Joint Public Hearing: Residential health care facilities and COVID-19

Senate Committees on Health, Aging, and Investigations and Government Operations
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GREATER NEW YORK HOSPITAL ASSOCIATION

Testimony of the Greater New York Hospital Association on

COVID-19 in Residential Health Care Facilities

Executive Summary

As the hospital association representing the hospitals on the front line of New York's fight against the COVID-19 pandemic, we are pleased to testify today to shed light on the question of COVID-19 discharges from hospitals to nursing homes and whether or not such discharges contributed to nursing homes' COVID-19 infection rates. **The claim that nursing home fatalities were caused by admissions from hospitals is not supported by the facts.**

First, let us state that nursing home staff have acted heroically during the COVID-19 crisis, caring for the most vulnerable New Yorkers during a pandemic that affects the frail elderly more than any other age group. They are to be applauded, commended, and supported.

The situation in nursing homes, however, cannot be separated from the situation in New York's communities. Researchers at the Mount Sinai Icahn School of Medicine recently reported that Mount Sinai Hospital patients had COVID-19 antibodies as soon as the week ending February 23. This indicates that there was community spread of coronavirus in New York in early February—long before restrictive visitation policies were implemented at nursing homes and long before coronavirus testing was available for nursing home staff or residents.

World-renowned public health experts believe that community spread is the primary reason for the presence of COVID-19 in nursing homes, including experts from the Harvard Medical School, Brown University School of Public Health, the University of Chicago, and the University of Toronto. In addition, these experts believe that the unique nature of nursing facilities and nursing home care leads easily to the spread of disease, particularly before staff realize either they or the residents they are caring for have been exposed.

Rigorous academic research studies from across the globe agree: COVID-19 patients are infectious for a relatively short period of time—a shorter period of time than it would have taken the typical nursing home resident to go from initial infection in the nursing home, to symptoms, to admission to the hospital, to being discharged back to the nursing home.

According to the New York State Department of Health (DOH) in its in-depth analysis:

- the average length of time from initial exposure to symptom onset is 5 days
- the average length of time from symptom onset to hospitalization is 8 days
- the likelihood of an individual spreading the virus to another individual approaches zero by 10 days from the onset of symptoms
- **the median length of hospital stay for a nursing home admission and discharge back to a nursing home was 9 days—this would be a full 22 days after initial exposure, 17 days from initial onset of symptoms, and 7 days after the patient was no longer infectious**

David Reich, MD, President of The Mount Sinai Hospital, stated this clearly last month when the DOH report was released. If this were not compelling enough, academic studies from South Korea, Singapore, Germany, and Hong Kong all confirm that peak infectiousness tends to occur before or at the onset of symptoms and decreases rapidly thereafter. **Given these facts, DOH's conclusion seems indisputable: nursing home residents discharged from hospitals were extremely unlikely to have been infectious when discharged back to their nursing homes.**

These studies corroborate what we, and more importantly our hospital clinicians, have believed since early in the pandemic: multiple factors, independent of admission policies, drove the number of COVID-19 deaths in New York nursing homes.

Despite New York having the highest number of overall COVID-19 cases in the nation, 44 states have had a higher percentage of COVID-19 deaths occur in nursing homes, according to an analysis by the *New York Times*. The Foundation for Research on Equal Opportunity found that New York's COVID-19 fatality rate in nursing homes is lower per 10,000 residents than in nursing homes in its neighbor states New Jersey, Connecticut, Pennsylvania, and Massachusetts. And now, unfortunately, current "hot spot" states like Florida, Texas, Arizona, Georgia, and Tennessee are seeing alarming increases in COVID-19 cases and deaths in nursing homes.

For all of these reasons, we do not believe that the March 25 DOH directive or discharges from hospitals to nursing homes had an appreciable effect on the spread of coronavirus in nursing homes.

Should there be a future surge, given that it is important for hospitals to safely discharge patients who can be cared for in alternate settings to free up hospital capacity, **we recommend establishing nursing facilities with infectious disease specialty units**. A number of nursing homes have been identified that can provide high-quality care to discharged, recovering COVID patients in separate units or buildings. These facilities meet stringent infection control criteria and have collaborative relationships with hospital partners.

