

## **Regional COVID-19 Coordination Center Operational Framework**

**Updated: March 27, 2020**

### **Overview**

The novel coronavirus (COVID-19), declared a Public Health Emergency of International Concern by the World Health Organization on January 30, 2020 and a pandemic on March 11, 2020, represents a clear and present danger to the health, well-being and economic stability of communities across the world. Following a public health emergency declaration by the federal Department of Health and Human Services on January 31, 2020, Washington Governor Inslee proclaimed a State of Emergency on February 29, 2020. Local emergency declarations were made throughout Washington following the governor's proclamation.

Healthcare facilities of all sizes have and continue to triage, evaluate and treat suspected and confirmed COVID-19 cases. Public health and other local and state agencies are coordinating local, regional and state response operations. In order to effectively continue delivering care to Washington patients within conventional and contingency standards, a state-wide approach linking healthcare facilities, public health and emergency management agencies, and emergency medical services is needed to equitably triage, place and transport patients requiring acute hospital care for COVID-19 related illness.

### **Concept**

Washington is composed of large, national healthcare systems; state-wide and local healthcare systems; large independent acute and other facilities; and numerous smaller clinics, inpatient facilities and outpatient specialty centers. While no individual or collective entity links disparate healthcare facilities across Washington, numerous partners currently impacted by COVID-19 or preparing for COVID-19 related impacts believe a centralized entity is required to direct patient placement to ensure maximum coordination and equitable distribution of patients across jurisdictional boundaries, established systems and responding agencies and institutions.

The Disaster Medical Coordination Center (DMCC) model is composed of local, regional and state-designated acute care hospitals volunteering as mass casualty incident and similar emergency patient placement coordination centers. The DMCC concept serves as a state-wide model for coordinated patient movement to appropriate acute care emergency departments; yet its limited scope in focusing on incident response patient movement to emergency departments requires adaptation for our current infectious disease emergency.

### **Purpose**

The Regional COVID-19 Coordination Center (RC3) is established to triage and place COVID-19 patients requiring acute emergency department or inpatient hospital care in an equitable manner across a wide area. It is designed to balance patient placement and transport to individual or multiple hospitals with sufficient capacity in order not to strain the resources of any single hospital or small group of hospitals. The RC3 serves as a focal point for COVID-19 patient triage, situational awareness, decision-making, bed



placement and ultimately patient transport to destination facilities with the capacity and capability to care for ill patients.

In addition to placing suspected or confirmed COVID-19 patients, the Center will also assist hospitals at maximum capacity seeking to decompress by transferring a group of COVID-19 or non-COVID-19 patients to other hospitals for continued care.

### **Scope**

The Regional COVID-19 Coordination Center is designed to place three or more patients at one time from any long-term care, alternate care or hospital facility requiring non-emergency transfer considerations to acute care hospitals. Given the urgency of the situation at hand, initially this document applies to Western Washington with the understanding and intent to be continually developed as a statewide model. While based on the Disaster Medical Coordination Center (DMCC) model, the RC3 will execute both new and existing partnerships, protocols and other initiatives beyond the scope of the DMCC concept.

The Center will also serve as a coordination hub for decompressing hospitals at or beyond capacity by placing patients from impacted acute care hospitals to similar settings. This decompression service will be implemented when at least three patients at once require movement to better stabilize the transferring facility.

This Framework is not currently designed for the RC3 to advise existing EMS agencies regarding patient placement from a non-healthcare facility incident scene or 9-1-1 dispatch scenario. EMS agencies will be receiving separate guidance documents through their reporting structure.

The Framework and operational aspects of the RC3 will be reviewed regularly by all stakeholders such as those listed below for quality assurance purposes.

### **Agency Coordination**

The Regional COVID-19 Coordination Center is led by Harborview Medical Center (Seattle, WA) in conjunction with University of Washington Medicine Transfer Center. It is supported by the Washington State Department of Health, local health jurisdictions, the Northwest Healthcare Response Network (NWHRN), EMS agencies, emergency management departments, and healthcare systems and facilities throughout Washington State.

