes as they occurred and restrictions are listed. Weekly or bi-weekly emails from our Safety Chair MD related to the current state of COVID in our area, mask criteria

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? 03/19/2020 we started to have difficulty to obtain supplies until Spring 2021

What resources did you have difficulty procuring? How did you fulfill these needs? N95 masks, plastic procedure gowns, gloves, cleaning supplies. Needs were fulfilled by searching for alternate vendors, or sources.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? EBAY, AMAZON, CareGear Manufacturing in Texas, ID BAND, Air Pura Air Purifiers, overseas companies

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe
We switched to centralized purchasing due to restricted quantities available. Started daily and weekly counts of critical PPE and cleaning supplies.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?
It made staff more aware of supplies and the need to conserve resources instead of taking them for granted. We have become better at staying on top of par levels and the need for appropriate storage and tracking of supply levels.

Provide THREE strengths related to RESOURCES.

1. Materials Management processes improved – Centralized ordering
2. Increased awareness of products available from varying vendors
3. Staff have increased awareness of resource conservation while maintaining infection prevention protocols

Provide THREE opportunities for improvement related to RESOURCES.

1. Easier process for division of stock for satellite locations
2. Communication
3. Not all vendors claims are correct related to quality. We ordered 25,000 KN95 masks from an overseas company with a letter of certification of their effectiveness. When they arrived, they appeared flimsy so we sent them to Methodist hospital for efficacy testing. They are basically a KN 20 in rating. Ten months later and we are still working on a refund from the vendor.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The managers and staff are all aware of the importance of par levels and preventing hoarding of supplies so that

everyone can practice safely and have the supplies they need to protect their patients and themselves.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks N95 and KN95, simple surgical masks, face shields, protective eye wear, gloves and gowns, HEPA filtration

What new materials/PPE/resources did you utilize that you had not previous utilized? We installed 1-2 Hospital Grade Hepa filters in each procedure room to improve air exchanges to decrease room turnover delays required.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Current policies created through the pandemic remain in place.

How did your facility address extended use and/or reuse guidance for PPE? We extended the use and or re-use of N95 masks due to limitations and availability

How did your facility address COVID-19 patient and employee testing? Screening only for patients and staff daily. All employees with symptoms sent for testing

What standard or innovative infectious disease barrier control methods did you use, if any? Plexi glass dividers installed between employee workstations and check in area, social distancing, limited patients and visitors in the lobby, blocked seating availability in the lobby.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Our facility would not be affected by a surge due to the nature of our business. We had a response plan that was ever changing as new developments arouse. We are more aware of our supply needs and have worked to make sure that we have adequate supplies to take care of our patient and employees.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Two staff members unable to wear the N95 masks for procedures. PAPR trial failed. Employees offered to relocate to other departments.

Provide THREE strengths related to INFECTION PREVENTION.

1. Strong leadership team
2. Staff and patient advocacy
3. Strong networking with local and global healthcare center to share ideas and best practices.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
1. Staff training
2. Materials Management
3. Patient Education

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic?
- Baptist Hospital, Methodist Hospital
- CDC, WHO, APIC
- MS and TN Department of Health
- Shelby County Health Care Coalition
- ASGE, SGNA
- Memphis Medical Society

Who were the responsible parties/job titles that were responsible for maintaining that communications?
- CEO/COO
- MD Safety Chair
- Safety and Compliance Manager
- Infection Preventionist
- ASC Managers

What were the topics of community meetings or work groups that your organization participated in? PPE procurement, Protocols in place, Risk Stratification of patients

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, Phone, Zoom Meetings

How did your organization address the distribution of federal, state, and local guidance? Weekly emails and updates from Safety Chair MD, posters

How did your organization address the distribution of federal, state, and local funding opportunities? Email

What community partners did you work with during the pandemic that you had not previously worked with? Memphis Medical Society, Mid-south Mask Makers,

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. ASGE, SGNA, Healthcare Coalitions, Memphis Medical Society, Mid-South Mask Makers (cloth Masks)

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Restrictions still in place

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Standardized Recommendations
2. Best Practice suggestion
3. Vendor recommendations and resources

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Price gouging for sales
2. Verification of product capabilities as described

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Better control of stock par limits and acting earlier if critical products become low

MEMPHIS SURGERY CENTER

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 23, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?
Surgeries were limited to only those deemed "essential" from March 23, 2020 to May 4, 2020, per executive order of TN Governor. All scheduling requests were reviewed and approved by the facility Medical Director. The schedule was consolidated so that the Center opened only one day each week to accommodate these procedures.

How often did that group meet/engage? Weekly? Daily?
The Incident Command members met/communicated several times per week (remotely) to review and discuss new directives and emerging information. The Governing Body met weekly.

Which components of incident were activated (i.e., which positions/groups were named)?
All components of the ICS were activated: Command, Planning, Operations, Logistics, and Finance/Administration

How was information disseminated throughout the facility to keep staff informed?
Zoom call, e-mail, phone calls, text messages, in person meetings, postings (signage).

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication with providers and patients (provided reassurance that the situation was taken seriously and we were doing all we could to enhance safety)
2. Collection of information- Stayed informed regarding the latest federal, state and local guidance and information related to the pandemic by continuously monitoring websites, news releases, alerts from professional organizations and through frequent communications with the MSEPC and other area facilities.
3. Setting priorities and objectives for reopening activities.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Command: Pandemic protocol/policy development was needed, including procedures for screening, testing, enhanced environmental cleaning and infection control practices.
2. Planning: Need for more frequent direct communication with staff during the incident (weekly virtual meetings or written updates, maintenance of updated contact information for each person)
3. Logistics: Expanded vendor list needed for obtaining scarce resources/supplies.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Utilization of additional means of communication (Zoom meetings, conference calls) with staff to keep them informed. Also ensuring that staff contact information is complete and current.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? May of 2020, the supply disruption lasted 2 months.

What resources did you have difficulty procuring? How did you fulfill these needs? Surgical drapes, Cave-wipes, cleaning supplies, hand sanitizer, and N95 masks were in short supply. We had to go through 3RD party vendors.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? 3rd party vendors, Amazon, MSEPC.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes, they continued to work but we had to find other resources for supplies that were in short supply. We only order supplies on an as needed basis.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Prior to the pandemic our facility did not stock N95 masks or procedure masks for visitors – we will maintain an inventory of these going forward. We do not intend to stockpile supplies but will increase inventory of some items (sanitizing wipes, hand hygiene products)

Provide THREE strengths related to RESOURCES.

1. Allocations/relationships with existing vendors
2. Relationship with University of Tennessee/UCH
3. Partnership with the Mid-South Emergency Preparedness Coalition

Provide THREE opportunities for improvement related to RESOURCES.

1. Need for expanded vendor list during shortages
2. Need to maintain/increase inventory of some items specific to a pandemic
3. Need to maintain relationships with other ASCs in the Memphis area,

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Our list of supply vendors has become broader.

INFECTION PREVENTION

What PPE (Personal Protective Equipment) and/or resources did you use to protect staff? To protect patients. (i.e., masks, face shields, half masks, etc.) Masks, eye shields, face shields, gowns and gloves for staff, masks for patients

What new materials/PPE/resources did you utilize that you had not previous utilized?
N95's

Does your organization have any plans of keeping any of your COVID-19 employee, or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, we will continue to implement our policy of no patient visitors in the pre-op and PACU areas, unless the patient is a minor or requires a support person. This has proved to be a beneficial practice -less crowded in these areas, less noise, promotes patient privacy and is also a good infection control strategy.

How did your facility address extended use and/or reuse guidance for PPE? We did not have to reuse PPE. However, in anticipation of a shortage of N95's we developed protocols for reprocessing them in the Steris V-Pro and with our UV-C light equipment.

How did your facility address COVID-19 patient and employee testing? Patients were not admitted to the Center unless they had proof of a negative COVID test within 5 days of the date of service. Staff were tested monthly and whenever there was a possibility of exposure. A testing site dedicated to our surgery patients and staff was established next door to the center by UCH, our corporate owner.

What standard or innovative infectious disease barrier control methods did you use, if any?
UV-C lights after terminal cleanings at night

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? No, we did not use or develop a surge plan. The GB did discuss how the Center could participate in the community response by providing supplies and/or equipment to area hospitals should the need arise, and to possibly care for non-critical, non-COVID patients should hospitals become overwhelmed.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
No

Provide THREE strengths related to INFECTION PREVENTION.

1. No shortage of PPE at MSC
2. Implemented COVID testing for patients and staff
3. Stayed current with the new guidelines by constantly monitoring all communications and implementing them at the center as recommended.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Become more familiar with alternative products/equipment that can be used to clean the center in case of shortages (and where to procure them)
2. Develop policies and protocols as needed to maintain constant readiness in the event of another outbreak. Continue to stay current with CDC guidelines for patient safety and employee safety with the ongoing pandemic or any emerging threats.
3. Educate staff and patients about how to stop the spread of infection in the center and out in the public (good hand washing, wear a mask, stay home if sick).

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Understanding the impact of UV-C lighting in enhancing cleaning and disinfection activities.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? MSEPC, Shelby County Health Department, TDOH, TASCA, regional hospitals and area ASC's and vendors. Who were the responsible parties/job titles that were responsible for maintaining that communications? Administrator and Quality Coordinator were responsible for communication with external agencies. OR Manager and Purchasing Coordinator oversaw communications with vendors

What were the topics of community meetings or work groups that your organization participated in? PPE, supply shortages, rates of infection in our area, hospital capacity and limitations and local authority plans to manage, COVID testing, re-opening protocols, vaccine development and distribution.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Zoom meetings, e-mail, phone

How did your organization address the distribution of federal, state, and local guidance? Discussions were held with the Governing Body weekly and information shared with staff as appropriate.

How did your organization address the distribution of federal, state, and local funding opportunities? We are corporate owned. UCH (University Clinical Health) handled these.

What community partners did you work with during the pandemic that you had not previously worked with? Weekly ASC calls that were in the Memphis area. Also participated in several calls with regional hospitals and SCHD officials.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? No, N/A

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, the coalition was a great resource for us during the pandemic. They supplied us with N95's, gowns, and UV lights were purchased with funds received from them as well. The Coalition also provided frequent communication regarding the pandemic and executive orders.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We discuss new guidelines as they occur and discuss changes that may be needed at our quarterly governing body meetings. There is increased appreciation for the need for emergency preparedness activities after experiencing this actual event (and not just a simulation!)

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Memphis area ASC weekly zoom meeting helped to share best practices
2. Maintaining relationships with community and state partners kept us current with new developments, guidelines and mandates
3. Ability to obtain needed supplies from these external partners

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Develop and maintain Memphis area ASC networking activities, even after the pandemic (via the MSEPC)
2. Continue to monitor federal, state, local and industry resources for existing pandemic and emerging events.
3. Continue to broaden our contacts for resources and supplies.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Memphis area ASC connections were established during the pandemic. It was extremely helpful to have weekly meetings and discuss re-opening protocols and new guidelines that were site specific to our facilities.

ORTHO SOUTH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan?
3/11/2020 OrthoSouth launches COVID -19 Task Force to ensure education and safety of staff and patients.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? For the month of April, OrthoSouth conducted urgent procedures only (elective stopped) resulting in decreased surgery center staffing and hours. 4/13/2020 OrthoSouth decreased surgery schedule to M, W, F. Visitors were no longer allowed in the Recovery Bays.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Weekly meetings scheduled. Daily as needed. (See Facility Timeline for specific changes in P&P-added at end of evaluation)

Which components of incident were activated (i.e., which positions/groups were named)?

- Infection Control Nurse – COVID Communications, Education, Contact Tracing, Employee COVID testing
- Administrator – Worked with COVID TASK FORCE to determine closures and policy updates/changes
- PREOP Manager – coordinated patient COVID testing with clinics

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? COVID TASK FORCE created to keep all facilities up to date on latest trends and requirements and assist with contact tracing and Employee COVID testing.

How was information disseminated throughout the facility to keep staff informed? The infection control nurse would meet with each department and provide latest updates from CDC. This information would be posted throughout the facility. Initial training was conducted with all staff including evaluation of proper PPE donning and removal. All staff were required to complete online education about COVID-19 once it was made available through HealthStream (online education platform). Policy updates/changes were reviewed as they occurred.

Provide THREE strengths related to INCIDENT COMMAND.