Testimony of the Greater New York Hospital Association on

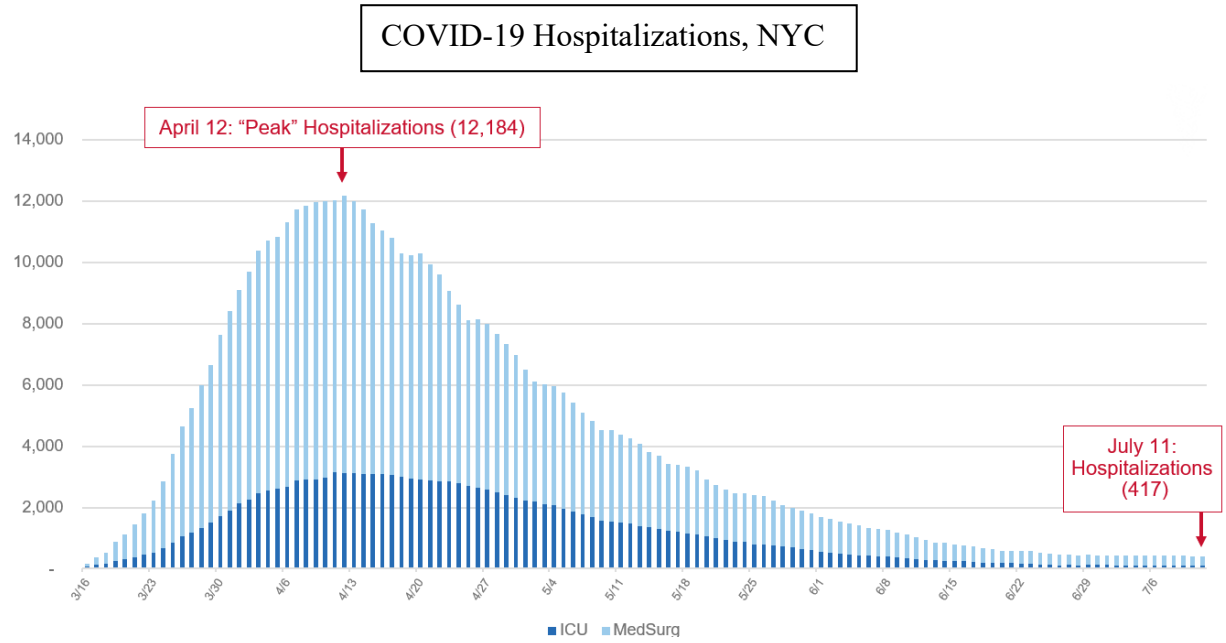
COVID-19 in Residential Health Care Facilities

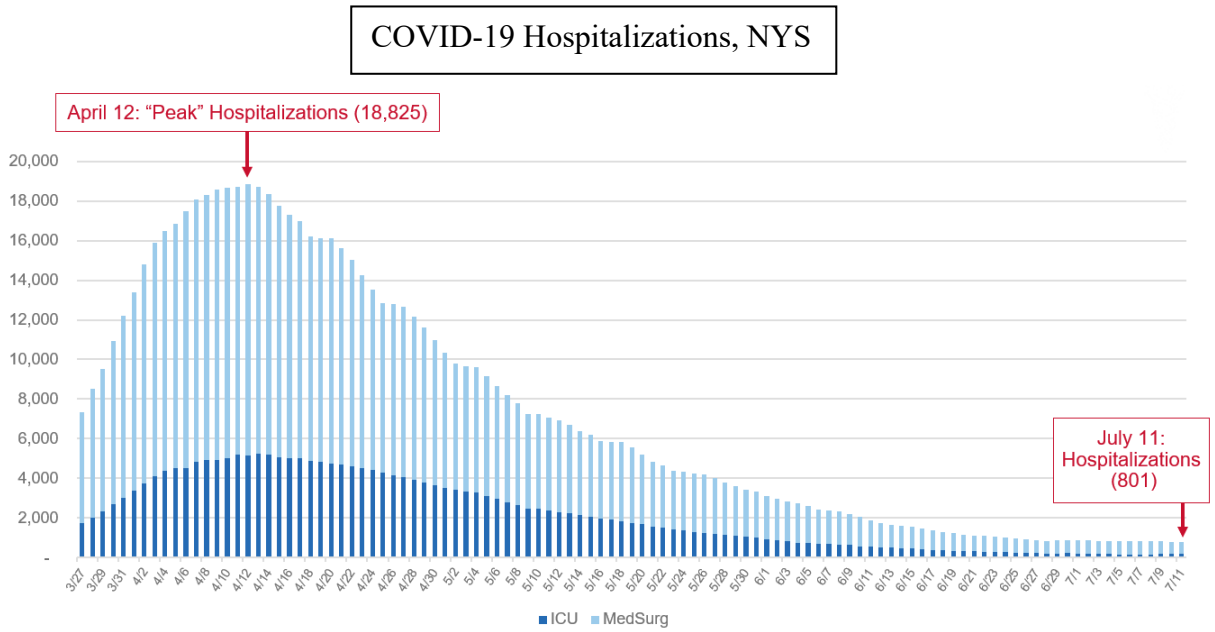
Chairs and members of the Assembly and Senate, thank you for allowing GNYHA to testify today on COVID-19 in residential health care facilities.

