The University of Texas at Austin
Value Institute for Health and Care
Dell Medical School & McCombs School of Business

In May 2020, Washington State Gov. Jay Inslee asked Vice Admiral Raquel Bono, MD (Ret.) to serve as the state's Director of Health System Response Management. Over a period of six months, Adm. Bono—a visiting scholar at the University of Texas at Austin's Value Institute for Health and Care—worked with leaders from across multiple government and economic sectors to develop a coordinated and effective response to the COVID-19 pandemic, prepare for subsequent patient surges, and provide recommendations for making Washington's health system more integrated and responsive to the needs of state residents.

In conjunction with Adm. Bono's role at the Value Institute, and in service to health leaders globally who are confronting the pandemic, we are publishing two major work products of the Washington State COVID-19 Health System Response Management team.

The first, the **Pandemic Dossier**, was presented to Gov. Inslee in May 2020. It contains recommendations for mounting a response to the pandemic and outlines plans for managing an expected surge in patient cases. The Dossier details steps for optimizing the interactions of public health and government agencies, designing a public health system care continuum, creating public-private partnerships, and developing a statewide health data system.

The second document, styled as a **Playbook**, was presented to Gov. Inslee in September 2020. It makes recommendations in five focus areas: acquiring and distributing personal protective equipment, implementing statewide Covid-19 testing, preparing for surges of patients, optimizing state health resources, and leveraging stakeholder relationships between the health care sector and other industries.

Adm. Bono will discuss the Pandemic Dossier and the Playbook during a webinar on December 10, 2020. You can register for that webinar here: bit.ly/36QnoZh

May 29, 2020

Dear Governor Inslee,

It has been an honor and privilege to serve you and the State of Washington as the Director of Health System Response Management during the COVID-19 pandemic. I am pleased to present you with the attached dossier that summarizes the team's efforts to achieve a coordinated and effective response to the COVID-19 pandemic, prepare the health system to handle a fall surge and provide recommendations for a more integrated system of health for all Washingtonians.

The launch of WA HEALTH and the drafting of Proclamation 20-24 are the enduring artifacts for the collective and coordinated efforts of the state's health care system that I addressed on your behalf. WA HEALTH provides a state-wide view of hospital capacity for acute care, ICU and surge beds, as well as PPE, staffing and ventilator availability. Proclamation 20-24.1 was created through the combined efforts of clinical communities, labor unions and the professional associations to guide the recovery of the health care system during Washington's "Safe Start," while facing ongoing COVID-19 infections and PPE shortages.

During our weekly conversations, I briefed you on several lines of effort to bolster Washington's ability to mount an effective response to COVID-19. In these pages you will find more information about each area, including analysis from experts serving on my team. This dossier also contains recommendations to optimize the state's health care system for a likely seasonal surge while positioning the state, local health and private industry to co-create a more integrated system of health by:

1. Optimizing interfaces between public health elements and governmental agencies;
2. Designing a public health system care continuum;
3. Creating more robust public-private partnerships with businesses and industries;
4. Developing an integrated data system that equitably supports health for all.

We know the health care community has done an exceptional job generating surge capacity and conserving PPE in the face of this pandemic. Now I encourage the great state of Washington to build upon the work and momentum the Health System Response Management team has rapidly set in motion. By doing so, I am optimistic you will realize an even more robust system, one ideally positioned for the future with shared resources and a truly collective view of patient wellness, care and service.

I am deeply grateful for the chance to assist you and all Washingtonians during this defining health crisis.

Respectfully,

Raquel "Rocky" Bono, MD

CONTENTS

TEAM

COVID-19 Health System Response Management (HSRM)

This work is the result of the diverse expertise and many contributions of our HSRM team members.

HSRM Director: Vice Admiral (ret.) Raquel "Rocky" Bono, Office of The Governor

Chief of Staff: Clark Halvorson, Washington State Department of Health

HSRM Team: Gloria Brigham, Washington State Nurses Association
Chris Davis, Office of The Governor
Jill Edgin, Washington State Department of Health
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Molly Voris, Office of The Governor
Ron Weaver, Washington State Department of Health
Susan Woodward, Office of The Governor

Thank you to each of these team members and the hundreds of experts, stakeholders and community members across the health care system who provided input into the HSRM team's work to strengthen Washington state's response to COVID-19.

SUMMARY

What's Inside
The purpose of this document is to illustrate to key leaders the Health System Response Management (HSRM) team's work from March 23 to May 31, 2020 and to inform and guide future actions related to state-wide response efforts to the COVID-10 pandemic and other health crises.

Each section in the following document contains a brief overview, analysis and recommendations in the following five work areas:

1. Fully implement WA HEALTH
WA HEALTH is a new, state-wide data system tracking critical information related to the COVID-19 response, including availability of hospital beds, personal protective equipment and ventilators. The data collected and displayed by this system supports decision making at the facility, local, regional and state-wide levels. The HSRM team played a critical role deploying this new system and recommends strategies to ensure WA HEALTH's continued success as a state-wide common operating and planning tool.

2. Inform long-term care strategy
The state's long-term facilities (LTCFs) are home to some of our most vulnerable populations. COVID-19 can spread rapidly in LTCFs and to other populations in our communities, filling nearby hospitals. The intent of the HSRM team's work in this area is to encourage a shared understanding of disease identification in LTCFs to forecast potential stressors on health care resources, inform PPE and testing strategies for these congregate populations and improve consistency and coordination between all entities that interact with the state's more than 4,000 LTCFs.

3. Design health care system recovery
Washington's health care providers took swift and effective action to preserve health care capacity by suspending non-emergency medical and dental procedures and conserving PPE. The HSRM team's work in this area resulted in a new proclamation from Governor Inslee on May 18, 2020, outlining the conditions under which medical and dental providers can safely resume non-urgent procedures, while maintaining surge capacity and protecting frontline health care workers. Now there is opportunity for further recovery planning and partnering with the health care system to evolve to a more integrated, responsive and effective resource for future public health emergencies.

4. Inform fall surge planning
The joint efforts of the state, the health care system and the public helped Washington "flatten the curve" in the face of an unprecedented global pandemic, and we learned many lessons along the way. The HSRM team reviewed best practices; conducted an environmental scan of PPE supply chains and testing and contact tracing; and considered other potential health care emergencies. From these assessments, HRSM developed recommendations to optimize the state and health care system's preparedness for the anticipated dual surge of COVID-19 and seasonal influenza this fall, to include more clearly defined roles and responsibilities and developing a regional approach for a coordinated emergency response.

5. Ensure smooth transition
Vice Admiral Bono's assignment has ended but the high-quality work in these four areas has ongoing value to the State of Washington and should continue. Based on the team's accomplishments, observations and diverse partnerships that occurred in the course of the HSRM's work, several recommendations are provided to continue efforts toward co-creating a more integrated, connected system of care for Washington. The basis for this integration recognizes the need for a robust, integrated data system that enables broader situational awareness and supports a transparent care continuum between population groups, public health officials, health systems and agency leads.

EXECUTIVE SUMMARY

GOAL 1: FULLY IMPLEMENT WA HEALTH FOR HOSPITALS

The WA HEALTH system has been adopted by all 107 acute care hospitals in Washington state. Leaders, including Governor Jay Inslee, cabinet-level state officials and hospital administrators, are now referring to WA HEALTH data to help inform decision making related to the COVID-19 pandemic response. Future success will require ongoing sustainable resourcing to provide system evolution, data governance, data quality and user support.

BACKGROUND

WA HEALTH (Washington Health care Emergency and Logistics Tracking Hub) was developed to gather key hospital data into a single dashboard to help leaders across Washington make effective, timely and informed decisions in response to the COVID-19 pandemic. When paired with expert context, WA HEALTH enables timely, data-driven decision making at facility, system, county and state levels regarding patient distribution, resource allocation, federal assistance requests and the overall health of the health care system. It also helps hospitals satisfy federal reporting requirements.

The portal receives periodic updates shaped by user feedback, state leadership needs and federal reporting requirements.

Currently, WA HEALTH collects hospital data on:

- Available beds;
- ICU capacity;
- PPE stores;
- Ventilator numbers;
- Staffing;
- Other equipment and supplies.

OBJECTIVES & RECOMMENDATIONS

Objective 1: Ensure WA HEALTH stays current with rapidly changing federal data requirements and state-wide decision-making needs.

Recommendations

- Establish a permanent business owner
- Continue collaboration with Microsoft
- Develop robust export and reporting capability at all user levels
- Continue collaboration with state leadership (Governor's office, Department of Health, Washington State Hospital Association, etc.) and hospitals
- Keep current with federal reporting requirements

Objective 2: Ensure technical support to help new and existing users transmit critical data and make informed decisions.

Recommendations

- Establish a permanent business owner
- Resource support channels at all tiers so users receive timely, accurate responses and ongoing education Resource data integrity efforts and troubleshoot issues

Objective 3: Develop robust governance to ensure appropriate use of system, access to data, public views and data security.

Recommendations

- Establish a permanent business owner
- Develop a governance group comprised of end users and data consumers; group should include:
    - Hospitals (large and small)
    - Health care coalitions
    - Department of Health
    - Local health jurisdictions (large and small)
    - Washington State Hospital Association (WSHA)
    - Other agency and organization partners

Objective 4: Identify and secure sustainable funding to appropriately resource WA HEALTH currently and into the future.

Recommendations

- Establish a permanent business owner
- Identify sustainment and growth costs
- Identify and secure funding to satisfy identified costs
    - Explore licensing or subscription service for end-user agencies
      Note: Could be impacted by objective 5.

Objective 5: Strategically expand WA HEALTH data fields to additional state and health care sector decision makers.

Recommendations

- Establish a permanent business owner
- Work with other agencies to determine if WA HEALTH is the right solution
- Determine ownership of project, contract with Microsoft, etc.

See following pages for detailed analysis regarding each of these recommendations.

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Fully implement WA HEALTH for hospitals

OBJECTIVE 1: ENSURE WA HEALTH STAYS CURRENT WITH RAPIDLY CHANGING FEDERAL DATA REQUIREMENTS AND STATE-WIDE DECISION-MAKING NEEDS.

To remain relevant, WA HEALTH must evolve with dynamic information needs at state and federal levels.

PROBLEM STATEMENT

WA HEALTH must evolve with the state's changing health care system needs and requires continuous technical updates. Implementing technical upgrades and helping hundreds of users adapt to future changes will require on-going labor and resourcing.

BACKGROUND/CURRENT STATE

On April 3, 2020, Microsoft demonstrated an information dashboard to the state's COVID-19 Health System Response Management team.

On April 6, 2020, a team including Washington State Department of Health (DOH) staff and Microsoft developers came together to discuss the technical and business requirements for launching this product on a large scale. WA HEALTH was launched on April 15, 2020, 12 days after its preview, and the team proceeded to configure, train and adopt the program for nearly 500 people. This work took a team of DOH staff and Microsoft resources—including a project manager, developers, technical support staff, business analysts, and organizational change management specialists—approximately six weeks.

ASSUMPTIONS

- WA HEALTH will remain an essential data reporting tool to inform current and future emergency responses.
- The state Department of Health will own, facilitate and support the current configuration of WA HEALTH, with acute care hospitals reporting to the system.
- There will be sufficient funding and staffing resources to continue WA HEALTH operations.
- Acute care hospitals will continue to report data.
- Information needs will continue to evolve at user, state and federal levels.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
State-level decision makers	**Rely on data to inform decisions**
Disaster advisory committees	**Rely on data to inform decisions**
Health care coalitions	**Rely on data to inform decisions**
Local health jurisdictions	**Rely on data to inform decisions**
Hospital systems & individual hospitals	**Enter data into the systems; rely on data to information decisions; use system to satisfy federal reporting requirements via WA HEALTH**

OPTIONS

Appropriately assign and resource WA HEALTH to address ongoing user support, system development and evolution.

