



Harnessing the Power of Hospitalists in Operational Disaster Planning

“...especially in times of crisis,
we show our best selves”

- RUTGER BREGMAN

Key topics

- Framework for capacity management/growth
- Flex staffing and training
- Adaptations to care models

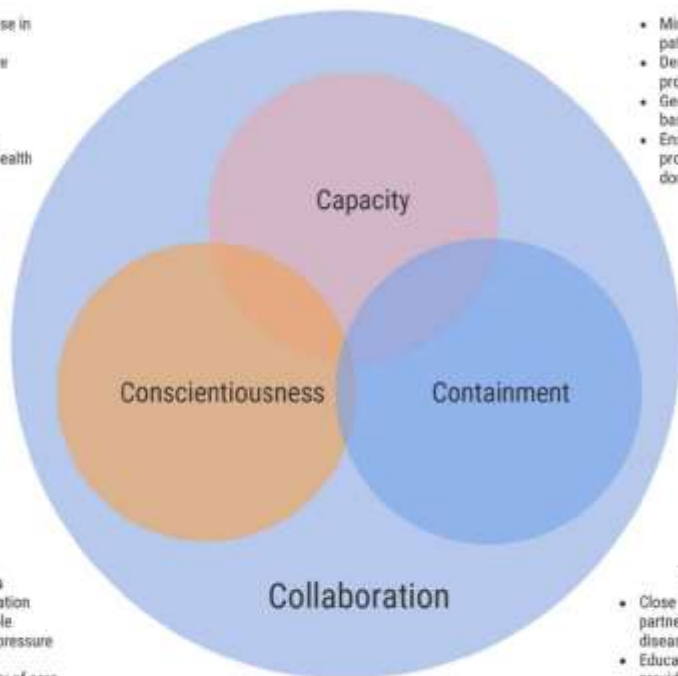


A Note of Gratitude

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4 C Approach to Hospital Capacity Planning for COVID-19 Pandemic

- Capacity**
- Tiered plan for increase in overall volume
 - Ensuring efficient care delivery models
 - Optimizing space
 - Utilization of non-hospitalist providers
 - Utilization of virtual health and modified visits



- Conscientiousness**
- Optimizing PPE utilization
 - Awareness of available ventilators, negative pressure rooms
 - Ensuring sustainability of care delivery models

- Containment**
- Minimize potential for patient/provider exposure
 - Dedicated COVID/non-COVID providers
 - Geographic cohorting of patients based on COVID status
 - Ensuring appropriate personal protective equipment and donning/doffing procedures

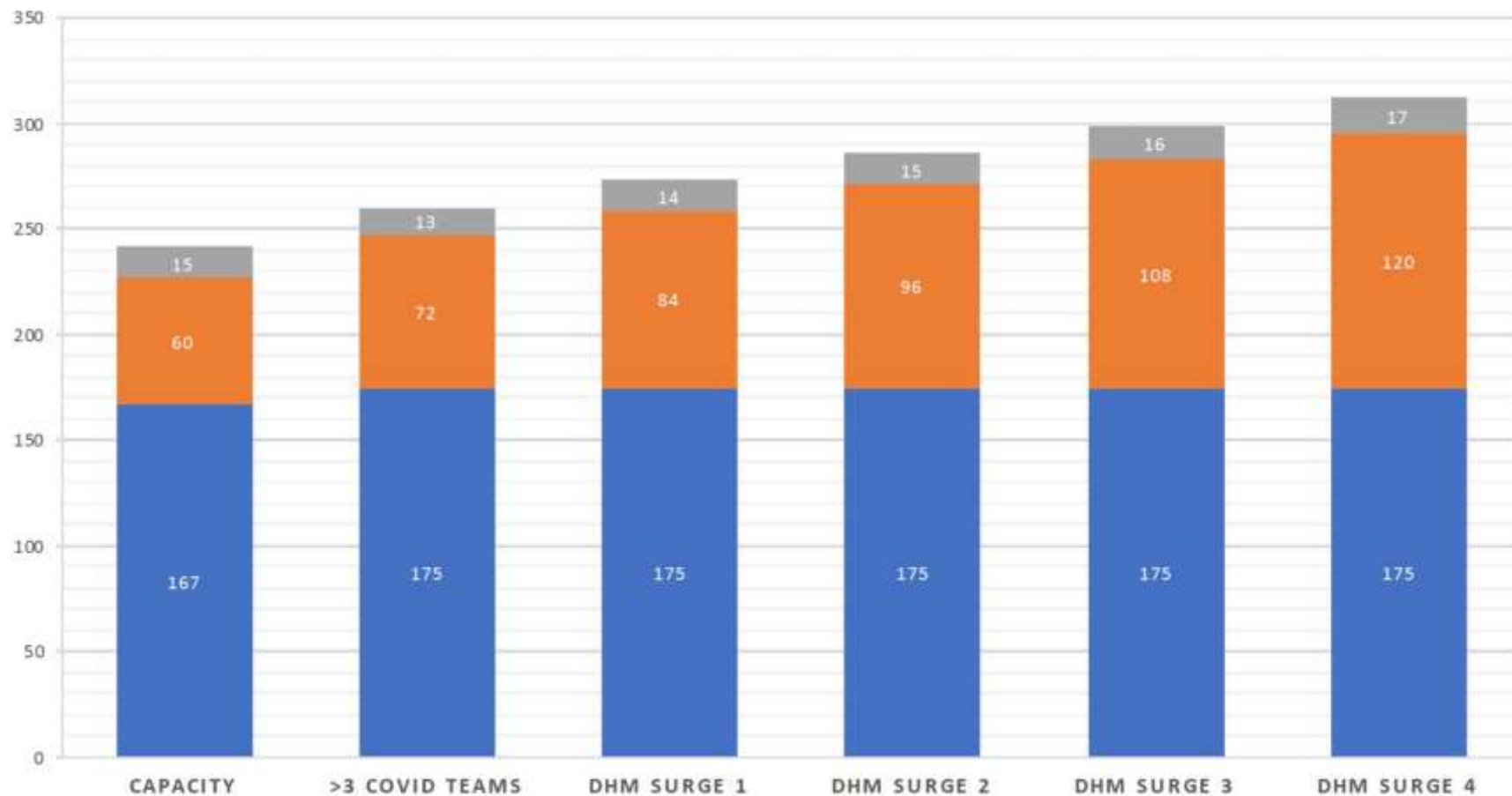
- Collaboration**
- Close communication and partnership with ICU, ED, infectious disease, and hospital leadership
 - Education for non-hospitalist providers in higher tiers
 - Collaboration with neighboring institutions to identify best practices
 - Online forums for discussion amongst internal/external division members
 - Provider support and wellness