1. Quickly put together multispecialty task force.
2. Multiple communication venues to keep staff informed with constant updates.
3. Monitored CDC websites/guidelines constantly and adjusted procedures accordingly.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Due to many sources offering guidance, communication was at times confusing. We could have improved communication by consolidating data weekly instead of daily. Many changes on daily basis.
2. Prioritizing testing to reduce the over utilization of test.
3. Could have provided better items needed for testing.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. We have consolidated our communication response to staff to be less confusing.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? 3/16/2020. How long did this last? Some items still on backorder.

What resources did you have difficulty procuring? Digital thermometers, PPE, Drapes, waterproof surgical gowns, medications. How did you fulfill these needs? Multiple vendors, out of town suppliers, sister centers, Amazon Prime.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? American Paper & twine for PPE, McKesson for medications, Amazon Prime.

Did your normal materials management mechanisms/policies/procedures continue to work? Yes, but created temporary management and storage procedures to accommodate.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We now have partnerships with national centers to share/procure supplies. We added back up supplies to our storage area which we will maintain.

Provide THREE strengths related to RESOURCES.

1. Strong partnerships across the country with differing needs at different times during the pandemic.
2. Numerous options and internet resources for medical supplies.
3. Staff education and buy in to conserve supplies.

Provide THREE opportunities for improvement related to RESOURCES.

1. Maintain higher par level to have access when in need.
2. Better security of supplies in demand.
3. More options for medication procurement.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Improved understanding among staff to conserve and monitor appropriate use of PPE.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) N95 were provided to Anesthesia staff for high-risk procedures. All staff were required to wear surgical/procedure masks, Face Shields provided for high-risk procedures. Goggles provided.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face Shields and Intubation boxes

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Infectious disease screening procedures in place prior to pandemic, the enhanced screening will probably continue even after Pandemic has resolved.

How did your facility address extended use and/or reuse guidance for PPE? We followed the reuse criteria that was published from manufacturer, CDC, FDA for N95. Anesthesia would be distributed one mask per day and cover N95 with surgical mask and face shield during intubation. We had enough surgical masks that these did not have to be reused.

How did your facility address COVID-19 patient and employee testing? Once pandemic was declared and the safer at home orders were placed, we required all patients to be tested via PCR prior to date of service and all staff were initially tested in April. Patients were screened via questionnaire on PREOP phones calls and again along with their caregivers on date of service including temperature checks. Employees completed daily screenings and temperature checks. Any signs or symptoms reported by staff resulted in testing and/or quarantine per CDC recommendations.

What standard or innovative infectious disease barrier control methods did you use, if any?

- PPE for airborne precautions on all high risk (aerosolizing procedures)
- Enhanced disinfection/cleaning procedures – including electrostatic cleaning when a staff member was found to be COVID positive
- Plexiglas barriers for reception

1. Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Weakness: Our current Infectious Disease Screening protocols did not originally cover the aspect of mass patient testing for preparation of identifying organisms that would impact their surgery. The plan was updated to incorporate testing of all patients prior to surgery, communication and education for positive patients and guidelines for scheduling/rescheduling based off results. Strength: Our current plan already had pre-screening measures in place to identify infectious patients such as flu, other infections…however, this plan was updated to be more targeted to identify COVID specific symptoms when screening.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No, with the emergence of potentially dangerous new disease, most were more than willing to do what was needed to protect themselves and others.

Provide THREE strengths related to INFECTION PREVENTION.

1. OSSC was able to recognize the threat early in the Pandemic and started enhanced screening measures to protect patients and staff. Enhanced screening measures started 1/22/2020.
2. OSSC developed a very structured contact tracing protocol allowing IC RN to quickly identify exposed parties and test/isolate per CDC criteria
3. PPE adherence resulted in almost no "work related" infections.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Could have been more diligent in monitoring and enforcing stronger travel limitations.
2. Could have restricted staff to limit cross contamination for those working in COVID hospitals and here at the ASC.
3. Could have expanded testing for any party entering facility.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Expanding testing to Vendors, New Hires, all patients.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? AEL Lab, COVID Task forces (Surgery Partners, OrthoSouth, Shelby Co., Coalition, BMG). Administrator, Infection Control RN, Leadership.

What were the topics of community meetings or work groups that your organization participated in? Testing, Policies, Resource Needs.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? All

How did your organization address the distribution of federal, state, and local guidance? COVID Task force received all guidance documentation and disseminated it to our facility via email, virtual meetings, etc.

How did your organization address the distribution of federal, state, and local funding opportunities? Leadership utilized PPE to maintain business plan.

What community partners did you work with during the pandemic that you had not previously worked with? Any new COVID specific task forces were utilized.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? We utilized Baptist for our vaccines to staff, which we had not utilized before.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. We questioned the county, the CDC, Surgery Partners Nationally. All were very responsive.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We have added policies and procedures to our emergency plan regarding the emergence of new widespread infectious diseases. We will now utilize this for potential threats in the future.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Supply Chain management of Surgery Partners allowed us to utilize national supplies.
2. Ease of communication with updates of evolving disease process.
3. AEL adaptability to quickly result testing for our patients/staff.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Earlier intervention by government entities to stop spread and promote containment.
2. Better segregation of Vendors accessing both inpatient and ASC facilities to mitigate cross contamination.
3. Improved vaccination processes for front line access.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began**.**
Vaccine access has improved for staff and public.

Radiosurgical Center of Memphis

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? Incident Command structure activated 3-20-2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Facility affected minimal because of our size but started on 3-20-2020 only doing One case daily. We were not considered elective but we downsized the number of workers and staff to only minimal needed requirements. Families for patients were also downsized to only One member per patient.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Our staff met daily on days with cases and minimal required staff on no patient days.

Which components of incident were activated (i.e., which positions/groups were named)? Incident Command, Safety Officer and Planning Sections were established.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Some logistics were used to establish emergency medical transport of unexpected problems or walk ups.

How was information disseminated throughout the facility to keep staff informed? Incident commander and safety officer kept all staff informed of updates and any new policies needed by changes or updates with the CDC.

Provide THREE strengths related to INCIDENT COMMAND.

1. Effective and proper use of the ICS system.
2. Ability to conform to ever changing COVID Information.
3. Placement of qualified personnel in proper positions.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Supplies, Resources
2. Communication between staff and facility.
3. Some lack of concern between the possible unknown with Physicians and staff.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. There should be better communication and concern for all staff and public between Physicians and coworkers when establishing the ICS.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? April of 2020. Some supplies are still hard to find.

What resources did you have difficulty procuring? How did you fulfill these needs? Gloves, N95 masks, surgical masks. Just had to wait for supplies to be available.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? None used same vendors as normal and waited for supplies.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Our policies and procedures worked as normal with the added policies such as, 1 case a day, Temperatures from everyone entering facility and masks worn by everyone in our facility.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? There are some supplies that we will keep a backup of but for the most part, everything we use has expiration dates that keep us from storing a lot of unusable supplies. Also, due to our facility size, we do not have a lot of extra storage room for mass supplies.

Provide THREE strengths related to RESOURCES.

1. Order when you believe the possibility of a problem exists.
2. Have several reliable suppliers.
3. Having good relationships with sales Reps with the companies you purchase from.

Provide THREE opportunities for improvement related to RESOURCES.

1. Money.
2. Extra stock.
3. Understand the need to purchase before time is critical.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. We always keep extra supplies of most critical and non-critical supplies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) N 95 masks and surgical masks for staff and regular face masks for all patients. Also, gloves were continuously changed after every contact with patient.

What new materials/PPE/resources did you utilize that you had not previous utilized? N 95 masks were worn more often than usual for the entire year of 2020.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? We are considering temperature screening everyone before entry into our facility as we are doing now. Visitors will remain 1 per patient until the hospital changes the policy.

How did your facility address extended use and/or reuse guidance for PPE? We had no extended use of PPE. Everything we use is disposable.

How did your facility address COVID-19 patient and employee testing? COVID 19 testing was done on every patient no more than 72 hours prior to treatment. As for employees, temperature screening was done daily and any symptoms that arose, the employee was sent to be checked.

What standard or innovative infectious disease barrier control methods did you use, if any? We kept our normal standard precautions along with the above policies.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? We do not deal with any Morgues.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We used our normal standard precaution and infectious disease protocols.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No issues with compliance with staff, family or patients.

Provide THREE strengths related to INFECTION PREVENTION.

1. Safety
2. Awareness
3. Training

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Communication with hospital
2. Transportation of patient to other areas of the hospital and clean up personnel for family areas.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Always awareness of staff and patient medical conditions.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? No external partners other than Coalition.

What were the topics of community meetings or work groups that your organization participated in? Only meetings with Coalition.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Virtual meetings phone and Emails.

How did your organization address the distribution of federal, state, and local guidance? Followed all CDC, State, County and Hospital guidelines.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Supported by Coalition.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Same planning protocol as we adopted at the beginning of COVID with strong communication with Coalition.

ST. FRANCIS SURGERY CENTER

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) March 3, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Canceled elective cases, only allowed essential personal to enter facility, enhanced screening on anyone entering facility

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Weekly or more frequently if needed

Which components of incident were activated (i.e., which positions/groups were named)? Facility admin, governing body, medical director, corporate partners

How was information disseminated throughout the facility to keep staff informed? Weekly conference calls and phone tree

Provide THREE strengths related to INCIDENT COMMAND.

1. Admins commitment to report to facility daily even though we were closed for patient care.
2. Supportive Governing board and Medical Director.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Communication between hospital and surgery center.
2. Better understanding of Incident Command.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Learned how to set up and participate in Zoom calls.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? April 2020

How long did this last? Continue to have issues with some items

What resources did you have difficulty procuring? PPE

How did you fulfill these needs? Restricted use. Locked up items. Assigned items. Reuse. Was able to get some items from coalition. Substituted. Cut back operations.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Lynn Medical

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Yes

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We kept items PPE behind lock and key.

Provide THREE strengths related to RESOURCES.

1. Supply tracking dashboard
2. Supply reserve
3. Perpetual inventory

Provide THREE opportunities for improvement related to RESOURCES.

1. Communication with hospital partner.
2. Removal of corporate approved vendor restrictions.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Product exposure. Ended up transitioning permanently to some substituted items

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, face shields, gowns, gloves, hair coverings, shoe covers

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not at this time, pending corporate guidance

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How did your facility address extended use and/or reuse guidance for PPE? Reused N95 for a day/week or until damaged or soiled. Disinfected face shields for multi-use.

How did your facility address COVID-19 patient and employee testing? Only tested if exposure or symptoms existed

Did your facility have or use an infectious disease surge plan? Emergency Pandemic Plan

What strengths and weaknesses have you since identified in that plan? Corporate Management Group assembled a COVID TEAM who developed Safety Protocols specific to COVID.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? No

Provide THREE strengths related to INFECTION PREVENTION.

1. Corporate "Return to Work" ramp up protocols were very effective.
2. This facility had no cases of COVID tied to facility.
3. There was a "COVID CSAR" available for questions.
4. Physicians supportive of performing only "essential procedures".
5. All staff readily reported symptoms and/or exposure to COVID and isolated or tested as needed.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Confusion about who, when and where to test staff following possible exposure.
2. Testing not readily available.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic?
Corporate COVID team

Who were the responsible parties/job titles that were responsible for maintaining that communications? Facility Administration

What were the topics of community meetings or work groups that your organization participated in? Executive Orders of Governor, PPE conservation, disinfection techniques, supply chain, testing processes, vaccine availability, education, surge capacity, employee return to work.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? all listed

How did your organization address the distribution of federal, state, and local guidance? email phone virtual meetings

How did your organization address the distribution of federal, state, and local funding opportunities? Corporate guidance

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Well supported with exception of testing centers and difficulty with vaccinations

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency?
No

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Guidelines provided by corporate partners prevented any outbreaks at my facility.
2. MSECP was helpful in providing PPE, water and hand sanitizer.

URO CENTER

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? 4/2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Elective surgeries were cancelled, patient's surgeries delayed, employees unable to work and obtain their full salary.

How often did that group meet/engage? Weekly- The center operated 2-3 days per week for emergent procedures during this time.

Which components of incident were activated (i.e., which positions/groups were named)? Call tree was used to notify employees of schedule, communication with vendors regarding supplies needed and when center would be open for deliveries, telephones were forwarded.