ANALYSIS

WA HEALTH data is in use by decision makers across the state (including in the Governor's Office) and is not readily replaceable. We must identify a team with the right skills, expertise and bandwidth and fund their work.

RECOMMENDATIONS

Continue to support WA HEALTH with the right leadership, staff and resources to retain and evolve WA HEALTH as the primary source of health care information for hospitals, local health jurisdictions, health care coalitions, disaster advisory committees and state agencies.

Rationale: All 107 acute care hospitals across the state have adopted WA HEALTH and are inputting unique data every day.

Next steps:

- Establish an owner for this work. It would be optimal to house WA HEALTH within a program that is deeply engaged with hospitals on mandated data collection and analysis and surveillance, such as the Communicable Disease Epidemiology group that runs many other data systems;
- Continue collaboration with Microsoft for ongoing system engineering and design
- To include development of robust export and reporting capability at all user levels;
- Continue collaboration with state leadership (Governor's office, DOH, WSHA, etc.) and hospitals to understand user needs;
- Keep current with federal reporting requirements;
- Integrate user feedback gained through ongoing user support calls and email.

CONTACTS

Name	Title and Org	Contact info	Role
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Fully implement WA HEALTH for hospitals

OBJECTIVE 2: ENSURE TECHNICAL SUPPORT TO HELP NEW AND EXISTING USERS TRANSMIT CRITICAL DATA AND MAKE INFORMED DECISIONS.

Robust technical support will ensure people use WA HEALTH appropriately generate the best quality data for decision making.

PROBLEM STATEMENT

Timely technical support is essential to reduce data error and user frustration, which can result in non-use of any system. For example, new users often have registration questions and need help with selections and permissions, or fixes for incorrect email addresses, as they learn to use the system.

WA HEALTH has unique data fields and questions that may differ from what users are accustomed to. In addition, these users can provide input that is critical to the system's ongoing success.

BACKGROUND/LESSONS LEARNED

When WA HEALTH launched on April 15, 2020, it was a product still in development. The Microsoft team often equated it to "building the plane while we're flying it" and remarked that we were doing in 12 days what they would normally take *at least six months* to accomplish.

The pace was understandable given the emergent nature of the pandemic response. We learned about the massive investment of time required to ensure users knew how to use the system and the benefits their data entry would bring. Our recommendations for on-going support and resourcing reflect this lesson.

Looking forward, we have learned we will need to help regular users keep up to speed with the inevitable system changes and updates to come. As noted earlier, all of these changes will require hospitals to go back into their facility set up and enter their baseline capacity numbers for each data field so they can continue to report accurate data, which cascades to aggregated reporting for counties, regions and the state.

To keep up with these demands, we have set up ongoing data quality work streams to monitor and validate the information we see in WA HEALTH. This is currently being done in collaboration with the Washington State Hospital Association and is consuming approximate two FTEs.

DOH and Microsoft also committed temporary resources to hold weekly (previously, twice a week) support calls for all WA HEALTH users. These calls have been instrumental in informing how questions were worded, identifying common pitfalls and providing technical assistance to hospitals related to federal reporting. The generosity of the user community in helping to make WA HEALTH the strongest product it can be has been humbling at every turn. They continue to dial in, often up to 150 callers per session, to provide feedback and support.

Going forward, WA HEALTH will need dedicated, long-term support resources to give users the information they need to provide the critical data that decision makers are already relying on. Designating this an "other-duties-as assigned" task poses significant to the success and efficacy the system has realized to this point.

ASSUMPTIONS

- WA HEALTH will continue to be a necessary data reporting tool for informing current and future emergency responses.
- DOH will continue to own and support the current configuration of WA HEALTH, with acute care hospitals reporting to the system.
- Appropriate funding and resources will be secured to sustain DOH operations of WA HEALTH.
- Acute care hospitals will continue to report data to WA HEALTH.
- Information needs will continue to evolve at the user, state and federal levels.
- User support needs will continue.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
State-level decision makers	**Rely on data to inform decisions; understand changes in data presented**
Disaster advisory committees	**Rely on data to inform decisions; understand changes in data presented**
Health care coalitions	**Rely on data to inform decisions; understand changes in data presented**
Local health jurisdictions	**Rely on data to inform decisions; understand changes in data presented**
Hospital systems & individual hospitals	**Frontline data entry users of WA HEALTH; must be able to create accounts and set up facilities; must interpret questions and enter correct data**

OPTIONS

- Appropriately resource ongoing technical support needs of WA HEALTH so that user issues can be resolved quickly and accurately.

ANALYSIS

- Assuming that WA HEALTH will continue to be used for COVID-19 response and beyond, there is no other option than continuing to provide timely and accurate customer support. WA HEALTH is already in use by decision makers across the state; we risk reducing the accuracy of the data and damaging trust with our partners if we fail to meet their technical support needs. We will need to identify staff with right the skill set, subject matter expertise and bandwidth, as well as the funding to support their work.

RECOMMENDATIONS

We strongly recommend continuing to support WA HEALTH with the right leadership and staff so that it remains a viable tool for hospitals, local health jurisdictions, health care coalitions, disaster advisory committees, DOH, and other state decision makers. Technical support is a foundational piece of meeting these commitments.

Rationale: WA HEALTH is already in use by all acute care hospitals, and the data it provides is used for decision making at all levels. This data is not easily reproduced by any other means. WA HEALTH users need ongoing support in order to continue providing the critical information already in use by decision makers.

Next steps:

- Establish an owner for this work. It would be optimal to utilize existing state technical support resources (HTS, WaTech, etc.) to provide these services.
- Appropriately resource support channels at all tiers so users receive timely, accurate responses to support questions and ongoing education to reduce support needs.
    - Ongoing user support calls
    - Tier 1 business support: setting up an account, help with answering questions
    - Tier 1 technical support: account complications beyond simple set up, isolated incidents of anomalous data displays, etc.
    - Tier 2 support: issues resulting from back-end configurations
    - Tier 3 support: system-wide issues requiring a Microsoft solution
- Appropriately resource data quality effort to troubleshoot data integrity issues and work with end users to resolve. (Currently data QA requires 1 DOH FTE and 1 WSHA FTE.)

CONTACTS

Name	Title and Org	Contact info	Role
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James Norris	**CHL Development Supervisor, DOH**	**james.norris@doh.wa.gov 253.576.5879**	**Technical expert on back-end systems**

Fully implement WA HEALTH for hospitals

OBJECTIVE 3: DEVELOP ROBUST GOVERNANCE TO ENSURE APPROPRIATE USE OF SYSTEM, ACCESS TO DATA, PUBLIC VIEWS AND DATA SECURITY.

Governance is critical to WA HEALTH's usefulness, relevance, security and responsiveness to the changing demands of users.

PROBLEM STATEMENT

The WA HEALTH system represents a significant step forward in our state's ability to collect, share and act on critical health care system data.

Ensuring the system *remains* a credible source of accurate, actionable information requires significant coordination, stakeholder outreach and discipline regarding access, data structure and decision making.

BACKGROUND/CURRENT STATE

The WA HEALTH team has been primarily focused on rapid development and deployment of the product, driving state-wide adoption and ensuring high-quality data inputs and outputs. Formal governance was intentionally deferred. The next 90 days is a critical time to establish this work to inform and support future iterations.

ASSUMPTIONS

- The information in the rest of this section assumes the following conditions are true:
- The WA HEALTH system remains in operation beyond the COVID-19 pandemic response
- Any governance group will be adequately staffed to organize and facilitate meetings, plan and track key work, maintain proper records of decisions, standards, work products, etc.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
Executive policy- and decision-makers	End users of this data at the Governor, Cabinet and Secretary levels make critical decisions around resource procurement and deployment based on this data. They require high-quality, current, actionable information to best serve the state.
End users	End users are hospital employees who enter the data. The system must be usable, responsive and serve their reporting requirements to ensure high participation rates and data accuracy.
Program business staff	Strong leadership and support are required from whoever ultimately owns the WA HEALTH system. Business staff are responsible for interfacing with end users and decision-makers to ensure the product meets their needs. They interface with IT staff to define requirements and implement changes in policy, business, or end-user needs.
IT staff	IT staff are responsible for technical maintenance, changes and tech support to ensure the system works as intended and evolves in line with changing business and end-user demands.
Regional coalitions, industry groups and labor organizations	Our health care system has many, many stakeholders. Working with respected, existing organizations ensures expert stakeholder feedback.

OPTIONS

No matter which direction the state chooses, an effective governance group needs to be a stable, well-organized body with the responsibility, authority and resourcing to act on the following areas:

- **Maintain and improve data reliability:** The system is only as good as the data being entered and reported out. The governance group should be responsible for regularly verifying data quality. .
- **Ensure appropriate access and security:** In adopting WA HEALTH, health care providers have demonstrated unprecedented cooperation and agreed to unprecedented transparency of data they historically consider sensitive. The state is responsible for ensuring this data is appropriately accessed through an empowered governance group.
- **Ensure consistent business, clinical and data descriptions:** WA HEALTH captures data about our state's ever-changing health care ecosystem and needs to keep up with related best practices and business policies to remain relevant.
- **Analyze and recommend upgrades**: The system will need to undergo technical and design changes as it evolves. The governance group should be responsible for and authorized to analyze change requests and provide expert guidance.

There are **two options** for a WA HEALTH data governance group:

1. **Multidisciplinary**: This option would include key state agency and emergency response representatives, as well as external labor, health care and business stakeholders.

2. **State employees**: This option would include only state business owners and IT staff, who would stay abreast of changes in technology, policy and user requirements and decide on behalf of system users.

ANALYSIS

1. **Multidisciplinary**

   Pros: To leverage expertise and build efficiency, it is considered best practice to include both data producers and consumers in a governance group.

   Cons: Requires robust staffing and commitment from the agency that owns WA HEALTH. Scheduling such groups can be a challenge.

2. **State employees**

   Pros: Marginally less investment up front. Communication and scheduling can be easier.

   Cons: This design puts the entire work, decision-making and communication burden on agency staff. In addition, this configuration risks the appearance of decisions made in a vacuum. Socializing changes with stakeholders who were not involved in the process can be more difficult.

RECOMMENDATIONS

We strongly recommend establishing and resourcing **a multidisciplinary governance group** of executive, agency, industry and end-user representatives as soon as possible to ensure sustained participation in the state's WA HEALTH investment. This group should be explicitly authorized and responsible data quality, data access, terms and definitions and recommending changes to the system.

Rationale: While the agency only option may appear easier, it is likely to be equally if not more labor intensive to maintain over time. In addition, it risks losing diverse industry expertise and peer-to-peer socialization, which would build upon the collaborative spirit that has driven WA HEALTH's success to date.

Next steps:

1. Choose governance model
2. Confirm responsible agency, system owner and resources
3. Identify key stakeholders and resources
4. Establish group

CONTACTS

Name	Title and Org	Contact info	Role
Erika Henry	**Emergency Operations Supervisor, DOH**	**erika.henry@doh.wa.gov 360.701.7532**	**Project lead for WA HEALTH Phase 1 implementation**

Fully implement WA HEALTH for hospitals

OBJECTIVE 4: IDENTIFY AND SECURE SUSTAINABLE FUNDING TO APPROPRIATELY RESOURCE WA HEALTH CURRENTLY AND INTO THE FUTURE.

The ongoing success of WA HEALTH relies on securing funding for the technical and staff resources to support it.

PROBLEM STATEMENT

The development of WA HEALTH was an unanticipated cost absorbed by WA DOH in order to quickly help hospitals and decision makers better understand the health care systems impacts resulting from COVID-19. Moving forward, it will be necessary to incorporate WA HEALTH into the state's broader information technology resource pool, which requires funding to support the system.

BACKGROUND/CURRENT STATE

Microsoft offered their consulting, design, engineering, and project management services at no charge to develop and launch early versions of the product. It's a mutually beneficial relationship – Microsoft is able to develop a product they can deploy for customers all over the world, and Washington gets critical help solving data challenges related to COVID-19.