Our framework

- Bowden, Burden et al. JGIM 2020.

DHM CAPACITY PLAN

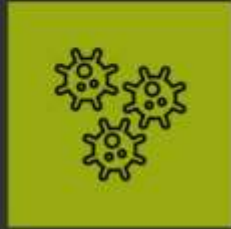
■ Gen Med Capacity ■ COVID Capacity ■ 48 Hr Flex Capacity



Our organizational structure



Clinical operations
team



Infectious Disease



Critical Care



Hospital leadership



Clinical care leadership
team



Pathways



Advanced technology



Data and Analytics

All supporting our clinical care teams

UHealth COVID-19 Inpatient Management Pathway

Has patient been tested for COVID-19?

No

Yes

Was the COVID-19 Test Negative?

Yes.
(-) Negat

- [Sensitivity SARS-CoV-2 PCR Test](#)
- [PPE Recommendations](#)

Note: Coinfections are uncommon, though new reports of rhinovirus co-infection and influenza infection are increasing so coinfection does not rule out COVID-19

No. (+) Positive OR
Potential Positive

Management

Anticoagulation prophylaxis

- Anticoagulation Prophylaxis order set

Note: COVID-19 patients are at [high risk for prothrombotic state](#)

Discuss and document goals of care and DNR status

- Code status AND document code status via COVIDCODE
 - [Code Status and Goals of Care Discussion Aid](#)
- For palliative treatments, consider using: [COVID-19 Palliative Care Symptom Treatment Sheet](#)
- Consider early [palliative care consult](#), if available, for high-risk patients or goals of care unaligned with prognosis. See [link, criteria for early palliative care consult](#)

Click the links below for management information:

- [Oxygen delivery](#)
 - For ≥ 8 L/Min O₂, OR patients with underlying lung disease: consider [Pulmonary/ICU](#) Consult for management assistance
- [Bronchodilators](#)
- [Antipyretics](#)
- [Anticholinergics](#)
- [Family or close contact for patient counseling](#)
- [Other medication considerations](#)
- [Other Infectious Disease Screenings](#)

Admission pathways

- Updated with latest information
- Shared across health system
- Selection of highlighted areas generates orders

Treatments and guidance

UPDATED FREQUENTLY

Floor Status Management

Note: There are currently no FDA-approved therapies for COVID-19. It is recommended to access potential treatments via [clinical trials](#), when possible. Outside of clinical trials, treatment options can be considered after careful consideration of risks and benefits, any existing data, and patient and/or family preference. See [NIH Treatment Guidelines](#).