Communication was important between vendors, physicians, clinics, staff, and patients
What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No additional positions noted

How was information disseminated throughout the facility to keep staff informed? By phone calls and text messages

Provide THREE strengths related to INCIDENT COMMAND.

1. Communication
2. Flexibility with schedule
3. Surgeons being flexible

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Earlier pre- op testing available for patients
2. Did not experience lack of PPE in our organization but still limited to surgeries performed by governor
3. Better assessment of current situation.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. We were required within our organization to do weekly PPE inventory; we are now much more aware of PPE stocked within our facility. Our company set up a warehouse for PPE, to compile PPE available but not needed, we could ship PPE not needed and could order PPE unavailable in our market. We are stronger logistically than we were before.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? June 2020

How long did this last? In a few situations this still exists, due to staffing and resources, most of issues resolved Jan 2020

What resources did you have difficulty procuring? It varied, PPE and assorted supplies and implants How did you fulfill these needs? Corporate supply chain and utilizing various vendors, some implants were purchased from a different vendor than usual.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Did not have vendors unfamiliar, just not the typical vendor, did order from corporate warehouse which was created due to COVID-19

Did your normal materials management mechanisms/policies/procedures continue to work? Yes, these continued to work

If not, did your organization create new and/or temporary management plans? Please describe.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? We are better prepared supply chain

Provide THREE strengths related to RESOURCES.

1. Corporate supply chain
2. How to manage PPE inventory
3. Materials management

Provide THREE opportunities for improvement related to RESOURCES.

1. The biggest opportunity is to stay calm, do not panic, order accordingly.
2. The biggest pitfall was companies who created panic and sold goods marked up 5-10 times

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Managing PPE, what is used daily, weekly, how to order, and thinking outside the box.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Face shields, eye wear, and masks

What new materials/PPE/resources did you utilize that you had not previous utilized? Full face shields

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Not sure at this moment, we follow CDC guidelines and will continue to follow

How did your facility address extended use and/or reuse guidance for PPE? We used CDC guidance for reuse of N-95 masks and wearing surgical mask per day unless soiled.

How did your facility address COVID-19 patient and employee testing? We required pre- op PCR test

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? This was included in our Infection Control Plan, we are outpatient surgery with pre- op testing, do not fall into Surge incident

Did you have any issues with staff and/or patient compliance to new infectious disease policies? as time went on reminding staff to keep their mask over the nose and mouth

Provide THREE strengths related to INFECTION PREVENTION.

1. Hand washing
2. Masking
3. Patient assessment

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Social distancing

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Hand hygiene has increased amongst all center staff

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Shelby County Health Department, Baptist Hospital, Surgery Partners Who were the responsible parties/job titles that were responsible for maintaining that communications? Medical Director, Chief Clinical Officer

What were the topics of community meetings or work groups that your organization participated in? Infection Control, PPE, Testing

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, ZOOM

How did your organization address the distribution of federal, state, and local guidance? Local team worked with TN and MS

How did your organization address the distribution of federal, state, and local funding opportunities? Local team

What community partners did you work with during the pandemic that you had not previously worked with? SCHD

Did you feel like your organization was supported by local community partners? Yes. State partners? Yes. Federal partners? Yes. If so, please provide examples. If not, please explain how you could have been better supported. SCHD, Baptist, TASCA, CDC

Provide THREE strengths related to EXTERNAL PARTNERS.
Communication

BEHAVIORAL HEALTH

CRESTWYN

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 2/15/21

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Staff and physicians/LIP commuting to the facility for work, and supply delivery was severely delayed due to road conditions. Insurance transportation/Ambulances were either not available or delayed for patients who were to be discharged or were being admitted.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily meetings to discuss. Staff from other departments who were able to come to the facility were assisting with facility departments as needed.

Which components of incident were activated (i.e., which positions/groups were named)? Activated logistics, planning, finance, and operations sections of the command center to address specific needs within their role such as transportation for staff, planning for food service needs, and overall hospital operations.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? No additional positions were identified.

How was information disseminated throughout the facility to keep staff informed? Daily leadership safety huddle reporting with staff updates throughout the day.

Provide THREE strengths related to INCIDENT COMMAND.

1. Teamwork
2. Dependability
3. Resourcefulness

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Accountability
2. Vendor relations
3. Inventory control.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Teamwork between staff and leadership.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? By day three or four, deliveries were not occurring and members of leadership were going to vendors to obtain necessary items. Full vendor deliveries were delayed by several weeks with ordered items being delayed due to depleted stock at vendor warehousing.

What resources did you have difficulty procuring? How did you fulfill these needs? Patient care needs, food service needs, cleaning supplies. Leadership was able to acquire the facility needs by utilizing non-vendor suppliers when able or going directly to vendor to obtain necessary items.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Utilized box warehouse suppliers (Sam's/Costco) if items were available, local grocery stores when food service items were needed, and local non-contract suppliers who had cleaning supplies or stock inventory needed for daily patient care.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Materials Management mechanisms worked albeit with delayed deliveries. Utilized temporary plans for direct pickup from vendor or utilized facilities listed above for supplies.

How did this pandemic/natural disaster change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Attempts to maintain a larger supply of items on hand, use of new supply vendors, with decreased access control for supply inventory.

Provide THREE strengths related to RESOURCES.

1. Resourcefulness of leaders to look outside of normal vendors
2. Teamwork to manage limited supplies
3. Flexibility of leadership and staff to assist when necessary.

Provide THREE opportunities for improvement related to RESOURCES.

1. Accountability of facility for supplies on hand
2. Increased vendor relations with local facilities
3. Increased level/monitoring of supplies on hand.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Increasing vendor relationships for alternative sources of supplies.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, gloves, face shields, bonnets, shoe covers, thermometers, isolation gowns, etc.

What new materials/PPE/resources did you utilize that you had not previous utilized? HazMat suits, N95 masks, cleaning/disinfecting supplies, etc.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Yes, in the event of an outbreak.

How did your facility address extended use and/or reuse guidance for PPE? Items were not reused. Keep a stock of emergency supplies on hand.

How did your facility address COVID-19 patient and employee testing? Patients are tested prior to admission and again if patient displays any signs of symptoms of COVID. Employees are tested related to signs/symptoms of COVID.

What standard or innovative infectious disease barrier control methods did you use, if any? Isolation of any symptomatic patient and employees are required to quarantine at home if symptomatic or positive.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? No surge plan due to facility not being able to acutely care for infected patients. Patients testing positive were sent to acute healthcare facility for care.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Staff and patient understanding of new guidelines/responsibilities.

Provide THREE strengths related to INFECTION PREVENTION.

1. Leadership preparedness
2. Staff understanding of PPE use responsibilities
3. Appropriate hand hygiene at all times.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Inventory preparedness
2. Staff/patient education as disease process knowledge changed
3. Process for staff and/or patients who tested positive related to notification, cleaning responsibilities, and isolation requirements.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Staff response to responsibilities within the facility.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? CDC, Shelby County, Cities of Germantown, Collierville, and Memphis, City of Memphis Emergency Coalition, Shelby County Health Department, State of Tennessee Board of Health

What were the topics of community meetings or work groups that your organization participated in? Local/County/State/Federal information sharing related to PPE on hand and COVID cases; educational needs related to COVID outbreak, isolation requirements, patient care responsibilities

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, phone, and virtual meetings (Zoom, Microsoft Teams, GoToMeeting, etc.).

How did your organization address the distribution of federal, state, and local guidance? Information was filtered through the CNO/CEO and was then passed to the staff/patients as education.

What community partners did you work with during the pandemic that you had not previously worked with? Shelby County Health Department, State of Tennessee Health department, CDC

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Facility felt we were supported by local, county, state, and federal community partners as the wealth of information sharing that occurred throughout the pandemic.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? While it may not be an emergency, the facility plans to keep a supply of emergency equipment/supplies on hand in the event of another event/natural disaster.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Willingness to share information/supplies
2. Professionalism across the systems
3. Knowledge base of parties involved.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.
Timeliness/amount of information shared emergency supplies who get them and how much and how often.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Teamwork across facilities with local, county, state and federal partners.

DELTA SPECIALTY

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 18, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? During the Safer at Home directive, we suspended visitation for patient population. There were no other significant changes to scheduling or policies.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily communication amongst facility leadership as to staffing needs, PPE and COVID rates. We received weekly and at times bi-weekly updates from our corporate office, sent routine monthly updates to staff or as guidance changed. This type of communication was standard throughout Fall 2020 when the corporate updates decreased to every other week. To date we continue to review staffing needs, COVID rates and PPE daily.

Which components of incident were activated (i.e., which positions/groups were named)? All components of the ICS were activated due to staffing concerns, PPE procurement, testing, media, and required state reporting.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Infection Control is not typically a position that is identified solely in the ICS structure; however, this was a critical portion of the COVID-19 pandemic and integral part of ensuring patient and staff compliance. Quality/PI is also another position that was essential in ensuring up to date guidance was being disseminated and facility compliance.

How was information disseminated throughout the facility to keep staff informed? The facility used emails, in person training/education, bulletin boards, newsletters, flyers, and staffing communication to keep staff informed.

Provide THREE strengths related to INCIDENT COMMAND.

1. Staff knowledge overall regarding ensuring patient safety.
2. Flexibility/openness to cross training, moving units and positions to ensure coverage and ability to adapt to the changing guidance quickly.
3. Communication overall was a strength in that we had a corporate company who disseminated information quickly to the facilities, the collaborative efforts of the community and facility responses, and the effective communication within the facility as guidance changed.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Patient education.

2. Dealing with psychiatric populations, compliance with mask use and social distancing can be a significant challenge despite the level of education provided.
3. Security of the facility, quickly developing the process for staff check in and streamlining to one central point of contact due to facility size was an opportunity.
4. Utility management or ensuring all devices and rooms are appropriate and operational was an opportunity for improvement.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Streamlining supplies and internal supply management was an opportunity for improvement and became a strength. Our facility has a materials management department, as we entered into the pandemic, supplies were maintained, ordered and delivered. When the pandemic occurred, we experienced a tightening of supply procurement initially. This also meant that we needed a strengthening of storage to reduce the risk of supply loss when shortages of masks, gloves and other items were announced. Throughout the year, processes for requesting, emergency supplies of items and maintaining stocked PPE became a strength for the facility.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Delta experienced a very small window of supply chain disruptions occurring in June/July. The disruption lasted approximately 30 days or less and mainly effected gloves, masks (surgical and N95) and hand sanitizer appropriate for the patient population.

What resources did you have difficulty procuring? How did you fulfill these needs? The main items during the disruption were specific size gloves, hand sanitizer (due to patient population and need for non-alcohol based), and N-95/surgical masks. During the height of the disruption, we were able to reach out to our corporate company and notify of procurement needs. There was also the institution of additional vendors that we did not utilize on a frequent basis prior to the pandemic. In addition, the use of the MSEPC supplies when needed and available.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? The use of Henry Shine was new to the facility for vendors.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. As a part of a corporate company, additional measures to ensure appropriate management of supplies. This included daily reporting by the CFO to the corporate procurement office and utilization of the par level system to keep supplies at an appropriate level as to not have shortages.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The pandemic helped the facility to develop a par level and maintain an appropriate level of supplies in the event of an emergency where supplies are limited. The par

level is a system that we will continue to utilize moving forward to help keep a proactive approach to supply management.

Provide THREE strengths related to RESOURCES.

1. The first was locating additional supplies stored in the facility for emergency when operating at full capacity and with an ED. When searching for additional N95 masks and items that we needed for the pandemic, a supply trailer was located and had been appropriately stocked for use during a disaster. This also meant that other facilities that were looking for specific items were able to be assisted by our facility.
2. Oversight and management of the resources by the corporate company allowed for a more systematic approach with guidance and effective communication about the needs of the facility and collaboration between facilities.
3. Communication between procurement at corporate, facility leadership and front-line staff on what items were needed and supplies available.

Provide THREE opportunities for improvement related to RESOURCES.