### **Clinical Guidance**

The RC3 must have rapidly available clinical expertise and data to effectively and safely triage and place patients requiring hospital care for COVID-19 and related illnesses, or to decompress hospitals of similar or unrelated patients. To execute this, the RC3 will rely on clinical guidance and decision-making from clinical experts. If the region is under governmentally declared Crisis standards of Care, clinical guidance will be determined by the Crisis Standards of Care (CSC) Regional Triage Team comprised of physicians and bioethics expertise among other sub-specialties appointed by the Washington State Department of Health (please see CSC Triage Team Guidelines for details regarding the CSC Regional Triage Team).

### **Partner Agreement**

In order to successfully implement the RC3's mission, hospitals (acute care, specialty and critical access) and long-term care facilities (skilled nursing, hospice, etc.) throughout Washington state agree to the following principles:

- All acute care and critical access hospitals will accept confirmed or suspected COVID-19 patients
- It is understood that bed placement and capacity is a complex multifactorial process. But in this time of unprecedented medical surge, all facilities agree to minimize the number of “reserved” or “closed” beds to that necessary to support critical function (e.g. trauma beds)
- Recognizing the importance of surge capacity, all facilities will fully utilize licensed beds and maximize any additional surge capacity. This includes AIIR, negative pressure rooms and instituting cohorting principles to maximize surge capacity.
- All long-term care facilities will continue to use 9-1-1 emergency services for emergency patient transport.
- All healthcare facilities will regularly input data via WATrac and/or RC3 Microsoft Emergency Response Dashboard at directed intervals.
- All healthcare facilities will respond to on demand RC3 data requests for information in a rapid and timely manner to support situational awareness.
- Healthcare facilities seeking RC3 assistance will establish communication with RC3 personnel as early as possible, and will provide redundant contact information, patient acuity and other key data points.
- All initiating facilities and receiving hospitals agree that patients may need to travel long distances in order align with the fair and equitable process outlined above.
- All healthcare facilities will provide two points of contact to the RC3. One point-of-contact must be available 24/7 and have the authority to accept patient transfers.
- The RC3 will bear no financial responsibility for patient placement, transfer or transport.
- All EMS arrangements and directions will be managed by the individual facilities not by RC3.

### **Operational Procedures (See Diagram)**

The Regional COVID-19 Coordination Center will fulfill its mission by conducting the following actions:

- Healthcare facility identifies a need for RC3 to assist in patient movement as identified by the following reasons:
  - a) Movement of >3 patients from outside facility (i.e. LTC)
  - b) Movement of >3 patients to decompress an acute care hospital
- RC3 is operational 24/7 and is contacted through a single recorded telephone number (TBD) with radio backup. The center is located at Harborview Medical Center (Seattle, WA).
- The center is staffed by an RC3 Coordinator (Registered Nurse) who will receive and document the request(s).
- The appropriate clinical guidance is obtained for decision-making process:
  - if crisis standards of care (CSC) have been declared, CSC Regional Triage Team contacted
  - if non-CSC situation, the RC3 physician contacted

- The physician(s) reviews data elements from facility transfer centers, online dashboards, etc. Direct clinical discussion may occur between multiple partners such as: facility transfer centers, local DMCC, clinical providers directly and any other pertinent partner. This review could include a request for healthcare facilities to update information sources and/or provide patient or facility data elements.
  - The senior level physician must have extensive knowledge of regional characteristics for both pre-hospital providers and hospitals, and is responsible for assessment of patient condition based on pre-hospital or facility description and triage to the most appropriate facility based on capacity and location.
- If patient cannot be placed in Washington State, the Washington State Department of Health should be contacted.
- Verbal and written confirmation of bed placement location will be submitted to the requesting and receiving facilities.
- Patient tracking should be considered if patients are being moved to non-traditional spaces or locations such as a field hospital, recovery center, etc. (specific terms/locations TBD). Routine long-term care or inter-facility transfers will be tracked by standard hospital procedures.

#### **Quality Assurance**

The RC3 will regularly review its processes and outcomes as part of its quality assurance/improvement processes. It will provide routine reports to state healthcare preparedness coalitions outlining among other data points: call volume, call origination locations, the number of patients placed, their placement location and any barriers or challenges to patient placement.

It is understood that during a response, changes to procedures, space, staff and supplies may occur rapidly. Therefore, this Operational Framework will be reviewed frequently by the RC3 and Northwest Healthcare Response Network. In times of CSC, DOH will ensure processes outlined herein align with changing operational procedures, resource challenges and any other impediments to full implementation.