However, this initial development period is coming to an end, at which time Microsoft will start collecting licensing fees for system use. Other costs include the DOH IT and business staff required to keep the system operational. This work has been a full-time job for several people since the end of March.

ASSUMPTIONS

- The WA HEALTH system remains in operation beyond the COVID-19 pandemic response.
- WA DOH continues to be the primary owner of WA HEALTH.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
Executive policy- and decision-makers	Users of this data at the Governor, Cabinet and Secretary levels make critical decisions based on this data. They require high-quality, current, actionable information.
End users	End users**, including** hospital employees, enter the data. The system must their requirements to ensure high participation rates and data accuracy.
Program business staff	Strong leadership and support are required from whoever ultimately owns the WA HEALTH system. Business staff interface with end users and decision makers to ensure the product meets their needs. They interface with IT staff to define and implement changes due to policy, business, or end-user needs.
IT staff	IT staff are responsible for technical maintenance, changes and tech support to ensure the system works as intended and evolves in line with changing business and end-user demands.
DOH financing	Proper financial accountability for this portal will be important as state government enters challenging budgeting environment in the coming months.

OPTIONS

1. Charge hospitals a licensing or subscription fee to continue to use WA HEALTH.
2. Identify general funding from the state to support the costs of building and sustaining WA HEALTH.
3. Identify federal funding to support the costs of building and sustaining WA HEALTH.

ANALYSIS

1. **Charge hospitals a licensing or subscription fee to continue to use WA HEALTH.**

   Pros: This approach would decrease the unexpected funding burden on WA DOH, and would give hospitals greater investment in ensuring the system is put to good use.

   Cons: Hospitals may simply decide to stop participating if asked to pay. Though they appreciate the value and benefits WA HEALTH provides, hospitals are in a period of challenging finances and do not want to commit to new expenses. Critical access hospitals in particular find this especially unattractive. Additionally, charging hospitals to use this system could impact the State's ability to drive design decisions by dispersing ownership responsibility.

2. **Identify state general funding to support building and sustaining WA HEALTH.**

   Pros: This approach reduces the unexpected cost burden of WA DOH to support this program. This approach also encourages buy in from state leadership to ensure this tool remains relevant for the broad base of users across state government currently accessing the system.

   Cons: It can be difficult to obtain general funding from the state. This type of funding can fluctuate or go away entirely.

3. **Identify federal funding to support the costs of building and sustaining WA HEALTH.**

   Pros: Federal funding is available to augment state and local funding for COVID-specific activities, potentially including WA HEALTH, especially considering that WA HEALTH helps hospitals meet federal reporting requirements.

   Cons: There are restrictions on how federal funding can be utilized, and it will require the careful, on-going attention by WA DOH finance staff to interpret guidance associated with these funds. This type of funding can fluctuate or go away entirely.

RECOMMENDATIONS

It is recommended to use a combination of Options 2 and 3. Under Option 3, the development costs to date can likely be covered by federal COVID-19 funding as part of our broader response activities.

Moving forward, WA HEALTH should be tied into broader agency efforts as an ongoing health technology systems program. Seeking foundational public health services funding (Option 2) would be appropriate. Stable funding will help WA DOH support WA HEALTH and continue to provide its services to other agencies.

Next steps:

- Establish a business owner for this work
- Identify sustainment and growth costs for this system
- Need to understand costs from Microsoft, HTS, WaTech, staffing, etc.
- Identify and secure funding to satisfy identified costs
-

CONTACTS

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Fully implement WA HEALTH for hospitals

OBJECTIVE 5: STRATEGICALLY EXPAND WA HEALTH DATA FIELDS TO ADDITIONAL STATE AND HEALTH CARE SECTOR DECISION MAKERS.

There are many potential uses for WA HEALTH, and several agencies have expressed interest in developing new functionality to suit a variety of health care information needs.

PROBLEM STATEMENT

State agencies have expressed interest in using WA HEALTH to tackle a variety of issues. Proper planning is required to identify priorities and define who owns, contracts for, and funds such development work.

BACKGROUND/CURRENT STATE

The reception for WA HEALTH has been enthusiastic. The HSRM team has had conversations regarding use cases for DSHS, DES, EMS regions and others. Some identified growth opportunities include tracking information from new sectors (such as long-term care facilities), and adding new questions about topics such as PPE, testing supplies, bed availability, and disease statistics. It makes sense to develop additional WA HEALTH capability in a way that meets users' strategic needs and increases the effectiveness of the state's COVID-19 response.

ASSUMPTIONS

- The WA HEALTH system remains in operation beyond the COVID-19 pandemic response.
- WA DOH continues to be the primary owner of WA HEALTH.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
Executive policy- and decision-makers	Users of this data at the Governor, Cabinet and Secretary levels make critical decisions based on this data. They require high-quality, current, actionable information.
End users	Current and future end users enter the data. The system must their requirements to ensure high participation rates and data accuracy.
Program business staff	Strong leadership and support are required from whoever ultimately owns the WA HEALTH system. Business staff interface with end users and decision makers to ensure the product meets their needs. They interface with IT staff to define and implement changes due to policy, business, or end-user needs.
IT staff	IT staff are responsible for technical maintenance, changes and tech support to ensure the system works as intended and evolves in line with changing business and end-user demands.
Financing staff	Proper financial accountability for this portal will be important at each agency.

RECOMMENDATIONS

Making the most of WA HEALTH depends on ongoing conversations with partner agencies and users regarding information needs, ownership, funding and staffing and other considerations. The following are some basic steps to ensure that work proceeds strategically.

Next steps:

- Establish an owner for this work
- Work with other agencies to determine if WA HEALTH is the right solution to meet strategic needs
- Determine ownership, resourcing and prioritization of potential projects, contract with Microsoft, etc.

CONTACTS

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###

GOAL 2: INFORM LONG-TERM CARE STRATEGY

Washington state has more than 4,000 long-term care facilities (LTCFs), including nursing homes, assisted living facilities, adult family homes and enhanced services facilities. The purpose of the recommendations below is to ensure a coordinated, effective response to identify and reduce risks associated with COVID-19 in these facilities.

BACKGROUND

LTCFs are home to some of Washington's most vulnerable residents, and the long-term care (LTC) system has been hard hit by the COVID-19 pandemic nationwide. The infection and death rates within LTC exceed the averages for the general public, and the coronavirus has the potential to quickly spread to other sectors of our community and rapidly fill the beds of nearby hospitals.

Washington state must make every effort to care for and protect LTC residents and LTC health care workers from further spread and future outbreaks. Developing strategies to address current needs for testing, personal protective equipment (PPE) etc., as well as developing long-term planning for future surges, is essential for the health of LTC residents, staff and the state as a whole.

OBJECTIVES & RECOMMENDATIONS

Objective 1: Develop shared understanding for disease identification in LCTFs to forecast potential stressors to health care resources and better prevent and control the spread of COVID-19 infections within these facilities. Ensuring the state has consistent guidance and messaging and is developing a robust testing strategy for all residents and LTC health care workers will be critical to this forecasting ability.

Recommendation 1

Develop understanding of current public health surveillance and reporting and improve coordination between local health jurisdictions (LHJs), DOH and the Department of Social and Health Services (DSHS). Due to the volume of guidance for long-term care, from local, state and federal entities, consistency among the more than 4,000 facilities within Washington state has been challenging. It would help to establish a recurring link between LTC providers and associations, using their experience on the ground and partnering with LHJs, DOH and DSHS as they develop and update guidance.

Recommendation 2

Develop LTCF testing strategy. This strategy will need to roll out in phases, given the logistical complications and challenges across LTCFs. The immediate goal is to test all employees and residents within nursing homes and assisted living facilities with memory care units, with the goal of completing this within two weeks for nursing homes and four weeks for assisted living. Additional plans will need to be developed for the remaining LTCFs, as well as a strategy for interval testing of all staff across all LTCFs.

Objective 2: Develop long-term care data dashboard system. Following the success of WA HEALTH for hospitals and hospital systems, it has been recommended to develop a similar dashboard for LTCFs.

Recommendation
Whatever vehicle is ultimately chosen, the dashboard should include:

1. Disease prevalence (in staff and residents);
2. Status of PPE;
3. Status of testing;
4. Beds and staff availability; and
5. Status of infection control practices and technical assistance.

Additionally, the dashboard will need to be accessible to DSHS, DOH, LHJs and potentially include a public-facing piece as well. Further, the ability to streamline and reduce the many avenues of reporting currently being done by nursing homes, in particular, should be a priority.

Reporting will likely need to be scaled for adult family homes and other smaller programs so that they are only required to provide a few baseline data points. Finally, the ability to use the platform to transmit data and information to federal partners would be incredibly useful. Mirroring WA HEALTH seems the best option for this, but there needs to be a review of costs, resources, data security, data input flexibility for small providers, etc. to determine how to move this forward and which vehicle may be best for this dashboard.

Objective 3: Develop and implement strategic approach to long-term care facility recovery.

Recommendation
Develop and implement statewide strategy for reestablishing the usual policies and regulations and making plans for the anticipated fall surge. CMS has issued guidance for “reopening” of nursing homes, which directs states to develop their own plans and procedures. DSHS, DOH and stakeholders would engage in a format similar to what happened with the health system reopening proclamation. This will allow key players to discuss how to restart things such as access for visitors safely and in accordance with the Governor’s proclamations. In addition, this group can brainstorm how to better prepare the long term care system for future surges and outbreaks of COVID19, as well as how to prepare for a possible concurrent influenza season this fall and winter.

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###

GOAL 3: DESIGN HEALTH CARE RECOVERY PLAN

The recovery of our health care system is critically important to maintaining the health and safety of Washingtonians who depend on that system and for ensuring that our state-wide healthcare resources are well positioned to face a potential fall surge in COVID-19.

BACKGROUND

When the COVID-19 crisis was beginning in the Seattle area, there were significant concerns from the Governor, the Department of Health, the health care system, patient advocates and others about the capacity available in hospitals to treat COVID-positive individuals.

On March 19, 2020, Governor Inslee issued a proclamation that restricted non-urgent medical and dental procedures to ensure there was capacity in hospitals to be able to handle a surge in COVID patients. Most non-urgent procedures ended.

As a result, the health care system began having financial difficulties. Additionally, it became evident that hospitals, ambulatory surgery centers and others were overly stringent in interpreting the proclamation. On April 29, 2020, at the request of hospitals, ambulatory surgery centers and dental facilities, the Governor issued an interpretive statement to clarify services that were permitted under the original proclamation, which allowed for more non-urgent procedures. Another clarification was issued on May 7, 2020.

The original proclamation was to expire on May 17, 2020, at midnight. The Governor's Office appointed Bill Robertson, President and Chief Executive Officer, MultiCare Health System, and Sally Watkins, Executive Director, Washington State Nurses Association, to lead a group of private sector members of health care and dental systems, including workers, to develop a framework to replace the existing proclamation with a new one that would reopen the health care system.

The group used a document provided by the state, and they altered it significantly to develop the final framework. Proclamation 20-24.1 can be found online here.

As the health care and dental systems move toward recovery, there are some important factors that need to be monitored to understand the capacity of the system, including:

- Ability of hospitals to surge beds by 20 percent;
- Appropriate available supplies;
- Appropriate PPE for health care workers.

Many of these factors are monitored and should be continued to be monitored through WA HEALTH entries by hospitals.

Recommendations
Below are important recommendations for the next phases of the health care system recovery.

1. **Monitor and adapt**: As the recovery efforts of the health care and dental system continue, it is critical to monitor various factors to ensure activities are continuing in a safe manner, including bed capacity in hospitals and PPE for health care workers. If there are problems that arise, it may be necessary to adjust the proclamation issued to address those issues.