GNYHA's members include urban, suburban, and exurban hospitals across New York State, from Buffalo to Long Island. Our members include public hospitals, voluntary safety net hospitals, academic medical centers, major teaching hospitals, and suburban community hospitals. All are committed to providing the highest quality care to all, regardless of ability to pay, 24 hours per day, 365 days per year. We are testifying today on behalf of these hospitals to shed light on the question of whether discharges of COVID-19 patients from hospitals to nursing homes contributed to COVID-19 infection rates in nursing homes. The claim that nursing home fatalities were caused by admissions from hospitals is not supported by the facts.

In response to COVID-19, New York's hospitals undertook the largest mobilization of health care resources in the nation's history. New York was the international epicenter of COVID-19 from March through May. Our members answered the call, cancelling all elective surgeries and procedures in March, increasing inpatient hospital and intensive care unit capacity by 50%, taking on a deadly virus about which little was known, and for which there remains no known cure. Our hospitals and their brave physicians, nurses, and other health care personnel saved thousands of lives while also mourning the loss of far too many New Yorkers to this terrible new disease. New Yorkers are rightly proud of the heroic role hospitals played throughout the pandemic.

These charts show the incredible increase in COVID-19 hospitalizations in New York City and New York State beginning in early March and peaking in mid-April.





Given this huge, steep increase in hospitalizations, it was imperative that hospitals discharge patients as soon as they were medically cleared for discharge to create the capacity to treat new patients who were flooding hospital emergency rooms and who often required critical care, including admissions from nursing homes, where COVID-19 infections were spreading. Lives depended on it.

Make no mistake: nursing home staff have acted heroically during the COVID-19 crisis, caring for the most vulnerable New Yorkers during a pandemic that affects the frail elderly more than any other age group. They are to be applauded, commended, and supported.

New York State Department of Health (DOH) Commissioner Dr. Howard Zucker has faced intense criticism over DOH's March 25 directive that no one can be denied admission or re-admission to a nursing home based solely on a confirmed or suspected COVID-19 diagnosis. Some have pointed to that order as the primary reason for the high number of nursing home deaths in New York.

We believe, however, that the March 25 directive reflected not only the sound clinical judgment of a State health department with vast infectious disease experience, but also New York's rapidly worsening COVID-19 landscape at that time. Furthermore, mounting evidence suggests that recovering COVID-19 patients who were discharged from hospitals to nursing homes did not spread the virus to other nursing home residents. **Rigorous academic research studies from across the globe agree: COVID-19 patients are no longer infectious after a relatively short period of time—a shorter period of time than it would have taken the typical nursing home resident to go from initial infection in the nursing home to having symptoms to being admitted to the hospital to being discharged many days, if not weeks, later.**

Earlier testimony has made you all familiar with the in-depth DOH analysis that was released on July 6, which found:

- the timing of nursing home staff infections correlated with the timing of peak nursing home resident mortality across the State
- nursing home employee infections were related to the most impacted regions in the State
- peak nursing home admissions occurred a week after peak nursing home mortality, illustrating that nursing home admissions from hospitals were not a driver of nursing home infections or fatalities
- most patients admitted to nursing homes from hospitals were no longer contagious when admitted and therefore were not a source of infection
- nursing home quality was not a factor in nursing home fatalities.[1]

But even before the DOH analysis was released, we, and more importantly our hospital clinicians, believed that multiple factors, independent of admission policies, drove the number of COVID-19 deaths in New York nursing homes.