1. Par levels and inventory were critical in this pandemic due to the continued changing guidance, "panic buying" and COVID rates. When the supply hit a certain level, more items should have been purchased, however, this initial process didn't occur and we found shortages within the facility of certain items.
2. Security of items were also an improvement opportunity as the pandemic became more intense, supplies were starting to disappear at a rapid rate increasing the need for more secure storage and communication about needs.
3. Communication about needs. As security with PPE became essential to maintain par levels, the process for communicating also needed to be disseminated and used. Communication was not a strength as many employees did not see the supplies on the units and therefore believed we had no PPE in the building. Making the request for items for immediate delivery was not clearly communicated with the staff at the time the changes were made.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Par levels and inventory was where most of the improvement opportunity existed. Using par levels, reporting to corporate, daily leadership updates and close monitoring of inventory/disbursement, we have simplified and communicated an effective process for supplies. Monitoring is occurring, security of items is occurring and overall, the materials management is highly effective at this time.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.). Mask, shoe covers, gowns, face shields, hair covers, N-95 masks, surgical masks were all items used to protect staff. Surgical/isolation masks were used for the patient population due to potential ligature risks.

What new materials/PPE/resources did you utilize that you had not previous utilized? There were no new materials/PPE/resources used that were not previous utilized.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Our facility will follow the specific guidelines according to the CDC, OSHA, Shelby County and corporate office. When COVID-19 is no longer an emergency, we will respond according to healthcare guidelines.

How did your facility address extended use and/or reuse guidance for PPE? Extended use for PPE was utilized with N-95 masks. The mask was given to staff with the expectation that the mask was used until it no longer had integrity. At which time it could be turned in for a new one. Staff were provided a paper bag to maintain and store the mask in.

How did your facility address COVID-19 patient and employee testing? Employees were tested offsite through their own PCP if symptoms were present. Patient testing was completed in house through rapid COVID testing if patient had symptoms of COVID-19 or were required for discharge placement.

What standard or innovative infectious disease barrier control methods did you use, if any? To increase infectious disease barrier control, social distance signs on the floor were used reminding staff, patients to maintain 6 feet apart to prevent the spread of COVID-19. In addition, hourly high touch disinfection cleaning was implemented on the units to decrease the spread of COVID-19.

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue? The on-site morgue was prepared for operation if needed, there was not a time during the pandemic in which it was utilized for COVID-19 reasons.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? A plan for infection disease surges was developed but did not need to be implemented during the pandemic.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? The patient population is primarily psychiatric which means that the compliance for patients wearing masks and maintaining social distance cues is limited. All attempts at reinforcing the guidance were made, however, patients refused repeatedly. Staff struggled with the mask use initially, however, continued efforts were made to gain 100% compliance with masking throughout the building and was reached and sustained.

Provide THREE strengths related to INFECTION PREVENTION.

1. As mask use among staff increased, the number of COVID-19 staff infections decreased. Masking, while initially was a weakness, became a strength at the facility.
2. Screening process for staff and patients. Once again, initially the screening process struggled to capture all the staff and patients to identify illness upon admission or entrance to the building. As time and practice became common, the screening process for patients and staff became a strength.
3. Education about COVID-19 was a strength in that we had a plethora of resources and information available, corporate, federal and local guidance and "experts" were available to discuss problems, question and infection control needs.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Masking was initially a significant opportunity for improvement. Throughout the pandemic, staff and patients alike disliked wearing masks but due to the potential risk, they were reinforced repeatedly. Masking was the biggest opportunity for improvement and quickly became a heavy focus with the facility.
2. Social distancing was an opportunity for improvement. Given the layout of the hospital for primarily med/surge capabilities, large group therapy sessions were not a primary thought and therefore spacing is limited to social distance. While it was a weakness, innovative ideas such as smaller groups, visual reminders and high touch cleaning to reduce the potential spread of COVID-19 were used.
3. Handwashing was also an opportunity for improvement.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. The screening process for COVID-19 for staff and patients was initially a weakness. After a patient with confirmed COVID-19 arrived on the unit and was not detected for a few days, the process for screening patients and communicating the COVID status were essential. Intake received additional training and heavy monitoring on documentation to review for COVID-19 status prior to transport to unit. The opening of a specific unit for COVID+ patients was developed so that they could be quarantined and reduce the risk of spreading to COVID- patients. In addition, the screening for staff, as mentioned earlier, gained significant improvement over the course of the pandemic, streamlining and promptly notifying appropriate leadership if someone presented ill or in need of additional screening for COVID-19.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? The Infection Control Preventionist maintained communication with the Health Department for reportable infections and the guidance for compliance. The CEO/Plant Ops maintained communication with the MSEPC, HRD communicated with OSHA, and the CFO with THA. There were several lines of communication between the facility and community partners.

What were the topics of community meetings or work groups that your organization participated in? THA and TJC held meetings related to COVID, progression and response. The Chief Nursing Officer attended virtual calls with other CNO's in the state discussing strategies and best practices.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Emails, phones, virtual through Zoom, Ring Central and Microsoft Teams.

How did your organization address the distribution of federal, state, and local guidance? Communicated federal, state and local guidance through email, newsletters, in-person education and bulletin boards.

How did your organization address the distribution of federal, state, and local funding opportunities? All funding opportunities were handled through email.

What community partners did you work with during the pandemic that you had not previously worked with? All community partners were previously worked collaborated with prior to the pandemic. There were no new community partners.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? All MOUs and agreements were in place prior to the pandemic. There were no new external partners or MOUs signed.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. There was significant support offered to the facility from the community. The health department, corporate office and THA all gave significant amounts of guidance, documents and webinars to keep everyone up to date on changing guidance.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We did not have any significant changes as it relates to partners and on-going communication and planning.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Communication between the facility and external partners
2. Knowledge disseminated from the facility and external partners.
3. Education provided from the external partners that we could in turn pass to our employees and patients.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Streamlining information- the guidance was changing so rapidly that while implementing new guidance it had changed again and many external partners did not have congruent guidance which caused conflicting implementation.
2. Consistent communication- external partners did not have congruent guidance throughout the pandemic, partially due to the trends in each state/city. However, significant time was placed on training and educating to the required regulations which were changing so rapidly.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Initially in the pandemic, there were many moments where the communication was overburdening and moments where communication was non-existent. Guidelines were changing so rapidly and it was not uncommon to get differing guidance from CMS, CDC, Shelby County, Tennessee Department of Health within the day. As more was known about COVID-19, we were able to see streamlined communication from the external partners which allowed for the more organized and efficient education and implementation of practice.

LAKESIDE

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? March 14, 2020

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation was stopped across campus effective March 2020. Clinical site rotations for nursing were interrupted and will not resume until August 2021.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initially and for over 60 days, daily interaction occurred with the senior command team. Daily communication was received from our corporate Incident Command staff for direction and/or communication with our staff. This changed to weekly, then bi-weekly and is now monthly since early 2021.

Which components of incident were activated, (i.e., which positions/groups were named)? CEO for the facility was identified as the Incident Commander and functioned as the Public Information Officer; The EOC Director functioned as the Safety Officer and took responsibility for all screening activities; Purchasing Manager functioned as the Logistics Section Chief and coordinated the PPE supplies with our corporate staff and our vendors; the CNO functioned as the Planning Section Chief; Infection Control Director worked as Operations Section Chief and handled all infection control and infection prevention activities; CFO functioned as the Finance Section Chief and updates HHS weekly; Dr. Ali functioned as the Medical-Technical Specialist.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Screening station staff were added to ensure 24/7 all individuals, staff, patients, vendors, are screened at a single point of entry to the facility. This station checks over 575 individuals daily.

How was information disseminated throughout the facility to keep staff informed? Shelby County Health Department updates, CDC updates, THA updates, Newsletter, postings on bulletin boards on units, shift hound messages, and overhead announcements several times a day.

Provide THREE strengths related to INCIDENT COMMAND.

1. Effective screening of all individuals entering the campus to ensure early detection of any symptoms, and to ensure patient and staff safety.
2. Masks are distributed to all staff and vendors at the single point of entry to the campus.

3. Communication with all staff, patients and providers that the facility follows all CDC, state and local guidelines to ensure safety.
4. Created a psychiatric setting with an effective milieu to ensure patients are safe with reduced risk for transmission of COVID-19 while receiving mental health and substance abuse treatment.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Improved technology for providers who elected to use tele-medicine for their patients.
2. Several applications such as Zoom, and DocuSign were implemented to assist in this process.
3. Improved technology for patients and families for family sessions.
4. Mask compliance for patients in a mental health hospital.
5. Patients are educated daily on the importance of compliance, are provided written and verbal communication on the importance of mask compliance in a community like setting, masks are readily available and distributed daily, and PA system announcements are done several times a day to remind patients of safety and to reduce risk of infection.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? The facility started experiencing supply chain disruptions in March 2020. There are still some items (non-alcohol-based hand sanitizer, paper scrubs) that the facility is struggling to obtain through normal supply chain.

What resources did you have difficulty procuring? How did you fulfill these needs? Hand sanitizer, cleaning disinfectants, PPE, paper scrubs. The facility utilized local resources (MSEPC) and corporate command center (UHS) to locate need resources.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? We used an individual that had ties to family members in China to purchase large quantities of PPE and infrared thermometers.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Our main vendors put everyone on allocation for supply requests, and this allowed a steady flow of resources for items we had purchased in the past. The corporate command center also implemented a “smart sheet” system that allowed all UHS facilities to send a daily inventory update of critical supplies, and the corporate office sourced and distributed resources as appropriate.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? The facility has increased the emergency inventory of PPE and hand sanitizer. The corporate office will also implement the "smart sheet" system as needed in the future.

Provide THREE strengths related to RESOURCES.

1. The facility allocation from vendors was very helpful.
2. The community support from MSEPC was a strength.
3. The corporate support was key for keeping needed resources on-hand.

Provide THREE opportunities for improvement related to RESOURCES.

1. Staffing was a challenge during the pandemic.
2. PPE and hand sanitizer were difficult to find at the beginning of the pandemic.
3. It was difficult to find disinfectant cleaning chemicals at the beginning of the event.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. It was difficult to find certain resources during the pandemic. The corporate command center implements a "smart sheet" system for all 400 UHS hospitals to use to provide inventory counts for critical resources. The corporate command center used this information to source and distribute needed items across the country.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Staff: N95 Respirators, Surgical Masks, hair covering, shields, gowns, gloves, shoe covering. Patients: Masks

What new materials/PPE/resources did you utilize that you had not previous utilized?
UV sanitizing equipment for N 95 masks

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? COVID screening of new admissions will continue. Employees will continue to be required to report illness symptoms after daily screening is no longer necessary.

How did your facility address extended use and/or reuse guidance for PPE? UV cleaning stations were utilized to disinfect staff N95 respirators that were not damaged or wet/soiled.

How did your facility address COVID-19 patient and employee testing? PCR and Rapid testing were utilized for patients exhibiting symptoms or post exposure. A separate isolation hall was

established to room presumptive positive patients pending test results. Staff were routinely rapid tested during outbreaks and removed from the schedule immediately if symptomatic or test results were positive.

What standard or innovative infectious disease barrier control methods did you use, if any?
Staff and patients were provided and expected to wear face coverings at all times. Staff providing direct care to COVID-19 positive patients were provided full head-to-toe PPE
Positive patients were placed in negative pressure rooms

What preparedness efforts did your on-site morgue engage in to prepare for surge? If you have no morgue, how did you address this issue?
No on-site morgue. Patients are transferred out to Medical Hospital ED's if medical status deteriorated to the point of respiratory or cardiac distress/failure.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response?
Strengths:

- Ability of hospital management to pull together to quickly devise a plan to ensure that every person entering our vast campus was properly screened.
- Communication with key personnel and local / state health department. This includes the ability to immediately respond as CDC guidelines were updated as the pandemic progressed.

Plan areas that were improved upon:

- Shortage of PPE supply, our management team was able to work with UHS corporate office and state / local health departments to ensure a steady supply of PPE was accessible to staff at all times.
- Patient Isolation areas were quickly assessed and negative pressure rooms added to house COVID positive patients and prevent transmission of airborne pathogens.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?
Our biggest challenge is/was ensuring patient mask compliance in our mental health hospital. Several steps are taken to educate patients on the importance of mask compliance: daily community groups to discuss the need to mask, PA system announcements to remind everyone in the hospital to properly wear a mask.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? The Infection Control Preventionist maintained communication with the Health Department for reportable infections and the guidance for compliance. The CEO/Plant Ops maintained communication with the MSEPC, HRD communicated with OSHA, and the CFO with THA. There were several lines of communication between the facility and community partners.