2. **Plan for a surge of COVID cases**: It may be necessary to issue additional proclamations if there is a surge of COVID cases and the state needs to prepare for additional capacity in the health care system. There could be an alternate version of a non-urgent procedure ban put into place that would allow for a more gradual prohibition on services, rather than all at once. This would allow the system to adjust to more restrictions and in certain areas and health care settings. For example, rural hospitals' financial vulnerabilities are different than those of larger health care systems. This is an area for examination going forward.

3. **Longer term health care system**: We have learned from this experience that the health care and dental systems are highly dependent on high volume, non-urgent services due to the structure of payment for services. Alternative payment arrangements should be explored to focus more on high-value care and less on elective procedure volumes.

###

GOAL 4: INFORM FALL SURGE PLAN

Develop recommendations to prepare Washington state for anticipated fall surge of COVID-19 cases.

BACKGROUND

Washington state is beginning to emerge from what may be described as the first phase of the COVID-19 pandemic. The health care community responded to the anticipated surge of patients, providing space, staff and supplies. Their diligent work allowed patients to receive exceptional care during an unprecedented public health emergency. In addition, the institution of non-pharmaceutical interventions and the public's adherence to these interventions resulted in "flattening the curve."

During this time, there was state-wide collaboration between emergency management, local health jurisdictions and many health care organizations and coalitions. Previous planning, exercising and relationships were foundational to the successes. However, as with all emergencies, we were able to identify gaps or misalignments that impacted some aspects of the response. We want to ensure we build upon these learnings to strengthen our future responses by expanding and deepening surge planning at all local, regional and state levels.

As we look to the coming fall months of 2020, we are faced with a potential resurgence of COVID-19. It is anticipated that with the public emerging from "stay home, stay healthy," there is a risk of exposure to a disease-naïve population. This, together with seasonal influenza – which historically impacts hospital admission by an increase of six to eight percent – provides another urgent opportunity for the health care community to be well prepared for medical surge needs.

This document provides focused recommendations for such a plan, drawn from lessons learned over the past few months and contributed to by our health care partners.

OBJECTIVES & RECOMMENDATIONS

Objective 1: **Improve coordination of state-wide surge planning to** ensure health care entities within Washington state have the ability to effectively respond to state-wide emergencies in a cohesive, data-driven way.

- **Recommendation:** Develop an integrated, state-wide data platform that utilizes existing systems (especially WA HEALTH) to provide situational awareness and visibility of health care, including (but not limited to) hospital and long-term care capacity.
- **Recommendation:** Revise the state's medical surge plan to more clearly define roles and responsibilities, with consideration to a regional approach to command and coordination.

Objective 2: **Increase the seasonal influenza vaccination rate** for all Washingtonians.

- **Recommendation:** Create a comprehensive public flu campaign with county partners and the health care community to encourage vaccination and other good health habits.
- **Recommendation:** Develop targeted campaign and outreach for vaccination of all staff and residents in long-term care and other residential facilities.

Objective 3: Create a state stockpile of personal protective equipment (PPE) for health care.

- **Recommendation:** Develop a PPE Taskforce comprising of key stakeholders (e.g. SEMD, DES, HCC, WSHA, DSHS) to develop a health care PPE policy and strategy with strategic goals to inform procurement, allocation and distribution.
- **Recommendation:** Develop a state stockpile of PPE for health care workers, with a standard set of products that has been reviewed by subject matter experts.
- **Recommendation:** Explore other supply chain options and business expertise in Washington state that may offer alternative solutions (business-to-business) with risk-sharing strategies. Additionally, consider reallocating purchase orders that have yet to be filled to establish a stockpile.

Objective 4: Exercise and test local and state response plans. The COVID-19 incident has provided an opportunity for many stakeholders to refine their response plans and develop tools to aid their response. It is important to understand how these new plans and tools may be integrated and utilized in the next phase of COVID-19 or another public emergency.

- **Recommendation:** Convene two exercise phases. The first phase would be a series of workshops on the issues identified as most critical to incident response. The second recommended phase is a weekly series of remote, one-hour seminars hosted by the Division of Emergency Preparedness and Response in collaboration with the State Emergency Management Division. These seminars would focus on providing stakeholders with a solid understanding of how various response processes work. The expected result is that the various processes integral to the response will be more effective and efficient.

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OBJECTIVE 1: IMPROVE COORDINATION OF STATE-WIDE PLANNING

To ensure health care entities within Washington state have the ability to effectively respond to state-wide emergencies in a cohesive, data-driven way.

PROBLEM STATEMENT

Washington state's health care system is comprised of a diverse array of multiple organizations. They range from tribal, public and governmental to private and non-profit. Each health care organization has the same goal in emergency response – providing the best possible care for the patient while protecting the public health. However the method of achieving these goals may be different.

Great strides have been made over recent years with surge planning within health care facilities. However, although some patient movement planning has occurred, it is not fully developed. Additionally, patient care does not align with political or geographical boundaries, which in turn constricts planning. **A regional approach is needed to improve the coordination of patients and resources.**

Further, in an emergency, access to concise, accurate data is essential for health care decision-makers at all levels. For medical surge planning, good intelligence about the problem must be at hand to formulate the solutions. Bed capacity, equipment and supply data, for example, must be readily available to ensure patients can be transported to the location that provides the best clinical care, resulting in the best patient outcomes.

In the event of a fall 2020 surge, there is a real risk that the number of patients needing care along the whole healthcare continuum will outweigh the "normal" current resources. This may result in an alteration of the standards of care the health system provides and a risk of increased morbidity and mortality.

BACKGROUND/CURRENT STATE

The health care system reacted quickly at the start of the COVID-19 response, both in creating surge health care capacity and conserving PPE. This was exceptional work and fulfilled the goal of being ready to provide care to all patients. The downside has been the negative financial impact to health care organizations.

Many lessons have been learned since February 2020, and there has been much collaboration within the health care system. Processes were put in place to support expansion into surge areas, and crisis standards of care were refined to reflect the new needs of COVID-19 patients, if required. Significant work was accomplished with the Healthcare System Quality Assurance program at the Department of Health (DOH), health care coalitions and the Washington State Hospital Association (WSHA) to expedite waiver processes and provide guidance on regulations. New tools such as WA HEALTH were designed, launched and adopted by health care in a very short amount of time to provide a developing source of data.

In the early days of the pandemic it was thought that the pediatric population was less impacted. However, there are now increasing reports of pediatric cases presenting with COVID-19-associated multisystem inflammatory syndrome (MIS-C) and Kawasaki disease. These phenomena, together with seasonal influenza and other upper respiratory tract infections, underscore the need to specifically prepare for pediatric patients.

The area of long-term care (LTC) and associated facilities remains a concern when we consider a fall surge. We know LTC residents are at high risk from COVID-19, yet we lack good visibility into this area of health care. This was particularly apparent in the early days of the pandemic, when a nursing home was impacted and a more coordinated approach to patient movement was needed.

ASSUMPTIONS

- There is high risk that the confluence of seasonal influenza and a resurgence of COVID-19 in the fall will put a significant strain across the healthcare continuum.
- WA HEALTH is supported and maintained with the right resources to provide current data to decision makers.
- Department of Health is the lead government agency in a fall surge response.
- In a fall surge, health care will have to consider reducing non-urgent medical and dental procedures to create space and conserve PPE.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
DOH	**Health care response and coordination, regulatory guidance and waivers**
HCC	**Health care situational awareness and communication. Coordination between health care, local health jurisdictions and local Emergency Management. Assessing some resource needs and allocation. Convening clinical experts to advise on patient management, crisis standards of care and other clinical issues**
LHJ	**Local public health coordination, epidemiology**
WSHA	**Policy and regulatory guidance for hospitals**
DSHS	**Coordination with long-term care and other associated health care providers**
Tribal Leadership	**To ensure equity in planning and response**
State EMD	**Resource request management and coordination**
LTC Associations	**Advice on LTC situation awareness and needs of LTC**

OPTIONS

1. Develop an integrated, state-wide data system utilizing existing systems such as WA HEALTH to ensure visibility of hospital and LTC situational awareness.
2. Maintain multiple existing data systems.
3. Revise the state medical surge plan to more clearly define roles and responsibilities with consideration of a regional approach to command and coordination.
4. Continued surge planning at the local level only.

ANALYSIS

Option 1. This would involve significant exploration and investment to determine the best solution with the existing multiple systems. Ongoing user support, management and governance of the system would need to be part of the plan to ensure success. As the system would cross multiple state entities, a decision would need to be made on where it would be housed. Cost is unknown.
The advantage would be excellent actionable intelligence to inform decision-making on multiple levels.

Option 2. This would offer no improvement. There would be minimal coordination between users of the different systems and no visibility to decision makers. Financial cost of maintaining systems would be consistent with normal operations.

Option 3. This would be a resource heavy and time-consuming project. However, it is an opportunity to incorporate lessons learned from the current COVID-19 incident, building upon new relationships and operational experience. The surge plan would examine the wider aspects of health care that could be leveraged to support an all-hazard planning approach.

Option 4. Continued planning at the local level would not provide the opportunity for vertical or lateral collaboration. Local planning is an essential component. However, it needs to be coordinated with other planning efforts for the response to be successful. This is particularly evident with patient movement, which frequently increases during an incident. Cost would be lower.

RECOMMENDATIONS

OPTION 1

Rationale

Further exploration into the sustainability, funding and development of WA HEALTH to incorporate LTC and associated nursing care environments. Future expansion considerations to include other essential health care services, such as ambulatory surgery centers, dialysis, clinics and blood banks.

Increasing transparency and availability of data provides the opportunity to make better-informed decisions. The ability to monitor health care trends (e.g. beds capacity) allows for load balancing of patients and resources between facilities to ensure the patient receives the right care in the right place and pressure on the health care system is shared. The ability to monitor LTC would allow hospitals to plan and surge up if the need arises. Investing in an integrated data system allows state and local agencies to work from the same data. This would be an invaluable tool in a COVID-19 or any other (all-hazard) response, regional to large scale state-wide.=

Next steps

- Form a multidisciplinary team of stakeholders (from IT, state agency leadership, users, HCC, LHJs) to further evaluate current systems and make recommendations.
- Source expertise to forecast the health care impact of a resurgence of COVID-19 and the ability of health care to collectively surge.
- Establish a lead and resources for the project (project management, clerical support, etc.).

OPTION 3

Rationale

Over the past four months, we have learned many lessons from our COVID-19 response. As we anticipate the next wave, we have the opportunity to review and improve. We have developed and deployed new tools to help us respond to the needs of the public, and we now need to incorporate these into future responses. A key area of improvement is to view a future surge proactively, with a more structured response. This planning would take significant time, however, some clear benefits could be achieved prior to fall, for example:

- Identify a command and control structure at a regional and state level.
- Identify clear roles and responsibilities with partners and state agencies.

- Involve other health care providers, such as LTC, ambulatory surgery centers, dialysis providers, etc.
- Continue to incorporate surge prevention strategies to decrease hospital visits, such as telemedicine.
- Plan for a phased response to include alternate care sites, thus helping to preserve acute care hospitals for the highest acuity patients.
- Specifically plan for a pediatric surge, acute care and ICU capability.
- Further develop patient movement strategies within regions, working with the Regional COVID-19 Coordination Center (RC3), REDi Operations Center (ROC) and Disaster Medical Coordination Centers (DMCC) as applicable.
- Consider a tiered approach to surge. Twenty percent needs to be maintained by hospitals, however, there may be need for a more targeted strategy.
- Staffing strategies for all areas of health care.

Next steps

- Identify a lead and planning team, including a plan writer and other support (project management, clerical, etc.).
- Form a multidisciplinary stakeholder group to review lessons learned and undertake a gap analysis from the current response.
- Establish regular focused meetings to start plan development.

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OBJECTIVE 2: INCREASE INFLUENZA VACCINATION RATES

PROBLEM STATEMENT

Influenza ("flu") disease causes significant morbidity and mortality in Washington state and the nation each annual flu season (approximately October through March). To date during the 2019-2020 influenza season in Washington state has reported:

- 103 lab-confirmed influenza deaths;
- 91 influenza-like illness outbreaks in long-term care facilities.