First, the situation in nursing homes cannot be separated from the situation in New York's communities beginning as soon as early February. Researchers at the Mount Sinai Icahn School of Medicine recently reported that a study of 500 random blood samples from patients at Manhattan's Mount Sinai Hospital, collected beginning the week of Feb. 9, showed that some patients had antibodies as soon as the week ending February 23.[2] **This indicates that there was community spread of coronavirus in New York in early February—long before restrictive visitation policies were implemented at nursing homes** (or hospitals, for that matter). This is also long before coronavirus testing was available for nursing home staff or residents.

And world-renowned public health experts believe that community spread is the primary reason for the presence of COVID-19 in nursing homes:

- **Harvard Medical School:** David Grabowski, PhD, Professor of Health Care Policy, after studying the impact of COVID-19 in nursing homes in 20 states, found that "it is spreading via asymptomatic and pre-symptomatic cases, and what we've learned is that in facilities that have been closed for weeks, we are seeing cases emerge. Those cases are emerging because of staff who don't know that they have the virus are coming in to work."[3]
- **Brown University School of Public Health:** Vincent Mor, PhD, Professor of Health Services, Policy, and Practice, after studying COVID-19 in nursing homes in 30 states, found that "it's a function of traffic; that is, **if you're in an environment where there are a lot of people in the community who have COVID, the patients in the building are more likely to have COVID**…If you are a larger facility versus a smaller facility, there is more traffic. Larger facilities simply have more staff, more people coming in and out of them. That's more traffic and more likelihood that someone will be coming in from the outside with COVID."[4]

[1] "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis," New York State Department of Health, July 6, 2020.
[2] "Seroconversion of a City: Longitudinal Monitoring of SARS-CoV-2 Seroprevalence in New York City", medRxiv preprint doi: https://doi.org/10.1101/2020.06.28.20142090.
[3] http://www.providermagazine.com/news/Pages/2020/MAY/Facility-Location-Determines-COVID-Outbreaks,-Researchers-Say.aspx
[4] Ibid.

- **University of Chicago:** R. Tamara Konetzka, PhD, Professor of Health Economics and Health Services Research, stated in Congressional testimony, "In some ways, the high rates of COVID-19 cases and deaths in nursing homes are not surprising: Nursing homes house, in close quarters, large numbers of people with multiple comorbidities who need hours of hands-on care on a daily basis. These realities of long-term care make social isolation impossible…**Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected**."[5]
- **University of Toronto Dalla Lana School of Public Health:** David N. Fisman, MD, MPH, and colleagues studied COVID-19-related deaths in nursing homes in Ontario—where 71% of all COVID-19 deaths in Ontario have occurred—and found that staff infections were the prime driver of infections in nursing homes. "Issues such as crowding, use of communal space, low staffing ratios, and high care needs (with resultant high density of physical contact between residents and staff) have long been recognized as key drivers of susceptibility to outbreaks in the LTC facility setting…**We also found that documented infection in facility staff, as opposed to residents, is a strong identifiable risk factor for mortality in residents**, with temporality suggesting that residents are infected by staff and not vice versa…The greater mobility and connectedness of staff, compared with residents, lends biological plausibility to this association."[6]

Second, there was the grim situation hospitals were facing. On March 25, the number of hospitalized COVID-19 patients in New York City alone was nearing 4,000 and increasing with astonishing speed. Unless hospitals could discharge recovering COVID-19 patients to free up desperately needed beds, they feared a repeat of the collapse of Italy's overwhelmed health system, where patients were dying in hospital hallways.

The March 25 directive, then, cannot be isolated from the dire situation on the ground—exploding numbers of COVID-positive cases in the community, hospitalizations, and ventilated patients. Hospitals were also coping with a scarcity of ventilators, ventilator drugs, and other supplies. Given these unprecedented circumstances, DOH's directive was not only reasonable, it was aimed at preventing the collapse of New York's health care delivery system.