What were the topics of community meetings or work groups that your organization participated in? THA and TJC held meetings related to COVID, progression and response. The Chief Nursing Officer attended virtual calls with other CNO's in the state discussing strategies and best practices.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Emails, phones, virtual through Zoom, Ring Central and Microsoft Teams.

How did your organization address the distribution of federal, state, and local guidance? Communicated federal, state and local guidance through email, newsletters, in-person education and bulletin boards.

How did your organization address the distribution of federal, state, and local funding opportunities? All funding opportunities were handled through email.

What community partners did you work with during the pandemic that you had not previously worked with? All community partners were previously worked collaborated with prior to the pandemic. There were no new community partners.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? All MOUs and agreements were in place prior to the pandemic. There were no new external partners or MOUs signed.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. There was significant support offered to the facility from the community. The health department, corporate office and THA all gave significant amounts of guidance, documents and webinars to keep everyone up to date on changing guidance.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We did not have any significant changes as it relates to partners and on-going communication and planning.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Communication between the facility and external partners
2. Knowledge disseminated from the facility and external partners.
3. Education provided from the external partners that we could in turn pass to our employees and patients.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Streamlining information- the guidance was changing so rapidly that while implementing new guidance it had changed again and many external partners did not have congruent guidance which caused conflicting implementation.
2. Consistent communication- external partners did not have congruent guidance throughout the pandemic, partially due to the trends in each state/city. However, significant time was placed on training and educating to the required regulations which were changing so rapidly.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Initially in the pandemic, there were many moments where the communication was overburdening and moments where communication was non-existent. Guidelines were changing so rapidly and it was not uncommon to get differing guidance from CMS, CDC, Shelby County, Tennessee Department of Health within the day. As more was known about COVID-19, we were able to see streamlined communication from the external partners which allowed for the more organized and efficient education and implementation of practice.

MEMPHIS MENTAL HEALTH

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) 02/26/2020
How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Visitation canceled, nursing school's clinical rotations canceled Visitation policies, essential worker protocol, Alternative Workstation protocol

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Initially, we met daily. The team met as needed due to COVID related mandates from the Federal/ State Government. This was daily, bi-weekly or weekly based on the need

Which components of incident were activated (i.e., which positions/groups were named)? Incident command, Operations, Planning, logistics, Finance, Admissions, Maintenance, Human Resources, Medical

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Infection Control, Nursing

How was information disseminated throughout the facility to keep staff informed? Signage, tv monitors in hallway, email

Provide THREE strengths related to INCIDENT COMMAND.

1. Staff available to form IC
2. understanding the "flow" of ICS
3. Plans in effect for ICS during this type of event

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Activation of the ICS system
2. Communication
3. training on ICS

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The implementation of ICS. Although Staff knew what it was the "overall" aspect of implementing it was more understandable. This became a strength when multiple "emergency events" happened at the same time (Ice Storm, Internal Flooding)

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? We are not sure. But somewhere later in 2020 concerns over where we would get our masks from grew.

What resources did you have difficulty procuring? How did you fulfill these needs? Gowns, N95s, medical masks – TEMA Gloves, masks, and gowns are the main items. Other non-COVID specific items are delayed or not available due to backorders, shipping delays, and allocations by Vendors. Sought alternative vendors, waited on shipping /backorder delays. For allocated items by Vendor, we have had to find alternative items or suppliers.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Vendor sources that I utilized that were unfamiliar to our organizations included Henry Shein, Medical Solutions, Animax, Dia Medical, Fisher Scientific, and Forestry Supplier. Note – some of these vendors were part of a statewide contract and used by other agencies in the state, our organization had not used them previously.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. No. We had to start giving out supplies from Infection Control to decrease the rate of usage. Some processes had to be modified such as issuing of gloves, masks, and gowns was monitored closely to ensure sufficient supply of those items were available. It was necessary for the organization to formulate a plan in the event of an outbreak at our facility and estimate burn rate of supplies so that we could ensure we kept a sufficient supply on hand.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? I believe we are more prepared to face adversity

Provide THREE strengths related to RESOURCES.

1. Strong procurement director
2. Organized supply distribution
3. Monitoring

Provide THREE opportunities for improvement related to RESOURCES.

1. Communication
2. working relationship with departments that depend on procurement
3. Knowledge of ICS

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. The need for procurement on an ICS level and much of a pivotal role they play.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) varied over time depending on circumstances but basically masks (N95s at times) and eyewear in patient areas and the addition of gowns when positive patients present
What new materials/PPE/resources did you utilize that you had not previous utilized? N95s and eyewear

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? employee screening continues upon entry to the building

How did your facility address extended use and/or reuse guidance for PPE? N95s changed weekly, medical masks changed every 3 days (or when visibly soiled)

How did your facility address COVID-19 patient and employee testing? Initially, every employee and patient were tested. After that, any symptomatic person was tested, any employee returning from quarantine, and all new patients and employees.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? We already had one in place but it was reviewed by Quality and Environment of Care for needed updates.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? There were some issues for people reporting testing or close contact testing

Provide THREE strengths related to INFECTION PREVENTION.

1. Knowledge
2. Supplies
3. Staff available for Information

Provide THREE opportunities for improvement related to INFECTION PREVENTION.
Communication (Information was only available from the CEO down)

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
The seriousness of Infection Prevention and how easily contact, transfer contact and how diseases move invisibly.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communications? Tennessee Department of Health, Mid-South Coalition

What were the topics of community meetings or work groups that your organization participated in? Current numbers and statistics, plans, supplies

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? email, occasionally by phone

How did your organization address the distribution of federal, state, and local guidance? We monitored CDC guidelines and made necessary changes,

How did your organization address the distribution of federal, state, and local funding opportunities? Procurement handled that on a state level

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Really can't answer this. But we did have conversations and decisions relating to whether we should request supplies from Mid-South Coalition since the State Supplied MSCEP.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Open communication
2. Transparency
3. Relationship strengthening

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Develop working relationships with more external partners
2. Maintain those relationships
3. Assign someone to do that

WEST TENNESSEE HOMES

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? It was activated on
How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The facility Safer at Home directive affected parents emotionally because there were no outside visits allowed, a screening policy was put into place before coming into the homes, all medical appointments and outings were stopped.
How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The group engaged daily to discuss the events and view the news updates.

Which components of incident command were activated (i.e., which positions/groups were named)? The incident component that was activated was Safer at Home.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Additional responsibilities were reporting the positive cases of COVID 19 daily.

How was information disseminated throughout the facility to keep staff informed? Information was disseminated throughout the facility by news updates, information from Open Lines, virtual meetings, and radio.

Provide THREE strengths related to INCIDENT COMMAND.

1. Keeping staff informed
2. Keeping up with the positive cases within the facility
3. Learning new ways of communication.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Being more prepared with the information
2. Making sure back up staff are available
3. Prepared to perform job duties.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began.
Narrative - One opportunity that became a strength since COVID 19 of Incident Command is being more prepared with information.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Limited disruption started when the world went on shut down. This lasted about three (3) months.

What resources did you have difficulty procuring? How did you fulfill these needs? Resources we had difficulty procuring were masks, face shields and gowns. Needs were fulfilled by reusing what we had at hand.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Management mechanism/ policies/ procedures worked but they had to be modified to fit the home needs. Meaning coverage was changed, floating stopped and sharing staff ended.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? This pandemic changed the preparedness plan moving forward by having more supplies available and vendors notified of emergency usage needed to be shipped to the facility.

Provide THREE strengths related to RESOURCES.

1. Working with what you had
2. Being creative with the material while be safe
3. Thinking outside the box of ways to maintain the resources.

Provide THREE opportunities for improvement related to RESOURCES.

1. Having ample of supplies available
2. Having a vendor ready to ship more or extra supplies
3. Notifying the higher up administrator of the situation at hand.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Narrative – One opportunity that became a strength since COVID 19 of Resources is reaching out to more vendors that handle the supplies that’s needed.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) PPE/ resources used were masks, face shields, gowns, gloves, and shoe coverings.

What new materials/PPE/resources did you utilize that you had not previous utilized? PPE/ resources that was utilized that had not be utilized was shoe coverings.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? Screening and the positive case of COVID 19 protocol be quarantine.

How did your facility address extended use and/or reuse guidance for PPE? Addressing the extended use of PPE was that all reusable PPE had to be sanitized.

How did your facility address COVID-19 patient and employee testing? Employees are tested once a week for COVID 19. Patients were advised to Safer at Home directive.

What standard or innovative infectious disease barrier control methods did you use, if any? Always protect yourself using the PPE as if everyone was infected.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? Infectious disease surge plan was to clean and wipe down everything once a case was reported within the home. The strength was controlling the spread and eliminating the virus.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Issues with staff no, some patients were not understanding of the no visits/ Safer at Home guidelines.

Provide THREE strengths related to INFECTION PREVENTION.

1. Using the PPE/ resources daily
2. Cleaning and wiping things down to eliminate the virus
3. Maintaining social distancing.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Having more PPE/ resources on hand
2. Ample supply of sanitizer
3. Supplies arriving in a timely manner.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Narrative - One opportunity that became a strength since COVID 19 of Infection Prevention is maintaining social distancing.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining those communications? Purchasing was responsible for communication to the external partners
What were the topics of community meetings or work groups that your organization participated in? Topic meetings were coverage and staffing within the homes.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Communication with external partner were emails and telephones.

How did your organization address the distribution of federal, state, and local guidance? Federal/ state/ local guidance was communicated by emails and virtual meetings.
How did your organization address the distribution of federal, state, and local funding opportunities? Organization talked about the funds.

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? None
Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Not supported locally, state or federally. The facility was not given PPE supplies and sanitizer like the hospitals which the Individuals that we care for are as critical as the hospital patients. Funding was not given to staff for hazard pay during the pandemic.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? We are still taking precautions by wearing a mask if we are within 6 feet of anyone and only going on community outings where we are able to space out. COVID-19 is still seen as an emergency.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Having some assistance
2. Knowing who's available within the community
3. Maintaining a relationship.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Communicate with the partners more not just in emergencies
2. Invite more partners in and visit the external partners environment.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began.
Narrative - One opportunity that became a strength since COVID 19 of External Partners is having more partners interaction.

PUBLIC HEALTH

SHELBY COUNTY HEALTH DEPARTMENT

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date) On March 8, 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? Some employees of Shelby County Government and the Health Department worked remotely from home.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. PHEPP would engage/meet daily either in person or virtual.

Which components of incident were activated (i.e., which positions/groups were named)? The entire incident command structure was implemented and used.

How was information disseminated throughout the facility to keep staff informed? Email, meetings, phone contacts.

Provide THREE strengths related to INCIDENT COMMAND.

1. Centralized collaborative decision making
2. Enhanced organization
3. Integration of all health department resources.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Enhanced training
2. Predetermination of roles and responsibilities
3. Become competent not just compliant with ICS.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. The opportunity to enhanced ICS training across the entire health department.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last? Supply chain disruptions began early in the event and the disruptions lasted until March of 2021.

What resources did you have difficulty procuring? How did you fulfill these needs? All forms of PPE (gloves, gowns, mask). Fulfilled by allocation with vendors. Supply demands that were not met by vendors were taken care of through the Shelby County EOC and the State of Tennessee.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization? Boundtree Medical became our just in time vendor as they have a large distribution center within 30 min to the area and were able to fill request with little difficulty rather quickly.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe. Initially we had some difficulty with internal finance not understanding emergency procurement and funding of critical supplies and equipment to supply the response effort. The situation was addressed.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations? Improving of inventory control measures, PHEPP warehouse reorganization, and, as stated above, and good understanding of emergency procurement processes by finance.

Provide THREE strengths related to RESOURCES.
Just in time supply with local vendors.

Provide THREE opportunities for improvement related to RESOURCES.

1. Seek vendor in non-emergent times … emergent declaration for purchasing
2. Realizing and reporting logistical needs early on in an event
3. Having more than one approved vendor to provided supplies and equipment to support an event – given the long-term need.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. A universal understanding of purchasing practices during a crisis and having multiple vendors for resources.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) All.

What new materials/PPE/resources did you utilize that you had not previous utilized? Face shields, gloves, hand sanitizer and wipes.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? YES, continued screening at some levels and enhanced awareness with new variants.

How did your facility address extended use and/or reuse guidance for PPE? We did not incorporate a reuse strategy.

How did your facility address COVID-19 patient and employee testing? Utilization of our COVID-19 Response Unit, drive through testing stations with our external partners.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? Common vaccine hesitancy with some employees.