It is expected that both influenza and SARS-CoV-2 will be circulating this fall and winter. Increased flu vaccination coverage can lessen stress on the health care infrastructure by decreasing clinic visits and hospitalizations and the number of people seeking diagnostic screening.

BACKGROUND/CURRENT STATE

Seniors, pregnant women, individuals with chronic medical conditions, infants and young children experience the majority of influenza-related severe illnesses and deaths. Individuals with obesity are also considered at higher risk for influenza (and other infectious diseases).

Outbreaks in long-term care facilities (LTCF) put residents at risk due to reduced immune response, even after influenza vaccination. Washington state laws and regulations support the safety and health of residents in LTCF through Washington Administrative Code (WAC) 246-101-305, which requires LTCFs to report all suspected and confirmed outbreaks to their local health jurisdiction. The Revised Code of Washington (RCW) 74.42.285 and WAC 388.97.1340 requires LTCFs to inform verbally and in writing the residents or their legal representatives about benefits of receiving flu vaccination. Lastly, LTCFs are also required to make the vaccine available to residents.

Although there are employer-based requirements for reporting and obtaining influenza immunizations, there is not a state-wide requirement for any population. Beginning January 2013, the Centers for Medicare and Medicaid Services (CMS) required acute care hospitals to report health care workers' influenza vaccination as part of its hospital inpatient quality reporting program. Since reporting began, there has been an upward trend of immunizations by employees, but there is no requirement for health care workers or volunteers working in LTCFs or home care providing clinical or companion visits to institutionalized individuals.

In a CDC opt-in internet survey panel of 2,265 U.S. health care personnel, coverage was highest among personnel who were required by their employer to be vaccinated (94.8 percent) and lowest among those working in settings where vaccination was not required, promoted, or offered on-site (47.6 percent). Health care personnel working in long-term care settings, the majority of whom work as assistants or aides, have lower influenza vaccination coverage than do health care personnel working in all other health care settings, which puts the elderly in long-term settings at increased risk for severe complications for influenza.[1]

Although Washington is a universal vaccination state for immunization in those under 19 years of age, which means the state purchases all recommended vaccines for children, health disparities do exist

1 Influenza Vaccination Coverage Among Health Care Personnel — United States, 2017–18 Influenza Season https://www.cdc.gov/mmwr/volumes/67/wr/mm6738a2.htm?s_cid=mm6738a2_w

regarding access to influenza vaccine as well as treatment to prevent worsening severity of symptoms and hospitalization. Obesity rates are also higher in some populations with adult, non-Hispanic whites at 25-30 percent, while non-Hispanic blacks and Hispanics are at 30-35 percent, putting individuals in those communities at higher risk. The National Immunization Survey (NIS) and the Behavioral Risk Factor Surveillance System (BRFSS) surveys saw an overall increase in influenza vaccinations for Washington populations from the 2017-18 flu season to the 2018 flu season — those aged 6 months to 17 years and those aged 18 and older increased by 4.7 percent and 8.2 percent, respectively.

Washington has one of the highest personal and philosophical exemption rates for school immunizations. There is a very active vaccine opposition community who actively challenges flu campaign efforts and is already connected to the stay-at-home protests and is spreading COVID misinformation. This will present a broad challenge this fall and when a COVID vaccine is available.

ASSUMPTIONS

- The Centers for Disease Control (CDC) is working on supplemental funding for immunization programs around enhanced flu vaccine this fall; we do not know specific CDC requirements, funding amounts, or exact timing.
- Safe vaccination will require appropriate PPE for health care workers.
- New strategies will be needed to offer vaccines safely and to reach everyone, since social distancing recommendations will likely be in place, and school, work and community vaccination events may not be able to take place in the same way as previous years. This could impact vaccine access and vaccination rates.
    - Most flu vaccine is already purchased – private and public purchase happens in the late winter/early spring for the coming flu season. The state already purchases flu vaccines for all children from birth through age 18. This vaccine is distributed to health care providers across the state.
    - There is no current state purchase of flu vaccines for any adult populations, and the number of uninsured adults has likely increased because of the economic crisis.
    - Many critical infrastructure workers may not have health insurance (some long-term care workers, grocery store workers and delivery drivers, etc.) and so don't have coverage for influenza vaccine.
- Acute Flaccid Myelitis (AFM), a cyclical, polio-like illness in children, is predicted to increase this fall; the CDC is working on an awareness campaign. AFM has no known cause, so this is always an area of concern for parents and one that anti-vaccination groups spread misinformation about. This could impact pediatric surge capacity.
- There will be active campaigns from groups opposed to vaccines to discount and discourage any influenza policy, legislation and advertising campaigns.
- Local health jurisdictions are reporting that they do not have capacity to support enhanced vaccinations this fall; we will likely need other partners if we wanted to perform mass vaccination clinics. (We could partner with pharmacies, medical/nursing/pharmacy students and schools.)

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
Washington State Hospital Association and individual hospitals	**Maintaining surge capacity** **Partner on prevention and vaccination messages**
Health care providers and medical associations	**Important group to be vaccinated** **Provide access to vaccine for the public** **Partner on prevention and vaccination messages**
Health plans	**Provide coverage for influenza vaccination** **Manage health impacts to those they cover** **Often offer incentives for vaccination, which can increase rates**
Health care worker unions	**Ensuring access to vaccination for members** **Allowing member choice in vaccination**
Residential care providers and associations	**Preventing outbreaks in their facilities** **Cost impacts** **May not offer, or pay for, vaccination for employees**

OPTIONS

- Priority groups to target in influenza vaccine campaign include:
  - All health care workers
  - Staff and residents of all residential care facilities
  - People of any age with chronic conditions
  - Adults aged 65 and older
  - Groups with health disparities for both influenza and COVID-19, including non-Hispanic blacks, Hispanics, and Native American populations
  - Low-wage earners who are essential workers within critical infrastructure
  - Those in congregate living situations, including farm worker housing, prisons, jails, on-campus college/university housing
  - Individuals experiencing homelessness
- Partner with pharmacies and health plans to provide incentives to increase influenza vaccinations to those who do not have an ongoing relationship, at no cost to the individual, would improve immunization rates specifically for those who may have health disparities, including those who are un- or under-insured.
- Influenza vaccination campaign to highlight the importance of flu vaccination for disease prevention and to help reduce impact on health care system.
- State purchase of influenza program for uninsured adults and uninsured essential workers.
- Identify options to increase influenza immunizations for essential workers in LTCFs, home health and other residential care settings; partnership between DOH and Department of Social and Health Services (DSHS) to lead this.
- Explore new partnerships to increase access and provide technical assistance:
  - Urgent care – state immunization program has not worked here. Could they become childhood vaccine providers? There will likely be insurance reimbursement issues for vaccination in urgent care. Could the Office of the Insurance Commissioner help?
  - Increase pharmacy vaccination – already many flu vaccines given here and most health insurance reimburses for pharmacy vaccination. This would be for adults; most pharmacies do NOT participate in the Childhood Vaccine Program and there is very limited

capacity or funding to expand this.
    - Help transition employer-sponsored influenza immunizations to other options while employees are telecommuting and may not be at the physical workplace?
    - Identify ways to increase support of non-traditional locations and resources for immunizations, including use of fire stations, school clinics and drive-through vaccinations. Supplementing resources for actual immunizations, including possible expansion of scope of practice to support non-traditional vaccinators; contracting with vendors at the state level; etc.

ANALYSIS

- Institutionalized adults are at greatest risk for exposure to both COVID-19 and influenza and are generally the least able to have an effective immune response. Improving vaccination rates for employees in LTC and home care could would provide increased coverage for this population.
- We need to ensure we're working with and reaching groups at greater risk, t, including non-Hispanic black, Hispanic, and Native American populations
    - Tribal members are at increased risk from morbidity or mortality from influenza. Partnering with them on culturally specific campaigns has worked well in the past.
- Vaccination of school-aged children prevents broader community transmission, but if schools or childcare do not have in-person learning in the fall, they may reduce this impact and reduce community spread.
- School-based health centers and school-located vaccine clinics (for K-12 and community college/trade school/colleges) may not be possible this fall; this could decrease access for children and young adults.
- COVID-19 isolation/social distancing fatigue may create issues during influenza season.
- Vaccination incentives have been shown to increase rates; as have workplace and school clinics and reminder/recall direct outreach to patients.
- No-cost vaccination is also important for increasing immunization rates; it can be a challenge with insurance coverage if someone receives the vaccine outside their routine health care provider, or at a pharmacy.

RECOMMENDATIONS

- We need a comprehensive flu campaign to encourage vaccination and other good health habits (hand hygiene, respiratory etiquette, etc.). This requires new funding.
- Use COVID grant model to give flu vaccination promotion grants to organizations that reach at-risk groups. Need new funding or to add to scope of current funding awards; expected supplemental federal flu funding may be able to cover this cost.
- The state sends flu reminder/recall mailings directly to people who haven't been vaccinated yet using Immunization Information System data. We need new funding to continue this.
- The state purchases additional funding for uninsured adults and essential workers. We need new funding – supplemental federal funding will not cover this.
    - Flu vaccine is approximately $20 per dose; even $200,000 would help us set up a program to get this vaccine to most at-risk/uninsured adults/essential workers.
- Targeted campaign and outreach for vaccination of staff and residents of long-term care and residential facilities; DOH and DSHS to partner on this.
- Explore partnerships with private sector (pharmacies and health plans) to offer incentives for flu vaccination.
- DOH to create guidance documents for alternative vaccination clinics, such as drive-through clinics.

Rationale

Will use best practice activities to increase flu vaccination rates of priority groups.

Next steps

- Write federal flu vaccination supplemental funding application when it is available and cover these recommendations as we're able
- DOH and DSHS to meet May 29, 2020 to start.
- DOH exploring options for purchase of additional flu vaccine for uninsured adults if there is new state funding identified to do this.
- Develop staffing plan in DOH to lead this increased flu vaccination work.

CONTACTS

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OBJECTIVE 3: CREATE A STATE STOCKPILE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)[2] FOR HEALTH CARE WORKERS.

The appropriate type and supply of personal protective equipment (PPE) is essential to secure the safety of the health care work force when providing patient care and to prevent cross contamination and further infection rates.

PROBLEM STATEMENT

The need for PPE has been central to the COVID-19 response. Without appropriate PPE staff cannot care for patients properly and run the risk of infecting themselves and taking the virus home to their families, creating a detrimental effect on physical and psychological wellbeing.

PPE requirements when caring for COVID-19 positive patients are stringent. The burn rate for PPE varies depending on the acuity of the patient – an intensive care unit patient requires more PPE than the average acute care patient. How the physical environment is set up (cohorting patients) can also impact burn rate. PPE also has to be worn when working with patients who have an unknown or suspected case of COVID-19.

Estimating PPE demand and use and devising allocation strategies is challenging nationwide. As COVID-19 spread in early 2020, there was an increased demand for PPE throughout the supply chain. As a cost-saving measure, hospitals and their suppliers have historically moved to a "just-in-time" type of inventory management. This posed difficulties for health care as their consumption of PPE steadily increased to a point where demand was greater than supply and the suppliers and manufactures could not keep up through their normal supply chains.
Health care facilities started to reach out to the state and their communities. Washington state had some remaining from previous responses, however much of it had expired.

Additionally, PPE shortages in LTC and home health were not recognized until later in the response. Caregivers in this sector could not adequately protect themselves during provision of care, increasing the risk of exposure and possible hospitalization for themselves and their clients.

On the other hand, the cancellation of non-urgent procedures and other PPE conservation measures had a positive impact on PPE supplies, ensuring more was available for the care of COVID-19 patients.