- For patients on supplemental oxygen or ventilator:
 - Order **dexamethasone PO 6 mg daily** for up to 10 days until discharge, whichever occurs sooner (if concern for poor enteral absorption, use **dexamethasone IV 6 mg daily**)
 - If patient is pregnant, consult O&GYN regarding use of steroids in pregnancy
 - If patient is pregnant, consult prior to giving dexamethasone
- For patients on supplemental oxygen but NOT requiring mechanical ventilation or ECMO:
 - Consider **Remdesivir** (by emergency use authorization) 200mg IV on day 1, then 100mg IV on days 2-5, for up to 5 days or until discharge, whichever is sooner.
 - [See criteria for remdesivir use](#)
 - Counsel patient / caregiver about risks, benefits, and alternatives, provide FDA fact sheet on EUA remdesivir, and obtain verbal consent
 - Monitor hepatic function tests daily while on remdesivir
- Consider [clinical trial](#) enrollment if appropriate.
- Convalescent plasma is not currently recommended for routine use. If desired, recommend enrollment in clinical trial. If patient does not wish to enroll in clinical trial, convalescent plasma is available by emergency use authorization (EUA). Prior to ordering EUA convalescent plasma, provider must counsel patient on risks, benefits, and alternatives, provide FDA fact sheet for providers and caregivers, and obtain verbal consent.
- Order **Anticoagulation Prophylaxis Order Set**, if not already ordered
 - See [anticoagulation recommendations](#)
- Conservative fluid management as tolerated to avoid precipitating ARDS
 - **Avoid maintenance fluids**
- Patients are at increased risk for **cardiomyopathy**
 - Workup as appropriate
 - If decompensation, consider: ECHO, EKG, Troponin, BNP
- Watch for signs of [Hyperinflammatory Response Syndrome](#)
 - Consider admit to ICU or Stepdown Status
- Consider early **palliative care consult**, if available, for high-risk patients or goals of care unaligned with prognosis.

Point of Care Ultrasound



Communication

- Weekly touch base with front line teams/COVID team lead
- Structured email communications
- Weekly town halls



HOMERuN Research Network

- <https://www.hospitalinnovate.org/covid19/>

Welcome to the COVID-19 Response Working Team Knowledge Base

 You must be an authorized and registered user to access these pages.

Not a member? [Register here.](#)



Thromboembolism and Anticoagulation

- [Overview](#)
- [Key Questions We Studied](#) 
- [Endnotes](#) 

VTE



Discharge Criteria

- [Overview](#)
- [Key Questions We Studied](#) 
- [Reference Materials from Collaborators](#) 
- [Links to Resources from Collaborators](#) 

DISCHARGE CRITERIA



Workforce Planning

- [Overview](#)
- [Key Questions We Studied](#) 
- [Tables & Endnotes](#) 

WORKFORCE PLANNING



Provider Well-Being and Support

Section Currently Under Development



Patient Experience

Section Currently Under Development



Clinical Pathways and Documentation

Section Currently Under Development



Medical Education

Section Currently Under Development



Antiracism, Health Equity, and Social Justice

Section Currently Under Development



Workforce Planning Overview

[Home](#) / [Workforce Planning](#)

Workforce Planning

- [Overview](#)
- [Key Questions We Studied](#)
- [Tables & Endnotes](#)

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Topic Area

In late December 2019, COVID-19 began its global spread impacting hospitals and health systems across the globe. Hospital disaster planning has more typically focused on overcrowded emergency departments and decompressing emergency rooms, however in the case of COVID-19, hospitals faced a variety of new challenges.¹⁻³ Health systems faced shortages in providers for patients on the wards and in the intensive care units, and also faced shortages in equipment and medications.^{4,5} Patients with COVID-19, at least early in the pandemic, seemed to have an average length of stay that was increased often with prolonged hospital stays in particular for patients requiring intensive care unit-level services, though this depends on the population studied.⁶ Communities were not equipped to have patients with a highly infectious disease transfer out to subacute nursing facilities or long-term acute care facilities, which caused further back logs in hospitals. With critical personal protective equipment on short supply^{7,8}, institutions quickly had to modify current practices, which resulted in rapid innovations in staffing models and daily operations.⁹

We conducted artifact review from approximately 10 health systems from across the United States. Based on those findings, we conducted a survey that was sent to 36 hospitals/hospital systems from May 18 to May 21, 2020. Twenty-nine sites responded to the survey (81% survey response). Themes that the survey covered came from our initial document review and broad experience from approximately 6 institutions who had experienced a surge. We further enhanced insights from our survey during HOMERuN Collaborative calls and will be carrying out more detailed site interviews.

Professional Society Guidance

- *Chest* has previously published a consensus statement for care of the critically ill and injured during pandemics and disasters.¹⁰
- Persoff and colleagues have published a framework for the role of hospital medicine in emergency preparedness.¹¹



Adaptations

- 89% of hospitals utilized geographic cohorting
- 63% utilized virtual visits
- Various adaptations on census and documentation requirements

A silhouette of a hand holding a vertical bar, set against a warm, golden sunset background with bokeh light effects. The hand is positioned on the left side of the frame, with the thumb and index finger gripping the bar. The background transitions from a bright yellow center to a soft orange and pinkish-purple at the edges.

How can we support our people?

Thank you!

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