Provide THREE strengths related to INFECTION PREVENTION.

1. Enhance hygiene compliance
2. Use of PPE
3. Social distancing obedience.

Provide THREE opportunities for improvement related to INFECTION PREVENTION. Continuance of prevention items in above question.

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began. Enhance hygiene, use of PPE when appropriate and recommended and/or required.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? EMA, CDC, SNS, FEMA, RHC, MSEPC, MRC Volunteers, TDH, City of Memphis Government, State EMS, Private EMS organizations, Media (all forms).

Who were the responsible parties/job titles that were responsible for maintaining that communications? Organizational leaders of each agency

What were the topics of community meetings or work groups that your organization participated in? COVID-19 Testing and Vaccine Campaigns and related planning efforts.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? All forms as listed.

How did your organization address the distribution of federal, state, and local guidance? PIOs along with email, phone, virtual meeting platforms.

How did your organization address the distribution of federal, state, and local funding opportunities? Finance and administration worked with local and State authorities to acquire Emergency COVID funding.

What community partners did you work with during the pandemic that you had not previously worked with? Non-Government Organizations (NGOs)

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement? NGOs

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes…TDH, EMA, Churches, MATA, other PHEPP Programs, and physician offices, clinics, and hospitals.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Include external partners in planning, training, and communications.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Collaboration
2. Improvement of relationships
3. Increase outreach efforts.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Outreach
2. Training
3. Collaboration.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Collaboration.

EMERGENCY MANAGEMENT

City of Memphis Office of Emergency Management

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date)
EM activated the Emergency Response Plan March 9th, 2020.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)? The City of Memphis Office of Emergency Management increased staff capacity and hours to address planning and response needs.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. The City of Memphis Office of Emergency Management attended daily internal meetings as well as meetings with all community stakeholders. In addition, OEM hosted the COVID-19 Joint Task Force Meetings for the region.

Which components of incident were activated (i.e., which positions/groups were named)?
City of Memphis Worked with Shelby County and the other municipalities to create the Joint COVID Task Force to manage the response within Memphis and Shelby County.

How was information disseminated throughout the facility to keep staff informed?
Standard means of Communications

- Print posters and flyers on the exterior of the building all entrance points.
- Print posters and flyers throughout the interior of the facility.
- Updated guidance and policies and procedures from the City of Memphis Leadership via emails updates and bulletins and meetings

Provide THREE strengths related to INCIDENT COMMAND.

1. Modular Organization
2. Manageable span of control
3. Unified Command

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Information and intelligence management
2. Incident facilities and locations
3. Comprehensive resource management

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last?

a. OEM started to have trouble in getting cleaning supplies the second week of March.
b. This challenge impacted OEM for about two months.

What resources did you have difficulty procuring? How did you fulfill these needs?

a. Cleaning supplies
b. Hand sanitizer
c. Surgical Masks
d. N95 Masks
e. Thermometers

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization?
OEM utilized a centralized ordering point for City of Memphis divisions that was established by the ESF-7 Lead, General Services Division, to acquire needed supplies throughout the event.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.
No, the normal supply chain for certain supplies was strained.
The City of Memphis Office of Emergency Management along with ESF-7 Logistics created a materials management system with policies and procedures for all City of Memphis Divisions and other stakeholders to request certain supplies, e.g., mask, gloves, gowns, face shields, goggles, cleaning supplies, etc.

- All City Divisions and response partners were organized into 16 Emergency Support Functions (ESFs), such as Firefighting, Law Enforcement, Transportation, and Utilities. These ESFs provide the structure for grouping functions most frequently used to provide support to the city during a disaster or Emergency.
- Every ESF has a Lead Agency and that lead agency was responsible for collecting and screening supply requests from supporting agencies and departments based on set criteria, e.g., number of employees, burn rate, public interface, etc.
- Once those requests were submitted to the Lead Agency, they were then placed in the ASANA platform and routed to ESF-5 Information and Planning for approval.
- Once approved they were sent to ESF-7 Logistics for fulfillment.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) N95 and Surgical Masks and Thermometers.

What new materials/PPE/resources did you utilize that you had not previous utilized?

- As CDC guidelines changed to recommend face masks for all, face coverings were encouraged and later required for staff as well as visitors to OEM.
- OEM contracted a janitorial service to increase and adapt cleaning protocols.
- Mandatory safety Checkpoints were established for staff where thermometers and additional cleaning supplies and masks were available for staff to perform self-checks.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)? The City of Memphis Office of Emergency Management will follow the policies put forth by the City of Memphis and the Division of Fire Services.

How did your facility address COVID-19 patient and employee testing? COVID-19 testing was made available to all OEM personnel, both symptomatic and non-symptomatic as supplies and protocols dictated.

What standard or innovative infectious disease barrier control methods did you use, if any? OEM personnel observed CDC guidelines and safety procedures.

Did your facility have or use an infectious disease surge plan? What strengths and weaknesses have you since identified in that plan? If you had no plan, have you created a plan based on your COVID-19 response? The City of Memphis Office of Emergency Management followed the City of Memphis Division of Fire Services Infectious Disease protocols and guidance.

Did you have any issues with staff and/or patient compliance to new infectious disease policies? There were no compliance issues at OEM.

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic? Who were the responsible parties/job titles that were responsible for maintaining that communication?

- It was important for the City of Memphis to engage in communication and coordination with neighboring cities, counties, and the State of Tennessee. Led by the City's Emergency Manager, Director Gina Sweat, and CAO, Doug McGowen, The City of Memphis Office of Emergency Management activated the City's EOC to coordinate emergency response on March 9th.
- The Office of Emergency Management communicated and coordinated with the following agencies throughout the pandemic.
    - Shelby County Health Department
    - Shelby County Emergency Management and Homeland Security Agency
    - Mid-South Emergency Planning coalition
    - Tennessee Emergency Management Agency
- The CAO, City Emergency Manager, OEM Manager, OEM Supervisors, and designees were responsible for attending meetings and maintaining communications with appropriate stakeholders for OEM throughout the COVID response.

What were the topics of community meetings or work groups that your organization participated in?

- The City of Memphis Office of Emergency Management hosted the Memphis Shelby County Joint COVID Task Force. The task Force calls addressed:
  - COVID-19 Data Trends in the Community, presented by the Shelby County Health Department
  - Emergency Support Function updates from City and County Partners
  - Updates from Hospital Partners
  - Updates from Education Partners
  - Updates on from Shelby County Mayor's Office
  - Updates from Municipalities in Shelby County
  - Updates from regional government partners
- Shelby County Emergency Managers Meetings
  - This meeting was for the Emergency Managers of Shelby County and the municipalities to discuss needs and ideas as it related to the COVID-19 response.
- ESF 7 Logistics Meetings
  - This meeting was to discuss the supply shortages and systems put in place to address those shortages.
- Memphis Surge Team Meetings
  - This meeting was to discuss the Hospital Surge issues.
- Division of Fire Services COVID Task Force Meetings
  - This meeting focused on the COVID response for the Division of Fire Services.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? The Office of Emergency Management utilized email, phone, and virtual meeting platforms throughout the COVID-19 response.

How did your organization address the distribution of federal, state, and local guidance? OEM worked with the Chief Administrative Officer's Office and the City's Office of Communications on strategies for distribution of federal, state, and local guidance. It was Distributed via:

- Print
- Digital
- Social Media

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported. Yes, information and resource flowed from the top down throughout the response efforts.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? OEM will continue to collaborate, plan, and exercise for events with City personnel from all City Divisions and Bureaus, County and State response partners and our non-Governmental partners after COVID-19.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Public and Private Sectors were able pool financial resources to improve the delivery of goods and services.
2. Enhanced response and recovery by maximizing available resources and ensuring integrated communications.
3. Having pre-established relationships with external partners allowed for greater clarity and situational awareness by being able to engage stakeholders throughout the community in a timely and efficient manner.

SHELBY COUNTY EMERGENCY MANAGEMENT AND HOMELAND SECURITY

INCIDENT COMMAND

When did you activate your facility incident command or emergency plan? (date)
Virtual Activation declared on March 23, 2020 to Level 4 Status.

How was your facility affected by the initial Safer at Home directives (i.e., canceled elective surgeries, visitation policies, or other closures)?

- The agency encountered minimal operational impacts relative to daily operations upon the issuance of the Safer at Home Order. The primary operating site, within the Shelby County EOC, is not customarily open to public access. Restricted access is not particularly problematic.
- Shelby County Government implemented Alternate Workplace Staffing procedures, which aligned with local Stay-At-Home Orders.
- Virtual Activation declared on March 23, 2020 to Level 4 Status. During the virtual activation, all ESF's were instructed to report situational updates through the virtual EOC.
- Shelby County Emergency Management currently maintains a virtual platform; therefore, procedures for transitioning to a fully remote platform were easily implemented.

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence.

- Upon the activation of the Shelby County EOC, local emergency services liaisons participated virtual coordination meetings approximately every 48-72 hours.
- Senior leadership from municipal jurisdictions conducted planning and coordination sessions more frequently, with coordination calls occurring approximately every 24-48 hours.
- As the incident stabilized, coordination and planning calls became more consistent and regimented, occurring on a consistent weekly cycle.

Which components of incident were activated (i.e., which positions/groups were named)?

- The Emergency Services branch of the Emergency Management structure was activated within the first 14 days of first positive case in Shelby County.
- Functions Include: ESF 4: Firefighting, ESF 5: Information and Planning, ESF 6: Mass Care and Human Needs, ESF 7: Resource Management, ESF 8: Health and Medical Services, and ESF 13: Law Enforcement
- Agency-based functions were activated within 7 days of the first confirmed case in Shelby County that included Planning, Information Management, Logistics, Finance, and Operations.

- Public information was by the SCHD due to the scope and nature of the incident; therefore, all requests and inquiries were routed directly to ESF 8 PIO designees.

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? Additional functions activated included Animal Services, Community Services Agency, and Shelby County Facility Support Services

How was information disseminated throughout the facility to keep staff informed?

- Shelby County employees were informed through multiple Social Media platforms, traditional broadcast outlets, print releases, emails, and virtual connection platforms (Zoom, GoToMeeting, etc.)
- Internal staff updates were disseminated through an internal incident management platform, traditional coordination calls, virtual meeting work sessions, and emails.

Provide THREE strengths related to INCIDENT COMMAND.

1. The Command-and-Control component was clearly identified, established, and easily implemented within the Virtual EOC.
2. Resource Management processes were pre-determined and increasing resource requests were easily accommodated
3. Emergency Response personnel understood and implanted the overarching organizational structure and functional components quite well. Most agencies utilize ICS and NIMS within their regular management of adverse incidents.

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Provide more training to external agencies and organizations that do not utilize ICS processes daily. Many external agencies have frequently misunderstood the application and implementation of ICS.
2. There were challenges relative to short and long- term planning goals specific to infectious diseases and public health. It may be helpful to create a planning committee that updates and maintains Pandemic and Infectious Disease Plans. It would be helpful to make these plans accessible to the appropriate agencies.
3. Information collection and dissemination was extremely difficult for the first 6 months of the incident. Multiple jurisdictional agencies voiced concerns at the lack of coordination and communication with healthcare officials. This created a cascading effect that sparked fear and frustration among first responders. It also created a perception that municipal agencies made no effort to plan or coordinate.

Narrative – What is at least ONE opportunity for improvement related to INCIDENT COMMAND that has become a strength (or close to) since the COVID-19 response began. Increased capabilities specific to Logistics and Resource Management.

RESOURCES

When did you begin to have supply chain disruptions leading to limited resources? How long did this last?

- Supply Chain disruptions were noted immediately upon virtual activation of the Shelby County EOC.
- Logistics personnel began having difficulty immediately is locating thermometers, Personal Protective Equipment, and disinfecting products.
- Supply chains began to stabilize in first 90 days due to purchasing restrictions implemented by many suppliers.

What resources did you have difficulty procuring? How did you fulfill these needs?

- Personal Protective Equipment (Gloves, masks, gowns-etc.,) thermometers, hand sanitizer, disinfecting wipes.

What procurement sources or vendors did you utilize that were new or unfamiliar to your organization?

- Logistics personnel expanded search to include national and international suppliers, bypassing Shelby County purchasing regulations, which is permitted during a disaster declaration.
- Also coordinated with the State EOC to expand Personal Protective Equipment pipelines.