BACKGROUND/CURRENT STATE

During the response significant effort has been applied to reducing the demand for PPE by extending the life of the products. DOH developed PPE conservation strategies (based on CDC guidelines) and provided these to the health care community. Decontamination systems were also utilized by the state and health care entities.

The State Emergency Operations Center (SEOC) is responsible for receiving PPE orders from health care via local health jurisdiction (LHJs). The Department of Enterprise Services (DES) is responsible for procurement, warehousing and distribution of PPE product.

2 This document is referring to PPE used across the health care continuum, not PPE used in other industries or areas, such as schools and the general public.

As requests started to come into the SEOC, it was evident there was no overall state or agency policy or strategy to guide allocation. DOH developed a tiered approach to allocation, which helped inform distribution. However, some key areas were initially missed, notably LTC, and corrections had to be made. Multiple other agencies also received requests, which made it difficult to respond efficiently.

Health care facilities use multiple types of PPE with varying levels of protection, manufacture, size and styles. This led to requests for specific PPE that were not always understood at the state level. Importantly, respiratory masks are not interchangeable and require fit testing equipment to ensure the mask suits the wearer. If a health care organization receives a different type of mask than usual, the wearer has to be re-fit tested, which can contribute to depleted o supplies.

Tier one prioritization coincided with the introduction of the WA HEALTH. As WA HEALTH collects information on PPE availability across the state's 107 acute care hospitals, it can enable prioritization between facilities when needed. This system continues to be refined.

SEOC and DES continue to improve and refine the state's PPE pipeline. However, as we prepare for an anticipated fall surge in COVID-19 cases, the state must develop a more sophisticated PPE policy and strategy with clear strategic goals. This work should also inform the creation of a state PPE stockpile for health care workers.

ASSUMPTIONS

- The health care community will exhaust its normal supply chain and resourcing mechanisms before approaching the state for PPE resources.
- As part of the Governor's May 2020 proclamation on non-urgent medical and dental procedures, health care will:
    - Adhere to DOH's PPE conservation strategies;
    - Maintain at least 20 percent surge capability, which includes equipment (and PPE).
- LTC has limited or zero stockpiling capability.
- The roles of SEOC and DES will remain the same.
- Allocation will be based on data-driven need.
- A state PPE stockpile will be limited to discreet numbers and types of PPE, as it cannot keep the full range of equipment required to meet every health care demand.
- PPE demand will increase in the LTC sector as it strives to meet CMS testing requirements.

KEY STAKEHOLDERS

Stakeholders	Interests/Impacts
DOH	**Health care response and coordination, regulatory guidance and waivers**
EMD	**State emergency management coordination, including managing resource requests to the state**
DES	**Purchaser, warehouse management and distributer for the state**
DSHS	**LTC regulation**
HCC	**Health care situational awareness, communication, coordination of stakeholders, convening clinical experts to advise (crisis standards of care)**
LHJ	**Requestor and user of PPE**
Labor representation	**Health care workers representation**
WSHA	**Hospitals representation (Note: WSHA has purchased PPE and distributed)**

RECOMMENDATIONS

- **Develop a PPE taskforce comprising of key stakeholders (e.g. SEMD, DES, HCC, WSHA, DSHS) to develop a health care PPE policy and strategy with strategic goals to inform procurement, allocation and distribution.**
- Explore the development of a state health care PPE stockpile
- Survey the health care community to determine their top 10 PPE priorities (types) and needs [a preliminary survey is currently being undertaken].
- Review the tiered PPE prioritization
- A state PPE stockpile would be a standardized number of items and types.
- At the beginning of an incident, healthcare would be included in a communication plan to increase awareness of the stockpile, its purpose and how to access it.
- Continue utilization of WA HEALTH to provide data to inform PPE allocation decisions.
- Explore other supply chain options and business expertise in Washington state that may offer alternative solutions (business to business) with risk-sharing strategies.
- Consider reallocating purchase orders that have yet to be filled to establish of a stockpile.

Rationale

Having a defined approach to establishing a state PPE stockpile will ensure it meets the needs of health care. To be successful, multiple processes need to be developed and operationalized, requiring multi-agency input and collaboration. Involvement of key stakeholders and socializing the end product will be important to ensure expectations are managed and health care is clear about what the process is and what the products are.

Next steps

1. At the state level, agree/disagree that a stockpile is a viable option and move forward with the work as applicable.
2. Establish a lead and resources for the project (project management, clerical, etc.).
3. Develop the PPE Taskforce.

CONTACTS

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OBJECTIVE 4: EXERCISE AND TEST LOCAL AND STATE RESPONSE PLANS

SITUATION

Public health and infectious disease experts agree that COVID-19 is likely to remerge in fall 2020 and co-exist with the usual influenza season. Two simultaneous respiratory outbreaks threaten to have a significant impact on the health care system. It is likely that additional events will exacerbate pressure on emergency preparation and response, as the lead up to fall is the wildfire season, and other incidents, such as measles and winter storms, may also occur. It's critical we use this intervening time to prepare our response systems with a coordinated, state-wide surge plan.

BACKGROUND

Washington State COVID-19 Health System Response Management has identified gaps in plans, processes and procedures that have delayed or hindered elements of the response to coronavirus. Washington has also begun the process of dialing back Non-Pharmaceutical Interventions (NPIs) and there is an expectation of spikes in case numbers associated with this. It will likely prove difficult to dial the NPIs back up once they been relaxed.

ASSESSMENT

There are multiple mitigation efforts, including vaccinations, public education, NPIs and addressing at-risk populations (e.g. in long-term care) that can be undertaken right now. Simultaneously, we can prepare by stockpiling resources and revising and exercising response plans. Better delineation and clarity of roles, responsibilities and process derived from plans is needed.

The COVID-19 incident has provided an opportunity for many stakeholders to develop tools to aid their response. Various dashboards have been created and the implementation of WA HEALTH has provided visibility into multiple data points that can inform high-level decision makers. It is important to understand how these new tools may be integrated and utilized in the next phase of COVID-19 or another public emergency.

Note: The demands of the ongoing COVID-19 response are a barrier to attending exercises and workshops for some stakeholders.

RECOMMENDATIONS

We recommend a two-phase exercise approach. The first phase would be a series of workshops on the top issues identified as most critical to incident response. A preliminary list of those issues includes:

1. Indicators and Thresholds
    a. Structures (health care system, EMS system, local health capability and capacity, etc.)
    b. Notification
    c. Situational awareness and information-sharing systems
        i. Single source reporting protocol

2. Command and Coordination
    a. Aligned regional response structure (health care does not align with county boundaries)

   b. Roles and responsibilities to form a common operating picture
   c. Coordination between health care, health care coalitions, emergency management, local health jurisdictions and state entities
3. Scarce Resource Decision-Making (staff, personal protective equipment (PPE), ventilators, anti-virals)
   a. Allocation
   b. Prioritization
   c. Distribution
4. Public and Partner Communication
5. Medical Surge
   d. Staff
   e. Supplies
   f. Structures
   g. Systems
6. Patient Movement
   a. Patient condition
   b. Transport availability
   c. Location of facilities with needed capability or resources
   d. Current bed status
   e. Number and location of patients by diagnostic category (COVID-19 positive or negative)
   f. RC3 and ROC roles

Each workshop should address only one issue, be no longer than two hours in duration and be facilitated by the Healthcare System Readiness Group. Participant input would be captured so as to be available to influence plan revisions. Due to social distancing, travel challenges and the demands of the ongoing response, it is recommended that the workshops be held in a virtual format. The expected result is that stakeholders will have a clear understanding of their roles, responsibilities and associated processes and will have identified needed revisions to their plans.

The second recommended phase is a weekly series of remote, one-hour seminars hosted by the Healthcare System Readiness Group. These seminars would focus on providing stakeholders with a solid understanding of how various response processes work. The expected result is that the various processes integral to the response will be more effective and efficient. A preliminary list of seminar topics is:

- Fatality management
- Data metrics
- Isolation and quarantine
- Long-term care
- Home care, hospice, etc.
- Testing
- Regional coordination ROC & RC3 (DMCCs)
- Regulatory flexibility – waivers for surge planning and staffing
- Crisis Standards of Care triggers
  - Waivers
  - Volunteer health providers
- Local Emergency Management-led community level tabletops (Organized by Emergency Management Division)

The seminars would be facilitated by nominated subject matter experts, and each seminar would address one or two topics, dependent on the topic's complexity. Time would also be included for Q&A and discussion of best practices.

While the workshops and seminars will be coordinated and hosted at the state level, we also encourage local partners to conduct their own community based workshop and/or seminars.

PROPOSED TIMELINE

- Workshops to be scheduled in the last two weeks of June 2020.
- Seminars to be scheduled in the second week of July 2020.

KEY STAKEHOLDERS (NOT LIMITED TO)

- Long-term care facilities
- Health care providers
- Health care coalitions
- Local Health Jurisdictions
- Emergency Management
- Washington State Hospital Association
- Long-term care associations
- State Department of Health (including Health System Quality Assurance)
- State Department of Social and Health Services
- State Emergency Management
- State Department of Enterprise Services
- RC3/ROC
- Labor unions
- Tribal nations
- Disaster medical advisory committee
- State and local medical officers

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GOAL 5: ENSURE SMOOTH TRANSITION

Vice Admiral Bono's assignment has ended but the high-quality work in the four previous areas has on-going value to the State of Washington and should continue.

BACKGROUND

Based on the team's accomplishments, observations and diverse partnerships that occurred in the course of the HSRM's work, several recommendations are provided to continue efforts toward co-creating a more integrated, connected system of care for Washington. The basis for this integration recognizes the need for a robust, integrated data system that enables broader situational awareness and supports a transparent care continuum between population groups, public health officials, health systems and agency leads.

RECOMMENDATIONS

1. Optimize interfaces between public health elements and governmental agencies;
2. Design a public health system care continuum;
3. Create more robust public-private partnerships with businesses and industries;
4. Develop an integrated data system that equitably supports health for all.

CONTACT

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APPENDICES

JAY INSLEE
Governor

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PROCLAMATION BY THE GOVERNOR
AMENDING AND EXTENDING PROCLAMATIONS 20-05 AND 20-24

20-24.1
Reducing Restrictions on, and Safe Expansion of,
Non-Urgent Medical and Dental Procedures

WHEREAS, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout Washington as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State; and

WHEREAS, as a result of the continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations, I have subsequently issued amendatory Proclamations 20-06 through 20-53 and 20-55, exercising my emergency powers under RCW 43.06.220 by prohibiting certain activities and waiving and suspending specified laws and regulations; and

WHEREAS, the COVID-19 disease, caused by a virus that spreads easily from person to person which may result in serious illness or death and has been classified by the World Health Organization as a worldwide pandemic, has broadly spread throughout Washington State, and significantly increasing the threat of serious associated health risks statewide; and

WHEREAS, the health care personal protective equipment supply chain in Washington State has been severely disrupted by the significant increased use of such equipment worldwide, such that there are now critical shortages of this equipment for health care workers. To curtail the spread of the COVID-19 pandemic in Washington State and to protect our health care workers as they provide health care services, it is necessary to prohibit all medical, dental and dental specialty facilities, practices, and practitioners in Washington State from providing non-urgent health care and dental services, procedures and surgeries unless specific procedures and criteria are met; and

WHEREAS, the extensive public-private collaboration between our state and local governments, and the state's hospitals, health systems, and other providers of clinical services in addressing the health care issues created for people and communities by the COVID-19 pandemic is commendable; and

WHEREAS, Washington State's collaborative approach has been effective in addressing the significant public health issues associated with the disease, while greatly expanding the clinical and operational capacity of the health system to effectively care for COVID-19 patients and safely provide preventive, diagnostic, outpatient, ambulatory, acute, and post-acute care for all people in need of care

via both in-person and virtual means. The professionalism, expertise, and compassion of Washington's clinicians, nurses, and other health care professionals during the COVID-19 pandemic has been exemplary; and

WHEREAS in the early days of the pandemic, I, in collaboration with the Washington State Department of Health and health care system partners, established a data-driven approach to addressing the health and safely of Washington's citizens and communities. The actions taken pursuant to this approach reduced the impact of the disease in the State. As the State moves into its Safe Start of the economy, it is important that the healthcare system move rapidly towards a more normal operating position and expand access to care for patients in a manner that is safe and equitable; and

WHEREAS, I support extending Proclamation 20-29, which requires telemedicine payment parity through year-end 2020, when the new parity law in SB 5385 will formally take effect. However, the extension must be approved by the Legislature.