Third, hospitals routinely discharge patients to nursing homes when they no longer need inpatient care but still need skilled nursing or rehab care. These discharges have long included individuals who are infectious or recovering from another illness. The Centers for Disease Control and Prevention (CDC) states that "patients can be discharged from the healthcare facility whenever clinically indicated"—that is, when a hospital's clinical staff makes the decision that inpatient care is no longer necessary.[7]

The CDC further recommends that receiving facilities such as nursing homes adhere to standard infection prevention and control recommendations, including appropriate personal protective equipment. When hospitals discharge these patients, they assume that nursing homes will safely care for them without further compromising the health of their other residents.[8]

[5] https://www.aging.senate.gov/imo/media/doc/SCA_Konetzka_05_21_20.pdf
[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768539
[7] https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
[8] Ibid.

Fourth, **infectious disease experts from across the globe believe that COVID-19 patients are only contagious early in their illness.** When discharged, many of these patients continue to test positive for the virus even though they do not transmit it. To wit:

- **South Korea Centers for Disease Control:** According to a recent study by South Korea's CDC, active monitoring, epidemiological investigation, and lab testing of patients discharged from hospitals found no evidence that they are still infectious despite still testing positive.[9]
- **Singapore National Centre for Infectious Diseases and Singapore Academy of Medicine:** A Singapore study found that COVID-19 patients are no longer infectious after 11 days of getting sick, even though some may still test positive.[10]
- **Charité -- Universitätsmedizin Berlin, München Klinik Schwabing and the Bundeswehr Institute of Microbiology:** A study conducted by German researchers at renowned medical schools and universities that focused on hospitalized COVID-19 patients reached the conclusion that transmission of the virus is most likely in the first 10 days from the onset of symptoms.[11]
- **University of Hong Kong, School of Public Health:** Researchers found that peak infectiousness occurs on or before the onset of symptoms, and infectiousness declined quickly within 7 days.[12]

We are still learning about COVID-19 in real time, but these studies suggest that a great many recovering COVID-19 patients who were discharged from hospitals to nursing homes in New York were no longer transmitting the virus. Most, if not all, would have been admitted to the hospital—often from nursing homes—once they were highly symptomatic, which would have been a number of days after first coming into contact with the virus in the nursing home where they lived. They then would have spent many days in the hospital.

According to DOH's in-depth analysis:

- the average length of time from initial exposure to symptom onset is 5 days
- the average length of time from symptom onset to hospitalization is 8 days
- the likelihood of an individual spreading the virus to another individual approaches zero by 10 days from the onset of symptoms
- **the median length of hospital stay for a nursing home admission and discharge back to a nursing home was 9 days—this is a full 22 days after initial exposure, 17 days from initial onset of symptoms, and 7 days after the patient was no longer infectious**

David Reich, MD, President of The Mount Sinai Hospital, stated this clearly last month when the DOH report was released. According to the international academic studies cited above, peak infectiousness tends to occur before or at the onset of symptoms and decreases rapidly thereafter. **Given these facts, DOH's**

[9] https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030, https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
[10] https://www.bloomberg.com/news/articles/2020-05-24/covid-19-patients-not-infectious-after-11-days-singapore-study
[11] https://www.sciencedaily.com/releases/2020/04/200403115117.htm
[12] He, X., Lau, E.H.Y., Wu, P. *et al.* Temporal dynamics in viral shedding and transmissibility of COVID-19. *Nat Med* **26,** 672–675 (2020). https://doi.org/10.1038/s41591-020-0869-5

conclusion seems indisputable: nursing home residents discharged from hospitals were extremely unlikely to have been infectious when admitted back to their nursing homes.

There is no blame here. The virus was widespread far earlier than anyone knew, and we were learning about it in real time. **New York's nursing home workers delivered heroic care during an unprecedented pandemic that took particular aim at the frail elderly. We are deeply grateful for their service.**

Finally, despite New York having the highest number of overall COVID-19 cases in the nation, **44 states have had a higher percentage of COVID-19 deaths occur in nursing homes**, according to an analysis by the *New York Times*.[13] The Foundation for Research on Equal Opportunity found that New York's COVID-19 fatality rate in nursing homes is lower per 10,000 residents than in nursing homes in its neighbor states New Jersey, Connecticut, Pennsylvania, and Massachusetts.[14] **And now, unfortunately, current "hot spot" states are seeing an alarming increase in COVID-19 cases and deaths, including Florida, ("Rising Virus Cases Spark Concern in Florida Nursing Homes"[15]) Texas ("Coronavirus is Rapidly Spreading in Texas Nursing Homes"[16]), Arizona ("Arizona Nursing Homes Brace for Another Coronavirus Surge"[17]), Georgia ("COVID-19 Continues to Raid Augusta Nursing Homes as Cases Increase Statewide"[18]), and Tennessee ("East Tennessee Nursing Home Reports 92 Coronavirus Cases"[19]).**

There is still so much that needs to be learned about COVID-19 and many lessons we can learn from New York's experience as the virus' international epicenter earlier this year. But there is one thing we do already know: Dr. Zucker's singular goal has been to limit COVID-19's spread, help hospitals weather a ferocious patient surge, and save as many lives as possible. We are grateful for his service to the people of New York.