Did your normal materials management mechanisms/policies/procedures continue to work? If not, did your organization create new and/or temporary management plans? Please describe.

- No- Resource management personnel contacted multiple vendors at the local and regional level with a minimal amount of success in locating materials and supplies.
- Agency personnel encountered multiple instances of entities advertising fraudulent and counterfeit merchandise.

How did this pandemic change your preparedness plan moving forward as it relates to emergency procurement, emergency storage, and other supply chain or stored inventory considerations?

- No changes in department procurement procedures. Current processes utilize best practices of sourcing supplies and resources through local, regional, and national suppliers of varying size.
- Supply Chain disruptions facilitated initiatives to improve procedures relative to inventory acquisitions and management. Specifically- storage, rotational distribution, maintenance, testing, and inventory control.

Provide THREE strengths related to RESOURCES.

1. Expanded capabilities of movement, security, and reconciliation of resources
2. Increased in controlled storage capacity
3. Improved understanding and application of material management

Provide THREE opportunities for improvement related to RESOURCES.

1. Provide more regional training on logistics management and resource requesting processes. Processes utilized during COVID have created confusion on the legal limits of supplying private and for-profit companies with publicly funded assets and supplies.
2. Provide more program guidance specific to the local, state, and federal regulations relative to resource requests and public assistance reimbursements. COVID has created much confusion on how public assistance works and what is legally permissible when seeking reimbursements. This is requiring a great deal of unravelling.
3. Identify enhanced planning processes focusing on Health and Medical preparedness and makes those improvements available to appropriate external agencies.
4. Multiple assets were damaged and /or destroyed during COVID activities. Update agency-based MOUs to include damaged and/or repairs. MOU's currently being revised to address damage and repairs to provisioned/loaned equipment.

Narrative – What is at least ONE opportunity for improvement related to RESOURCES that has become a strength (or close to) since the COVID-19 response began. Improved capabilities and processes specific to Inventory control, and materials management.

INFECTION PREVENTION

What Personal Protective Equipment and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Personal Protective Equipment was used for staff only- Masks, gloves, disinfecting wipes, disinfectant spray. Patient care not within agency scope.

What new materials/Personal Protective Equipment /resources did you utilize that you had not previous utilized? UV lightning, Cloth facial coverings.

Does your organization have any plans of keeping any of your COVID-19 employee or patient safety policies in place when COVID-19 is no longer an emergency (i.e., screening, visitation, etc.)?

- Patient safety policies are not applicable to this organization.
- Social distancing and utilization of virtual platforms will continue during routine operations

How did your facility address extended use and/or reuse guidance for Personal Protective Equipment?

- Utilized guidance provided by TDH regarding usage of N-95/KN-95 masks in correlation to cloth masks.
- Staff not providing direct patient care utilized cloth masks.

How did your facility address COVID-19 patient and employee testing? Used recommended SCHD guidance on exposures and testing/re-testing.

Did you have any issues with staff and/or patient compliance to new infectious disease policies?

- Mask compliance was initially problematic during the first 6 weeks
- Initial vaccine hesitancy

Provide THREE strengths related to INFECTION PREVENTION.

1. Alternate Workplace Staffing system and resources in place prior to Stay-At-Home Order. Easily activated and implemented
2. 90% compliance with masks mandates and social distancing.
3. 90% vaccination rate among staff members.

Provide THREE opportunities for improvement related to INFECTION PREVENTION.

1. Developing Sheltering Annex which incorporates non-congregate components
2. Maintain readily accessible supplies of infection control supplies such as hand sanitizers and disinfecting spray

Narrative – What is at least ONE opportunity for improvement related to INFECTION PREVENTION that has become a strength (or close to) since the COVID-19 response began.
Expand planning frameworks to incorporate more pandemic specific guidance such as facial coverings, virtual work environments and social distancing

EXTERNAL PARTNERS

What external partners did you communicate with the most during the ongoing pandemic?
Over 50 public safety/emergency response agencies in Shelby County are currently engaged in the Memphis/Shelby County UASI working Group.

Who were the responsible parties/job titles that were responsible for maintaining that communication?

- General communications authorized through agency administration - Director and Deputy Administrator
- The PIO is typically responsible for communication of information such as was seen in this incident. Due to the scope and scale, the Shelby County Health Dept- but it was not clear who was responsible for maintaining communication.

What were the topics of community meetings or work groups that your organization participated in? COVID- All working groups suspended activity not related to COVID. All activity focused on COVID from March 2020 till about 30 days ago.

What were the primary ways in which you communicated with external partners (email, phone, virtual meeting platforms, etc.)? Email, Sitreps, Briefings, web-based incident management platforms, virtual meetings-multiple platforms, and coordination calls

How did your organization address the distribution of federal, state, and local guidance? Planning section monitored the changing guidance and distributed to administration for review and approval in dissemination. All information is reviewed prior to distribution. COVID specific guidance shifted in a matter of hours, creating challenges in maintaining situational awareness

How did your organization address the distribution of federal, state, and local funding opportunities? For funding specific to EM, information was distributed via email, sitreps/briefings, virtual incident management platforms, and coordination calls.

What community partners did you work with during the pandemic that you had not previously worked with? Community Services Agency

Has your organization created any new MOUs/agreement during this pandemic with external partners? Who were those partners and what was the topic of agreement?

- No new agreements but several were updated to include the ARC, CSA, and SCHD.
- Multiple pieces of equipment were damaged.

Did you feel like your organization was supported by local community partners? State partners? Federal partners? If so, please provide examples. If not, please explain how you could have been better supported.

- Yes and No- local support was extremely disjointed and uncoordinated. Emergency response agencies are limited in the authorities relative to command and control of public health incidents. Emergency response agencies struggled to coordinate with healthcare organizations.
- State agencies provided an incredible amount of support and guidance. Communication was well organized and thorough.

How has your organization's emergency planning changed moving forward as it relates to partners and on-going communication and planning after COVID-19 is no longer an emergency? Planning now incorporates more virtual and alternate technologies as well as adjusted implementation.

Provide THREE strengths related to EXTERNAL PARTNERS.

1. Many existing partnerships were utilized during the pandemic for strategic allocation and usage of resources.
2. Many perimeter agencies and organizations were engaged and responsive to invitations and work sessions that have historically been unengaged.
3. Communication and information sharing with other emergency response agencies was outstanding.

Provide THREE opportunities for improvement related to EXTERNAL PARTNERS.

1. Coordination with Shelby County Health Department was challenging.

2. The scope of the incident limited the authorities of emergency response agencies, but many planning and coordination matters required to command and control through SCHD.

Narrative – What is at least ONE opportunity for improvement related to EXTERNAL PARTNERS that has become a strength (or close to) since the COVID-19 response began. Agencies who have historically been detached from collaborative planning efforts where engaged and receptive specifically within emergency services branch.

EMERGENCY MEDICAL SERVICES

MEMPHIS FIRE DEPARTMENT

INCIDENT COMMAND

How was your facility affected by the initial Safer at Home directives? No changes to MFD response personnel staffing. Admin staffing worked from home

How often did that group meet/engage? Weekly? Daily? Feel free to include any changes in occurrence. Daily in the beginning, which transitioned to weekly, bi-weekly, etc. as the response became "normalized."

Which components of incident were activated (i.e., which positions/groups were named)? All

What, if any, additional positions and/or responsibilities were identified that were not part of the traditional incident command? All positions were included in traditional IC roles in branches, divisions, and groups

How was information disseminated throughout the facility to keep staff informed? Email and verbally

Provide THREE strengths related to INCIDENT COMMAND.

1. Defined chain of command
2. IAPs
3. Identification of objectives

Provide THREE opportunities for improvement related to INCIDENT COMMAND.

1. Not all MFD personnel are familiar with expanded ICS structure
2. Civilians utilized for testing, vaccinations were unfamiliar with ICS
3. Personnel did not refer to IAPs to identify chain of command and responsibility

RESOURCES

What resources did you have difficulty procuring? All forms of PPE How did you fulfill these needs? Utilized purchasing power of City of Memphis and multiple vendors to purchase large quantities of PPE and cleaning supplies.

Did your normal materials management mechanisms/policies/procedures continue to work? Some did, some did not. If not, did your organization create new and/or temporary management plans? Please describe. I believe so, but the details are not known to me.

INFECTION PREVENTION

What PPE and/or resources did you use to protect staff? To protect patients? (i.e., masks, face shields, half masks, etc.) Masks, face shields, gloves, gowns

What new materials/PPE/resources did you utilize that you had not previous utilized? None. However, while N95s, gowns, and face shields are part of our inventory, they were rarely used prior to COVID 19.

How did your facility address extended use and/or reuse guidance for PPE? N95 were reused unless exposed to known or suspected COVID 19 patient during early response before sufficient inventory was available. Other items were single use.

How did your facility address COVID-19 patient and employee testing? Free testing for employees was offered regularly for each division when supply chain allowed.

*Facility did not submit evaluation documentation for EXTERNAL PARTNERS section.

FINDINGS FOR POTENTIAL ACTION BY THE HEALTHCARE COALITION

The beginning months of the global COVID-19 pandemic was a unique and trying time for our region's healthcare facilities. Never have we experienced such an impactful event affecting every aspect of healthcare, and everyday life, simultaneously. Although we have planned, prepared, and exercised for infectious disease pandemics, we were not prepared for the level, and length, of response the event would require.

To capture an overview of our facilities' experiences to the initial struggles of the pandemic, MSEPC developed the evaluation documents represented in the preceding sections. Through these evaluations, we found several issues common to most of the participating facilities. Since these items represent trends across the entire region, MSEPC considers addressing the issues in a more strategic approach to improving capabilities for all member healthcare organizations.

Overall Strengths and Improvement Opportunities

The COVID-19 pandemic response required a whole community-based approach. All facilities involved proved their resilience and dedication to protecting the lives of our residents. The communication and collaboration between healthcare providers in hospitals, clinics, rehabilitation centers, home health agencies, hospice agencies, renal care centers, ambulatory surgery centers, behavioral health centers, Emergency Management, Public Health, Emergency Medical Services, and others was the greatest strength of this response. Each entity quickly implemented innovative ideas to manage the supply chain and other unprecedented issues.

Although communication with external partners was a great strength, many facilities indicated internal communication to the front-line workers needed improvement. Changes were happening so quickly, and often made or established at an executive or corporate level, but information dissemination to front line staff took longer. For many facilities, updated information was unusual, atypical, or completely against long-used practices. Most of the time, these changes were necessary to adjust to supply chain issues, scientific unknowns of the pandemic, or staffing issues. Decisions were difficult to make and slower to implement widely.

As healthcare facilities across the world began to respond to the same virus, they also began to compete for the same supplies. Vendors were forced to establish allocation limits or refuse to take on new customers so they could preserve their inventory. Vendors that would sale to facilities often marked up the prices of their products or the only products available were different models or styles and some lacked the same regulatory approvals to the products facilities were using prior to the pandemic.

Many facilities, including MSEPC, discussed the possibility, and feasibility, of stockpiling critical supplies or increasing par level amounts compared to pre-COVID because of these supply chain issues. Ironically, the supply chain issues made it nearly impossible to consider

stockpiling in the moment, so the only thing left to do was to survive the pandemic with the resources at hand. Partnerships like MSEPC and other Coalitions; local, state, and federal allocations through programs like the Strategic National Stockpile (SNS); and access to vendors proved to be a vital asset and highlighted the need for further discussion surrounding resources at a regional level.

Incident Command

Nearly all our facilities reported activating the Incident Command System (ICS), or Hospital Incident Command System (HICS) more specifically, to some level as the pandemic began in March. Positions varied from facilities as well as the frequency of meetings, but evaluations showed that facilities could expand ICS as intended to meet the demands of the initial response.

For some facilities, although ICS was activated without issue, they still reported some disorganization among the positions. Exercises often provided limited and very organized exposure to the ICS or HICS structure for potential positions. And, as we quickly found out, real world mass casualty events often occur and are resolved in a much shorter time span, limiting the need for full, and extended, HICS activations. Because of this, and the need for the rotation of HICS positions, many staff filling positions has limited knowledge of HICS or the proper implementation process.