WHEREAS, recognizing that health status is impacted both by social determinants of health and untreated health conditions, it is vital that public and private sector participants in the health care system work to enhance public health capabilities and capacity, such as testing, contact tracing and follow-up, and that access to appropriate care be expanded as safely as possible; and

WHEREAS, the exercise of clinical judgement by healthcare and dental professionals related to the care of patients is essential, and it is essential for all of our health and dental partners to follow the same procedures as outlined in this proclamation and work together to protect the health of all of our residents; and

WHEREAS, the worldwide COVID-19 pandemic and its progression throughout Washington State continues to threaten the life and health of our people as well as the economy of Washington State, and remains a public disaster affecting life, health, property or the public peace; and

WHEREAS, the Washington State Department of Health continues to maintain a Public Health Incident Management Team in coordination with the State Emergency Operations Center and other supporting state agencies to manage the public health aspects of this ongoing incident; and

WHEREAS, the Washington State Military Department Emergency Management Division, through the State Emergency Operations Center, continues coordinating resources across state government to support the Department of Health and local health officials in alleviating the impacts to people, property, and infrastructure, and continues coordinating with the Department of Health in assessing the impacts and long-term effects of the incident on Washington State and its people.

NOW, THEREFORE, I, Jay Inslee, Governor of Washington, as a result of the above-noted situation, and under Chapters 38.08, 38.52 and 43.06 RCW, do hereby proclaim that a State of Emergency continues to exist in all Washington State counties, that Proclamation 20-05 and all amendments thereto remain in effect, and that Proclamations 20-05 and 20-24 are amended to immediately prohibit certain medical and dental procedures, with exceptions, and as provided herein.

I again direct that the plans and procedures of the *Washington State Comprehensive Emergency Management Plan* be implemented throughout state government. State agencies and departments are directed to continue utilizing state resources and doing everything reasonably possible to support implementation of the *Washington State Comprehensive Emergency Management Plan* and to assist affected political subdivisions in an effort to respond to and recover from the COVID-19 pandemic.

I continue to order into active state service the organized militia of Washington State to include the National Guard and the State Guard, or such part thereof as may be necessary in the opinion of The Adjutant General to address the circumstances described above, to perform such duties as directed by competent authority of the Washington State Military Department in addressing the outbreak. Also, I continue to direct the Department of Health, the Washington State Military Department Emergency Management Division, and other agencies to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

FURTHERMORE: based on the above situation and under the provisions of RCW 43.06.220(1)(h), to help preserve and maintain life, health, property or the public peace, I hereby prohibit all medical, dental and dental specialty facilities, practices, and practitioners in Washington State from providing non-urgent health care and dental services, procedures, and surgeries unless they act in good faith and with reasonable clinical judgment to meet and follow the procedures and criteria provided below:

COVID Assessment:
Local health jurisdictions (LHJs) in collaboration with their health partners, should assess the COVID-19 status in the communities they serve. This assessment should be updated on a regular basis. Important COVID-19 disease information relevant to this assessment is available at https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard, and LHJs should have relevant information as well.

Expansion/Contraction of Care Plan
Each health care, dental or dental specialty facility, practice, or practitioner must develop an expansion/contraction of care plan that is both congruent with community COVID-19 assessment described above, consistent with the clinical and operational capabilities and capacities of the organization, and responsive to the criteria provided below.

Expansion/contraction of care plans should be operationalized based on the standards of care that are in effect in the health care facility, practice or practitioner's relevant geography as determined by that region's emergency health care coalition, as follows:

- Conventional Care Phase – All appropriate clinical care can be provided.
- Contingency Care Phase – All appropriate clinical care can be provided so long as there is sufficient access to PPE and, for hospitals, surge capacity is at least 20%.
- Crisis Care Phase – All emergent and urgent care shall be provided; elective care, that the postponement of which for more than 90 days would, in the judgement of the clinician, cause harm; the full suite of family planning services and procedures, newborn care, infant and pediatric vaccinations, and other preventive care, such as annual flu vaccinations, can continue.

Criteria for Resuming Non-Urgent Procedures

Until there is an effective vaccine, effective treatment, or herd immunity and until supply chains for PPE return to a more normal status, hospitals and LHJs will work together to maintain some level of surge capacity in our health care system and prudently use PPE so that we can keep health care workers safe and provide the needed health care to our communities. To this end, the following must be met by health care, dental and dental specialty facilities, practices, and practitioners:

- Exercise clinical judgment to determine the need to deliver a health care service, in the context of the broader health care and dental needs of patients and communities and in the context of the pandemic, and within the parameters of operation provided by the health care, dental or dental specialty facility, practice or practitioner setting in which they are providing services.
- Continuously monitor capacity in the system to ensure there are resources, including ventilators, beds, PPE, blood and blood products, pharmaceuticals, and trained staff available to combat any potential surges of COVID-19, participation, as required by Department of Health guidelines, with the WA HEALTH data reporting system to allow for a state-wide common operating perspective on resource availability.
- Follow Department of Health's current PPE conservation guidance, which will be regularly reviewed and updated by the Department of Health, as published on the Department of Health website at https://www.doh.wa.gov/Emergencies/Coronavirus. If the health care facility, practice or practitioner's PPE status deteriorates, adjustments to expansion of care will be required.
- Review infection prevention policies and procedures and update, as necessary, to reflect current best practice guidelines for universal precautions.
- Develop a formal employee feedback process to obtain direct input regarding care delivery processes, PPE, and technology availability related to expansion of care.
- Appropriately use telemedicine. Appropriate use of telemedicine will facilitate access to care while helping minimize the spread of the virus to other patients and/or health care workers.
- Use on-site fever screening and self-reporting of COVID-19 symptom screening for all patients, visitors and staff prior to (the preferred approach), or immediately upon, entering a facility or practice.
- For clinical procedures and surgeries, develop and implement setting-appropriate, pre-procedure COVID-19 testing protocols that are based on availability, Department of Health guidance, if any, and/or relevant and reputable professional clinical sources and research.
- Implement policies for non-punitive sick leave that adhere to U.S. Centers for Disease Control and Prevention (CDC) return-to-work guidance.
- Post signage that strongly encourages staff, visitors and patients to practice frequent hand hygiene with soap and water or hand sanitizer, avoid touching their face, and practice cough etiquette.
- Maintain strict social distancing in patient scheduling, check-in processes, positioning and movement within a facility. Set up waiting rooms and patient care areas to facilitate patients, visitors and staff to maintain ≥6 feet of distance between them whenever possible, consider rooming patients directly from cars or parking lots, space out appointments, and consider scheduling or spatially separating well visits from sick visits.

- Limit visitors to those essential for the patient's well-being and care. Visitors should be screened for symptoms prior to entering a health care facility and ideally telephonically prior to arriving. Visitors who are able should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control.
- Ambulatory patients, who are able and when consistent with the care being received, should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control.
- Frequently clean and disinfect high-touch surfaces regularly using an EPA-registered disinfectant.
- Identify and implement strategies for addressing employees who have had unprotected exposures to COVID-19 positive patients, are symptomatic, or ill, which should include requiring COVID-19 positive employees to stay at home while infectious, and potentially restricting employees who were directly exposed to the COVID-19 positive employee. Timely notification of employees with potential COVID-19 exposure and appropriate testing of employees who are symptomatic should be a component of these strategies. Follow CDC cleaning guidelines to deep clean after reports of an employee with suspected or confirmed COVID-19 illness. This may involve the closure of the business until the location can be properly disinfected.
- Educate patients about COVID-19 in a language they best understand. The education should include the signs, symptoms, and risk factors associated with COVID-19 and how to prevent its spread.
- Follow requirements in Governor Inslee's Proclamation 20-46 - *High-Risk Employees – Workers' Rights*.

ADDITIONALLY, for purposes of this Proclamation, evaluation of "harm" is the same as described in the May 7, 2020, Updated Interpretive Statement related to Proclamation 20-24, and is repeated here: The decision to perform any surgery or procedure in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices, including examples of those that could be delayed should be weighed against the following criteria when considering potential harm to a patient's health and well-being:

- Expected advancement of disease process
- Possibility that delay results in more complex future surgery or treatment
- Increased loss of function
- Continuing or worsening of significant or severe pain
- Deterioration of the patient's condition or overall health
- Delay would be expected to result in a less-positive ultimate medical or surgical outcome
- Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
- Non-surgical alternatives are not available or appropriate per current standards of care
- Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed

Furthermore, diagnostic imaging, diagnostic procedures or testing should continue in all settings based on clinical judgement that uses the same definition of harm and criteria as listed above.

ADDITIONALLY, when making health system care capacity decisions, health care, dental and dental specialty facilities, practices, and practitioners must, in addition to the above, consider 1) the level and trending of COVID-19 infections in the relevant geography, 2) the availability of appropriate PPE, 3) collaborative activities with relevant emergency preparedness organizations and/or LHJ, 4) surge capacity of the hospital/care setting, and 5) the availability of appropriate post-discharge options addressing transitions of care.

ADDITIONALLY, given the geographic diversity of Washington, the variability in COVID-19 disease burden within the state, and health care system capabilities and capacity, no uniform approach to expanding access to care is possible nor would any such approach be effective or wise. It is essential that health care system participants act with good judgment within the context of their patients' needs, their environment, and their capabilities and capacity.

This Proclamation is retroactive to 11:59 PM on May 17, 2020, and shall remain in effect until the state of emergency, issued on February 29, 2020, pursuant to Proclamation 20-05, is rescinded, or until this order is amended or rescinded, whichever occurs first.

Violators of this order may be subject to penalties pursuant to RCW 43.06.220(5).

Signed and sealed with the official seal of the state of Washington on this 18th day of May, A.D., Two Thousand and Twenty at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

JAY INSLEE
Governor

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TO: Interested Stakeholders

FROM: Governor Jay Inslee

DATE: April 29, 2020

SUBJECT: **Interpretive Statement Related to Proclamation by the Governor 20-24, Restrictions on Non-Urgent Medical Procedures**

Background. On March 19, 2020 Governor Inslee issued Proclamation 20-24 with the goal of ensuring hospitals and the health system would have enough surge capacity and personal protective equipment to manage an influx of patients with COVID-19. The Proclamation applies to services delivered in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices in Washington State. The Proclamation will remain in effect through May 18, 2020.

As providers across the state have significantly adjusted operations in response to the Proclamation, the need for additional guidance has been identified. The purpose of this statement is to provide that guidance.

It is the position of the State that the Proclamation allows performance of all services considered to be "emergent" or "urgent" for which delay would result in worsening a life-threatening or debilitating prognosis. Clinicians should use clinical judgment to determine performance of procedures considered to be non-urgent or "elective."

In addition, given the evolving and fluid nature of pandemics in general, and COVID-19 in particular, clinical judgments regarding non-urgent or "elective" procedures need to be viewed through the lens of relative harm to patients of treatment versus deferment, in terms of potential patient and provider contraction of COVID-19.

The remainder of this document pertains to health care services, procedures, and surgeries falling into the non-urgent or "elective" category.

Considerations in determining "harm" to the patient. The Proclamation limits, "healthcare services, procedures, and surgeries that, if delayed, are not anticipated to cause harm to the patient within the next three months…" The Proclamation goes on to provide examples of procedures to delay, which include, "most joint replacements, most cataract and lens surgeries, non-urgent cardiac procedures, cosmetic procedures, some endoscopy and some interventional radiology services."

