Idaho Hospital Association

COVID-19 Report to Members ~ August 20, 2021

Reports are sent on Tuesdays, unless there's breaking news.

Hospital capacity crisis update

Unless the current trajectory of COVID hospitalizations and the high acuity of those patients drastically changes in the coming days, all projections indicate that Idaho's tertiary hospitals will all be full and Crisis Standards of Care (CSC) will be triggered. To help mitigate CSC and keep facilities available to treat patients, a number of new steps are being taken around the state.

Many of our hospitals already find themselves in "contingency standard of care" where they have set up beds in hallways and conference rooms. With the growing number of hospitals in "contingency" and the likelihood of a recommendation being made to move to "Crisis Standards of Care", Idaho's CSC Advisory Committee met yesterday to refresh members on the difficult job they may be asked to perform, and to walk through a scenario to make sure everyone understood the process -- a scenario that is already starting to play out in north Idaho and the Treasure Valley.

Today, hospitals, physicians, transfer center leaders, Emergency Medical Services (EMS), and state agencies began daily Medical Operation Coordination Cell calls (MOCC). These calls are designed for making real-time patient movement decisions, as well as work on healthcare volunteer management and other operational issues. The calls will foster the necessary communication across emergency services, hospitals, post-acute healthcare facilities and state agencies to tactically address patient load-leveling and unique patient transfers in order to keep some emergency capacity at capstone sites (large hospitals) as well as maintaining some capacity to receive and stabilize time sensitive emergencies such as stroke, heart attack, and trauma.

Discussions from today's MOCC call included:

- The long-term care strike team is working on a financial incentive for post-acute facilities to take any hospital discharge. Additionally, it was requested that the state find a work around for allowing long term care facilities to take COVID positive patients directly from assisted living facilities without having to pass those patients through an emergency department to help keep capacity available.
- Staffing resources have been requested through the Idaho Office of Emergency Management (IOEM) which were forwarded to FEMA. The first request was denied by FEMA and IOEM staff are working to determine the reason for denial.
- In order to augment hospital staffing, the health districts are pushing out messages to recruit medical reserve corps (MRC) volunteers and DHW is working with the Idaho Boards of Medicine and Nursing to reduce barriers to get healthcare volunteers in facilities. The Board of Nursing has implemented an **expedited path for those with unencumbered licenses to have them temporarily reactivated**. Please direct others who would like to volunteer to **www.volunteeridaho.com** to register. Registered volunteers are assigned to regional MRCs within the state's health districts. The MRCs will work to coordinate volunteers with the hospitals or other facilities.
- It was also noted that hospitals should consider their emergency operations plans before seeking volunteers. If your plan states that the facility won't use volunteers, the hospital will need to reconsider that and possibly remove that from the plan. The facility, not the state, determines if a hospital will use volunteers and will be responsible for onboarding and training in accordance with their plan. Hospitals are also encouraged, if they have not already, to consult with the legal or administrative teams about background checks, processes for onboarding, etc. before volunteers are requested or brought in.

In addition to the MOCC and other calls, the Treasure Valley hospitals and area EMS agencies are operationalizing a process for "rolling bypass or divert" of emergency departments. The goal for the region is to not have all facilities on bypass at the same time and to make the initiated bypasses as succinct as possible. In addition, the emergency departments are working to be on "bypass" which would still allow them to take time sensitive emergencies as opposed to full "divert" which is when no patients are accepted.

With all facilities in the area in crisis mode, this process will allow some facilities to be on bypass in hours-long increments and move patients within the hospital or to other facilities to free ED capacity. The facilities which are in the "least-worst" state will continue to take ED patients. Facilities that were on bypass will then be restored to taking patients. This process is being refined as it unfolds. Two concerns which were shared at the MOCC and in the statewide hospital capacity call this morning:

- While this process of diverting patients will include close communication with EMS agencies, there is a need to address those who come to emergency departments in personal vehicles which creates a patient safety challenge. The group is working through that process to make sure patients are safely transferred to another facility when needed.
- The state has been asked to tackle the issue of transfer costs for those patients who must be moved to another facility because of bypass status. Hospitals felt that neither the patient nor the hospital should have to absorb those costs.

In a glimmer of good news this morning, IHA CEO, Brian Whitlock, reported that there may be an opportunity to create regional facilities to provide monoclonal antibody treatments in non-hospital settings. These treatments are for those who are COVID positive and are at risk for severe illness. The infusion therapies have shown the ability to lessen the severity of the illness and avoid hospitalization.

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