Facilities should strongly consider establishing, and enforcing, minimum HICS course requirements (100, 200, 700, and 800, for example) for anyone expected to hold a Command Staff position. Since these courses are online and highly general, facilities should conduct routine exercises and drills to enhance exposure of staff to HICS processes and principles.

The MSEPC should also consider establishing a training schedule to offer introductory or refresher courses more broadly to the Coalition membership facilities. These trainings should review both the basics of HICS as well as more in-depth overviews of specific aspects of HICS such as the use of Job Action Sheets and other forms, requesting and assigning resources, and using Coalition sponsored information sharing platforms during events.

Resources

Previously conducted supply chain issues, and developed plans for continuity of operations, did not include the level to which resource availability was affected. The global nature of the response led to extreme shortages in supply to meet the extreme heights of demand. Nearly every aspect of our lives was somehow impacted by this resources availability crisis.

Larger facilities, especially those with corporate control, were able to reach out to partners in other states and countries to fulfill resource needs like gowns, masks, gloves, and other PPE products – but it came with a high price tag. Smaller facilities reported struggling to find PPE in the quantities needed from their usual vendors, and had to rely on more innovative means to

procure resources, like Amazon, Walmart, and other consumer sites where they would be competing against local residents for similar products.

MSEPC was provided limited supplies from the Strategic National Stockpile by the state and federal governments, but it was not enough to effectively supply all our healthcare partners. And much of the PPE received was either expired (although deemed acceptable because dire circumstances) or unsafe for the intended use (exam gown provided but surgical gown needed, for example). MSEPC distributed all resources provided through an established resource request system, but it was still a struggle to assist facilities in finding items they were requesting that the Coalition did not have.

Although it was meant as support, the government procurement of millions (billions) of PPE products made it a more competitive market for healthcare facilities. The distribution of the PPE products obtained by county emergency management from state partners was difficult to manage and understand. Emergency management leaders were not aware of the process of allocations for our private healthcare partners and how many vendors were refusing to take on new customers and imposing strict limits that made it impossible for our facilities to maintain proper inventories on their own.

The MSEPC, as an organization, and its members individually should consider establishing a supply list of necessary all hazard items, minimum par levels for the facility and region, and a vendor directory to aid with future events.

As the pandemic lingered on, staffing resources also became an issue as travel nursing agencies began offering substantial pay rates with enticing benefits. Many facilities lost workers to these agencies and because of the national staffing shortage, were forced to resort to hiring staff from travel agencies, subsequently paying the substantial pay rates. Pay differences among workers became an issue and facilities began to explore ways, such as bonus pay or increased hourly rates, to retain the staff they could.

The MSEPC has nearly no resources available to assist with staffing support outside of advocating on behalf of our facilities to the state to offer assistance. State assistance often comes in the form of staffing grants, executive orders to provide licensure expansion, requests to suspend surveys, and other innovative measures. A group of representatives from each acute care hospital, emergency management, public health, and EMS was convened early in the pandemic response that provided necessary insight into the struggles of our healthcare facilities to make our Coalition’s voice among state leadership louder and more focused on our immediate needs. While the resources we requested were not always made available, through this established group, we were able to more clearly communicate our requests.

Infection Prevention

So much of the COVID-19 pandemic research and studies were happening in real time, right before our eyes. Although facilities had planned and prepared for infectious disease outbreaks, no facility had a continuity of operations plan, supply chain support, resources access, or

processes and procedures in place to sufficiently respond to a global pandemic affecting all aspects of healthcare in all areas of the world at the exact same time.

Initially, entities struggled to understand what measures should be taken to protect staff, patients, visitors, and the communities. And because of supply chain issues, the discussion quickly moved to what measures could be taken, choosing from the supplies and resources that were available. The frequently changing directives from regulatory authorities sometimes complicated this process and often resulted in confusion and distrust in protective measures being mandated.

To curb confusion and ensure compliance, 'just in time' training was often utilized with infection prevention methods. PAPRs, half face respirators, and other equipment not as frequently used prior to the pandemic was quickly adopted by facilities. Training materials, demonstrations, and standard operating procedures were continually reviewed and updated for staff.

Prior to COVID, MSEPC had begun working towards establishing an infectious disease subcommittee to ensure all practical and timely information was provided to members of the MSEPC through various distribution channels. That progress was derailed a bit as infection preventionists were hard at work educating leadership and staff within their facilities. MSEPC is eager to reestablish a working group among our member facilities to once again ensure all MSEPC members have educational resources and any best practices at their disposable for future events.

External Partners

External partners proved to be essential during this response- especially when it came to resources. However, several entities reported they did not work with any external partners at all, which is unlikely. It may be helpful, during future events and requests for information, to provide definitions for these terms to help entities understand exactly what is being requested.

Some issues with external partners, mainly vendors, included fear of COVID transmission and refusing to enter healthcare facilities to complete regularly scheduled equipment maintenance and deliveries. Although education was provided and PPE was available, some partners were still very reluctant. This was unexpected and hard to navigate in the beginning resulting in lack of availability for some services and resources. Continued communication to build trust and understanding between facilities and their vendors could assist with this issue as the pandemic continues or for future events.

The MSEPC continued to meet monthly and invite all members but quickly found it was difficult to maintain meeting schedules and facility attendance during the local COVID-19 response. MSEPC did, however, establish and maintain participation on several local task forces that also included representation from acute care hospitals, EMS, public health, long term care and assisted living facilities, and other partners engaged in the local, regional, and state responses.

Due to the nature of the how the groups were created, typically using higher level leadership positions as required attendees and speakers, the flow of information from the MSEPC to facilities changed a bit. Because of this, several facilities reported being disengaged from

communications although their facility was still actively engaged with the MSEPC. This detour was an unintended consequence and should be looked at from the MSEPC to ensure all member facility representation is kept abreast of issues related to current events.

Strengthened relationships among facilities and local leadership is one of the biggest strengths we can take from the COVID-19 response. Although there are still improvements that can be made to the flow of information among all facilities in our region, we have identified where are partnerships are weak (lack of plans or processes regarding partnerships, resources request processes, stockpiles or caches to share). And we will use where our partnership is strong (new relationships and understanding of each other's' roles, responsibilities, and needs) to continue to grow our region into a more prepared and resilient community through reliance on the strength of our Coalition members and partners.

APPENDIX A: ACRONYMS

Acronym	Term
AAR	After Action Report
ASPR	Assistant Secretary of Preparedness and Response
COP	Common Operating Picture (VA)
DOA	Dead on Arrival
ED	Emergency Department
EEGs	Exercise Evaluation Guides
EEI	Essential Elements of Information
EM	Emergency Management
EOP	Emergency Operations Plan
ER	Emergency Room
HCC	Health Care Coalition
HCC	Hospital Command Center (VA)
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
HRTS	Healthcare Resource Tracking System
HSEEP	Homeland Security Exercise and Evaluation Program
IC	Incident Command
ICS	Incident Command System
IP	Improvement Plan
JMCRHD	Jackson-Madison County Regional Health Department
MH	Mental Health
MLH	Methodist Le Bonheur Healthcare
MSEPC	Mid-South Emergency Planning Coalition
NIMS	National Incident Management System
PAPR	Powered Air Purifying Respirator
PPE	Personal Protective Equipment
RHC	Regional Healthcare Coordinator
RMCC	Regional Medical Communications Center
RN	Registered Nurse
SCHD	Shelby County Health Department
START	Simple Triage and Rapid Treatment
TDH	Tennessee Department of Health
TEMA	Tennessee Emergency Management Agency
VA	US Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center

APPENDIX B: EXERCISE PARTICIPANTS

Participating Organizations
Acute Care Hospitals
Baptist Collierville
Baptist DeSoto
Baptist Memphis
Baptist Tipton
Baptist Women's and Children's
Lauderdale Community
Le Bonheur Children's
Methodist Germantown
Methodist North
Methodist Olive Branch
Methodist South
Methodist University
Regional One Health
St. Francis Bartlett
St. Francis Memphis
St. Jude Children's Research
Acute Care Rehab Hospitals
Encompass Central
Encompass North
Select Specialty
Dialysis Centers
DaVita Downtown #02432
DaVita Midtown #06841
DaVita Ripley
Fresenius Airways
Fresenius Bartlett #6198
Fresenius Graceland #
Fresenius Midtown #4000
Fresenius- Mt. Moriah #7843
Fresenius Summer #
Fresenius Tipton #1541
Fresenius Whitehaven #4001
Skilled Nursing/Assisted Living Facilities
Applegrove Living
Allenbrooke Nursing and Rehabilitation
Ave Maria
Christian Care Center of Memphis
Graceland Rehab

Kirby Pines Senior Living
Majestic Gardens
Memphis Jewish Home
Mid-South Rehab- Brookdale Dogwood Creek, 360 Total Rehab at The Village at Primacy Place, and 360 Total Rehab at Town Village at Audubon Park
Millington Healthcare
Parkway Health and Rehabilitation
Ripley Healthcare and Rehab
St. Clare Health and Rehab
The Kings Daughters and Sons Home
Trezevant Episcopal Home Allen Morgan
Home Health/ Hospice
Baptist Reynolds Hospice House
Crossroads Hospice
No Place Like Home
Ambulatory Surgery Centers
Campbell Clinic Surgery Midtown and Germantown
East Memphis Surgery Center
Eye Care Surgery Center
Gastro One- Wolf River and Wolf Park and DeSoto
Memphis Surgery Center
Ortho South
Radiosurgical Center of Memphis
St. Francis Surgery Center
Uro Center
Behavioral Health
Crestwyn
Delta Specialty
Lakeside
Memphis Mental Health
West Tennessee Homes
Public Health
Shelby County Health Department
Emergency Management
City of Memphis Office of Emergency Management
Shelby County Emergency Management/Homeland Security
Emergency Medical Services
Memphis Fire Department

APPENDIX C: IMPROVEMENT PLAN

This IP has been developed specifically for the Mid-South Emergency Planning Coalition as result of the real world COVID-19 response documented from evaluations provided for the timeframe of March 13, 2020 – September 30, 2020.

MSEPC accepts responsibility for assuring that the improvement plan issues identified will be integrated into an exercise in the next budget period.

Issue/Area for Improvement	Corrective Action	Capability Element[1]	Start Date	Completion Date
Incident Command				
Individual facilities need to expand employees' knowledge of HICS to increase qualified availability to fill HICS positions.	Facilities should establish, and enforce, minimum HICS course requirements to include 100, 200, 700, and 800 for anyone expected to hold a Command Staff position.	Planning, Training	Immediately	On-going
Increase availability to ICS courses throughout MSEPC membership.	MSEPC will establish a training schedule to include introductory and refresher courses to review basics of HICS and offer more in-depth overviews of specific aspects of HICS.	Training	Once COVID-19 impacts have lessened, hopefully FY22.	On-going. Offered quarterly once started.
Resources				
Lack of extensive vendor directories to support supply chain issues.	MSEPC to work with vendors and other resource provides to establish a directory of potential vendors utilized by healthcare facilities.	Organization, Equipment	January 1, 2021	On-going. Updated with new vendors as information received.
The MSEPC has little to no resources available to assist with staffing support.	Establish and maintain work groups to include local healthcare leadership with purpose to identify success advocacy strategies to support staffing needs.	Planning, Organization	Immediately	On-going. Meeting daily through COVID-19 response.

[1]Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

Issue/Area for Improvement	Corrective Action	Capability Element	Start Date	Completion Date
Infection Prevention				
Staff not familiar with new personal protective equipment utilized during COVID-19.	Facilities should establish Just In Time Training procedures to increase knowledge of previously unfamiliar equipment and processes related to PPE.	Training, Equipment	Immediately	On-going
Lack of infectious disease subcommittee for MSEPC.	MSEPC to establish and maintain an infectious disease subcommittee work group to address needs of healthcare facilities.	Planning	Once COVID-19 impacts have lessened, hopefully FY22	On-going. Convene quarterly once created.
External Partners				
Facility MSEPC contacts were inadvertently replaced with executive level contacts, disrupting standard communication flow.	Develop monthly newsletter to increase information sharing among all MSEPC members.	Organization	July 1, 2021	On-going. Released monthly once started.
Facilities expressed interest and necessity in knowing more about fellow member facilities contacts and services.	MSEPC to collect information and develop directory to include all member facility contacts and services provided. Distribution list to be posted online.	Organization	July 1, 2021. Information collected with annual member updated.	On-going. Updated with new facility information as it is received.