Should there be a future surge, given that it is important for hospitals to safely discharge patients who can be cared for in alternate settings to free up hospital capacity, we recommend establishing nursing facilities with infectious disease specialty units. A number of nursing homes have been identified that can provide high-quality care to discharged, recovering COVID patients in separate units or buildings. These facilities meet stringent infection control criteria and have collaborative relationships with hospital partners. We have attached to this testimony a paper we have authored in collaboration with our member hospitals that contains this recommendation as well as others in the event of a second wave of COVID-19 in New York State.

[13] https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html
[14] https://docs.house.gov/meetings/GO/GO00/20200610/110776/HHRG-116-GO00-Wstate-RoyA-20200610.pdf
[15] https://abcnews.go.com/Health/wireStory/mounting-virus-cases-spark-concern-florida-nursing-homes-71963689
[16] https://www.nbcnews.com/news/us-news/coronavirus-rapidly-spreading-texas-nursing-homes-state-figures-show-n1233909
[17] https://www.cnbc.com/2020/06/28/arizona-nursing-homes-brace-for-another-coronavirus-surge-as-cases-rise.html
[18] https://www.wrdw.com/2020/07/07/covid-19-continues-to-raid-augusta-nursing-homes-as-cases-increase-statewide/
[19] https://www.wate.com/news/east-tennessee-nursing-home-reports-92-coronavirus-cases/

COVID-19 WAVE 2 PATIENT LOAD REDUCTION AND LOAD BALANCING STRATEGIES (7.16.20)

Working draft prepared by GNYHA in collaboration with member hospitals

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Purpose: Develop and formalize processes that support collaborative patient load balancing across hospitals, with the goal of reducing patient surge in any particular hospital or group of hospitals.

Activation of these strategies: The goal will be to tie activation of these strategies to broader surge indicators used by government entities, with input from the hospital/health care community.

Notes:

- A foundation for these strategies will be the activation of waivers that provide flexibility for patient transfers.
- Throughout this document, references are made to GNYHA's Sit Stat 2.0 system. This is a web-based situational awareness platform that is used to collect and display key data points for use by hospitals, health systems and agency response partners. Currently 115 hospitals across New York State participate in the program.

STRATEGY 1: REDIRECT EMS TRANSPORTS AWAY FROM HOSPITALS WITH ELEVATED ED, INPATIENT VOLUME

Create a three-level self-reported qualitative measure of hospital capacity: 1) normal level (green), 2) elevated surge (yellow), and 3) significant surge (red), and program this indicator into GNYHA's Sit Stat 2.0 system. The measure will be defined in the system as follows:

> Compared to a regular day, this status best describes your hospital capacity—normal level, elevated surge, significant surge. This is a qualitative measure and should account for emergency department (ED) volume including boarding, inpatient volume, all staffed available beds, and planned transfers and discharges. This measure will be used by emergency medical services (EMS) to inform patient transport decisions.

Hospitals will be asked to update this measure each morning in GNYHA's Sit Stat 2.0 system, and then throughout the day when changes in status occur. Hospitals will determine what role/department should provide this information.

EMS agencies via access to GNYHA's Sit Stat system will monitor this indicator, modifying destination decisions to the extent possible as described below:

- Hospitals flagged yellow (elevated surge): [TBD – in discussion with key stakeholders]
- Hospitals flagged red (significant surge): [TBD – in discussion with key stakeholders]

STRATEGY 2: FORMALIZE AND SUPPORT PROCESSES TO FACILITATE PATIENT TRANSFERS

Throughout the spring COVID-19 patient surge, daily, large health systems transported patients within their own hospital network and to alternate care sites, and accepted transfers from independent hospitals. The structures and processes below

are designed to facilitate these processes and create regional indicators used to activate additional transport resources and use of alternate care sites.

Key Assumptions

- Independent hospitals transfer patients out, relying to the greatest extent possible, on established transfer relationships and processes.
- All health systems actively load balance patients within their own health systems, using existing resources, structures, and processes.

Preparedness Phase

GNYHA will:

- Conduct outreach to all independent hospitals in the downstate region, and asks them to indicate the primary and secondary health systems they would use for patient transfers. Each hospital will also be asked to designate a tertiary health system that would be utilized if the first two are unable to meet their needs. This information will be captured and visible in GNYHA's Sit Stat 2.0 system.
- Conduct outreach to all health systems in the region (NY, NJ, CT) and ensure that transfer center and command center information is included in GNYHA's Sit Stat 2.0 system (see sample image below).
- Bring together health system transfer center leaders to share best practices developed during the initial COVID patient surge, and center processes and practices to be used during future events.

Health Systems	Health System Transfer Center Phone #
Albany Medical Center	518-262-4661
Atlantic Health System	877-441-4450
Hackensack Meridian Health	732-776-3486
Montefiore Health System, Inc.	718-920-2800
Mount Sinai Health System	646-605-5905 or 1-800-TO-SINAI
New York-Presbyterian Hospital	800-697-7828
Northwell Health	212-434-3216
NYC Health + Hospitals	844-442-2337 or transport@nychhc.org
NYU Langone Health	212-263-7014
Stony Brook Medicine	631-444-1911

Response Phase

- Independent hospitals request transfers as needed to meet patient needs and alleviate pressure on their facility.
- Health systems actively load balance among their system facilities as needed.
- System occupancy information (calculated using NYS Health Emergency Response Data System (HERDS) data) is made visible in Sit Stat 2.0 to provide situational awareness to hospitals, health systems, and agency partners. For large health systems with geographic diversity, GNYHA will consider sub-system reporting.
    - When more than half of involved health systems have an occupancy rate of 80% or higher, additional transport resources and the government-supported alternate care sites (see below) will be activated.

STRATEGY 3: FORMALIZE AND SUPPORT PATIENT DISCHARGE OPTIONS FOR PATIENTS THAT NEED CONTINUED CARE

During a patient surge, it is important that hospitals can safely discharge patients who can be cared for in an alternate setting to free up existing capacity. To this end, GNYHA and member hospitals will pursue the concepts below:

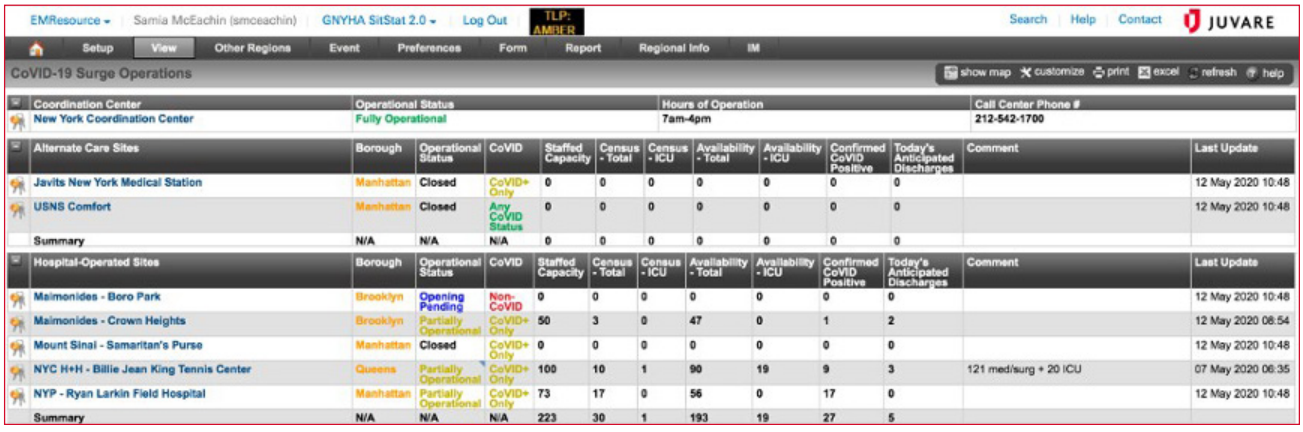
Nursing Facilities with Infectious Disease Specialty Units: A number of nursing home facilities have been identified that can provide high-quality care to discharged, recovering COVID patients in separate units or buildings. These facilities meet stringent criteria related to infection control and prevention practices and level of care provided and have collaborative relationships with hospital partners.

Note: Executive Order (EO) 202.30, which prohibits discharge of hospitalized patients to a nursing home without first obtaining a negative COVID diagnostic test, is in effect until August 8. GNYHA is engaging with the Governor's Office and State Department of Health about application of this EO to the facilities described above.

- Preparedness Phase
  - GNYHA, in collaboration with long term care partners, will collect key information for each of these facilities and develop a dedicated view in Sit Stat 2.0. This view—similar to the COVID-19 Surge Operations View below—will be available to hospital and health system transfer and command centers to enable use of these facilities.
  - GNYHA and long term care partners will set up a system so that daily updates including bed availability can be provided and made visible in the Sit Stat 2.0 system.
- Response Phase
  - Once activated, each participating nursing facility will provide bed availability updates each day by 8:00 a.m. Understanding that many nursing homes have preferential relationships with certain hospitals, facilities would also indicate if they were open or closed to transfers from across the region on a particular day.

Government-Supported Alternate Care Sites: During a significant patient surge, government-supported alternate care sites will play a critical role. The lessons learned during the initial patient surge should drive collaborative planning among government and health care stakeholders.

- Preparedness Phase
  - Work with City, county, and State officials to understand and inform their plans for standing up alternate care sites including location, level of care provided, capabilities, staffing, personal protective equipment and supplies, and from where transfers will be accepted. *Please see the Appendix below for recommendations from GNYHA and its members.*
  - Build out sites in existing COVID-19 Surge Operations View in Sit Stat 2.0 and ensure staff are designated and trained to provide bed availability updates.
- Response Phase
  - Once activated, each alternate care site will be asked to provide bed availability updates each day by 8:00 a.m.
  - Each site will monitor transfer processes and provide updates to hospitals as needed.



APPENDIX: GNYHA RECOMMENDATIONS RELATED TO GOVERNMENT-SUPPORTED ALTERNATE CARE SITES

Government-supported alternate care sites (ACS) should be managed by a local health system team or a contracted health care administration team knowledgeable of the area.

Hospital administrative and operational experience, as well as knowledge of the local/regional health care eco-system, are critical to the success of an ACS. Any planned ACSs should have this relationship established in advance and the selected team should be included in planning.

Design ACSs to support moderate-acuity patients in the convalescent phase of illness.

Given the long length of stay of many COVID-19 patients, ACSs are well-suited to care for moderate-acuity patients in the convalescent phase of illness. Focusing on this population allows for maximum inpatient decanting and greater hospital throughput to care for incoming patients. Working with the administrative team, the ACS must ensure that it can meet the full clinical needs of such patients, including the small number that may decompensate, as well as discharge planning needs.

Create a centralized admissions process for all government-supported ACSs, educate all hospitals and health systems on the process, and allow transfers from all hospitals in the region.

All government-supported ACSs should be available to all hospitals and health systems across the region. Admissions should be arranged through a single centralized admissions hub with the transfer process as streamlined as possible. The admissions process should be documented in detail and broadly disseminated.

Further develop resources and systems to aid with patient identification and transfer.

During the initial COVID-19 patient surge in early 2020, GNYHA developed an Alternate Care Site View within its' Sit Stat 2.0 Situational Awareness system that housed key information about each ACS. During future waves this resource can be used by hospital command centers and health system transfer centers in advance of contacting the admissions hub. Successful models developed during the first wave including identifying patients through electronic medical record queries and sending clinical teams to assist with the transfer process, should be further developed and utilized.

Open government-supported ACSs in a sequential manner based on pre-developed triggers.

Government-supported ACSs should serve as a safety net to the health care system and be opened once regional indicators of infection and occupancy demonstrate the need. ACSs should be opened in a sequential manner to reduce stressors on staffing and supply chains.

Develop ACS staffing models that do not directly undermine health care staffing models.

During a patient surge health care staff are the most valuable commodity. Hospitals and health systems will utilize multiple staffing strategies including redeployment of existing staff, per diem staff, staffing agencies, and volunteer portals to meet their own needs. It is critical that government-supported ACSs develop staffing models that do not draw from these same sources.