The Proclamation does not provide a definition of "harm." To clarify, the Governor leaves assessment of harm up to the individual clinician. In order to assess harm, clinicians should consider if a patient's illness or injury is: causing significant pain, significant dysfunction in their daily life or work, or is either progressing, or at risk to progress. Additionally, clinicians should assess the risk of harm that could be experienced by a patient as a result of undertaking the surgery or procedure during the COVID-19 pandemic.

The decision to perform any surgery or procedure in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices, including examples of those that could be delayed in the Proclamation, should be weighed against the following criteria when considering potential harm to a patient's health and well-being as described above:

- Expected advancement of disease process
- Possibility that delay results in more complex future surgery or treatment
- Increased loss of function
- Continuing or worsening of significant or severe pain
- Deterioration of the patient's condition or overall health
- Delay would be expected to result in a less-positive ultimate medical or surgical outcome
- Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality
- Non-surgical alternatives are not available or appropriate per current standards of care
- Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed

Furthermore, diagnostic imaging, diagnostic procedures or testing should continue in all settings if disease is suspected, based on clinical judgement that uses the same definition of harm and criteria as listed above.

Prerequisites to performance of healthcare services, procedures and surgeries. Foundational to the performance of any healthcare service, procedure, or surgery permitted under Emergency Proclamation 20-24 is the ability to meet infection prevention and control standards, maintain appropriate personal protective equipment supplies, as well as following Department of Health (DOH)-issued guidance on use of personal protective equipment (PPE). For permitted procedures requiring an overnight stay, hospitals will not exceed 80% of available bed (licensed and staffed beds) capacity.

Specifically, the following PPE prerequisites are required before facilities can perform procedures, surgeries, or services permitted under Emergency Proclamation 20-24:

- Facilities must provide health care workers (direct patient care and affected ancillary staff) with appropriately sized and sufficient quantities of PPE to perform essential job functions.

- Facilities must be aligned with Washington State Department of Health's PPE Usage Guidelines - PPE Conservation Strategies (Yellow), which says personal protective equipment is discarded and replaced when it is soiled, damaged, or hard to breathe through.
- Facilities must follow the Washington State Department of Health's Guidance on Extended and Re-use of PPE by Healthcare Personnel (HCP).
- Facilities must have on-hand and in the facility 7 days of appropriate PPE.
- Facilities must report accurate counts of PPE available and in the facility daily, as well as PPE on order, to the WA Health system.
- Facilities must report following required DOH guidelines for PPE use and conversation to the WA Health system.
- Health care workers have access to COVID-19 testing and to timely notification (within eight (8) hours of awareness) of exposure to COVID-19.
- Facilities must report on COVID-19 positive health care workers by facility and profession/position to the WA Health system.

Outpatient clinic visits. The Proclamation permits outpatient clinic visits, both in hospital-based clinics and other outpatient clinic settings. While not addressed in the Proclamation, the Governor encourages clinicians to weigh the benefits and risks of such visits to patients given the active presence of COVID-19 in our communities. He also encourages clinicians to use telehealth visits where possible. If a clinician determines an outpatient clinic visit is necessary, all steps possible should be taken to promote social distancing measures and reduction of infection risk by appropriate use of hand hygiene and PPE-use protocols.

Penalties and enforcement. The Proclamation states, "Violators of this order may be subject to criminal penalties pursuant to RCW 43.06.220(5)," making anyone found to be in willful violation of the order guilty of a gross misdemeanor. The department finds that documented clinical decision-making reflecting application of the Proclamation and this statement to the clinical matter(s) or case(s) under consideration will serve as evidence that performance of the health care services, procedures or surgeries was not a willful violation of the Proclamation.

COVID-19 Health System Response Management Team

DECISION PAPER

Problem Statement:
Michael O'Hare, from FEMA Region 10, contacted Robert Ezelle, of Washington State Emergency Management Division, requesting that Washington recall and make available as many of the ventilators supplied to it by the Strategic National Stockpile (SNS) as possible.

Background:
In planning and preparing for the COVID-19 pandemic, Washington State requested 1,000 ventilators from the SNS. Washington has received 500. The ventilators were distributed across the state at the request of hospitals to build surge capacity.

Assumptions:
- The Society of Critical Care Medicine (SCCM) estimates that at least 950,000 coronavirus patients in the US could require ventilators. US hospitals only have 160,000 of these machines between them, per the SCCM.
- While the vast majority of people with COVID-19 disease experience mild symptoms, about 6-10% need hospital care, with older patients at higher risk.
- Washington received 474 of 1000 requested SNS ventilators (LTV 1200s), to be used for non-COVID patient care. 421 have been identified to be available for redistribution across the country.
- Washington has also purchased 385 ventilators, with an additional 800 procured and expected to arrive in the next several days and weeks, when Washington may need those most.
- Other areas of the country are experiencing an exponential increase in new cases and deaths. The death toll in New York, the state hit hardest by the coronavirus pandemic, surpassed 3,500 on Saturday, April 4, recording 630 deaths in 24 hours.

Key Stakeholders & Interests:
Washington State Hospital Association, regional hospitals, local county health departments, elected officials, healthcare coalitions, Tribes and other state and Tribal Nations across the country.

Options:
- Reject request, retain SNS ventilator stock to support Washington's response efforts.
- Recall the SNS ventilators that are not in use at this time, provide to FEMA Region 10 to distribute to the hardest hit areas of the country.

Analysis:
- Current modeling reports that Washington will be positioned to support invasive ventilator needs, without the SNS ventilators.
- Washington has reduced the demand for ventilators by reducing the number of people contracting the disease, thanks to mitigation strategies that include physical distancing and hygiene rules.

Recommendations:
Recall 421 SNS ventilators not in use, make available to FEMA to distribute across the country.

Contact:
Clark Halvorson: clark.halvorson@doh.wa.gov.

COVID-19 Health System Response Management Team

DECISION PAPER

_____	_____	_____
Vice Admiral (ret) Raquel Bono, MD, MBA COVID-19 Health System Response Management	Concur	No concur

COVID-19 Health System Response Management Team
Century Link DOD Field Hospital – DECISION PAPER

Problem Statement:
Washington has been requested to evaluate the need for the alternative care facility at Century Link Field. There is a sense of urgency to ensure that Washington will have patients utilizing the site this week, or look to deploy to an area of greater need.

Background:
The Department of Defense opened a 272-bed alternative care facility in Century Link on April 4 for non-COVID patients. The facility has been approved for low acuity, COVID-19 negative patients to transfer from acute care facilities with them a plan of care.

WSHA has indicated that the local hospitals are concerned that there is a mismatch between what the Century Link facility provides and what the system needs. They have decompressed through discharging patients and eliminating non-urgent surgeries.

Assumptions:
1. Currently modeling indicates that WA Hospitals will have capacity (acute care beds, intensive care beds, and ventilators) to meet the modeled demand.
2. Bed availability for low acuity care for patients is not at a critical level, and there are no patients identified for transfer to the facility
3. There are over 100 LTC facilities with at least one positive COVID-19 patient.
4. The region has successfully implemented the social distancing mitigations, resulting in a reduction of the R_o.
5. There are areas of the US where hospitals are not able to meet the current demand.

Key Stakeholders & Interests:
WSHA, Hospitals in the Seattle Metro and expanded region, Federal partners (DOD FEMA, and HHS), Patient Advocates, Northwest Healthcare Response Network, Public Health Seattle King County (PHSKC), Areas of the US with high patient care demand.

Options:
- Retain DOD Field Hospital to support WA response efforts.
- Support the redeployment of the DOD Field Hospital, to provide support to the hardest hit areas of the country.

Analysis:
- Current modeling reports that Washington will be positioned to support invasive patient needs without the DOD Field Hospital at Century Link.
- Washington has reduced the demand for hospital capacity by reducing the R_o, and number of patients by mitigation strategies that include social distancing and hygiene rules.

Recommendations:
Support the redeployment of the DOD Field Hospital, to provide support to the hardest hit areas of the country.

Contact:
Clark Halvorson, clark.halvorson@doh.wa.gov

Vice Admiral (ret) Raquel Bono, MD, MBA COVID-19 Health System Response Management	Concur	No concur

COVID-19 Health System Response Management Team

DECISION PAPER – Hospital Utilization Surveillance in Washington State

PROBLEM Statement:

Accurate and rapid data on hospital occupancy, staffing availability, and equipment are needed to guide resource allocation. These data need to be provided to hospital administrators, public health officials, and disaster response teams for more coordinated system wide decision making.

Background:

Washington State currently has two separate systems that compile data on hospital bed availability, supply needs, and other resources. WATrac (Washington System for Tracking Resources, Alerts, and Communication) that collects granular data on available beds and hospital diversion status. The Washington State Hospital Association conducts a hospital survey process designed to elicit greater detail on "space, staff, and stuff". The Vice President's task force has also mandated the collection and reporting of Data of COVID-19 testing.

Assumptions:

There is currently no mandate under Washington state law requiring health care facilities to report data to WATrac or the daily COVID-19 surveys. DOH could make reporting mandatory by writing a Public Health Order to that effect.

Key Stakeholders & Interests:

- Tribal Nations
- Hospitals (approximately 115 in Washington State);
- Washington State Department of Health (DOH);
- Local health departments;
- The Northwest Healthcare Response Network (NWHRN); (REDi) in eastern Washington.
- The Washington State Hospitals Association (WSHA)

Options:

- Status Quo
- Deploy the PowerApp tool developed by Microsoft with Swedish and NWHRN to facilities statewide and build PowerBI visualizations for public and private usage and decision making

Analysis:

WATrac and WSHA surveys provide rich and complementary data the system is new, not uniformly used and reporting/dashboard capability has not yet been established.

Recommendations:

COVID-19 Health System Response Management Team

DECISION PAPER – Hospital Utilization Surveillance in Washington State

Work with Microsoft NWRHN, REDi, WSHA to develop and deploy the PowerApp and build PowerBI visualization tools to provide accurate and rapid data on hospital occupancy, staffing availability, and equipment shortfalls needed to guide resource allocation. Provide these data to tribal nations, hospital administrators, public health officials, disaster response teams, and the CDC to meet federal requirements.

Contact:
Clark Halvorson, clark.halvorson@doh.wa.gov

Vice Admiral (ret) Raquel Bono, MD, MBA COVID-19 Health System Response Management	Concur	No concur

Comments -

PPE RECOMMENDATION

FOR: David Postman, Chief of Staff
FROM: VADM Rocky Bono
DATE: April 27, 2020

SITUATION

The state's personal protective equipment (PPE) procurement and distribution system is inadequate to meet Tier 1 personnel needs for supporting the current and surge demands of the health care system, enabling a state-wide testing and surveillance program and providing sufficient protection to the staff of long-term care facilities (LCTF).

BLUF: A reliable and sustainable PPE procurement, acquisition and distribution system is required to allow execution of the above processes, as well as support any recovery efforts undertaken as community mitigation efforts are eased.

Background

- On Jan. 21, 2020, Washington state and the CDC announced the first diagnosed case of COVID-19.
- On Jan. 22, 2020, Washington state stood up its Incident Management Team.
- On Feb. 19, 2020, a Life Care Center resident was emergently transferred to a hospital with COVID-19 complications. In the following week, two additional residents required acute hospitalization.
- By March 18, 2020, 101 of 120 Life Care Center residents had been diagnosed with COVID-19; 34 had died for a case fatality rate of 33.7 percent.
- In early March, loaned executives from Microsoft and Amazon reported to the Washington State Emergency Operations Center (SEOC) to assist with the procurement, acquisition and distribution of PPE.
- On March 23, 2020, the Washington State COVID-19 Health Resources Management Director reported to the Cabinet.
- On April 2, 2020, Gov. Inslee directed aggressive procurement of PPE to support frontline health care workers (HCW), EMS and testing centers in support of Washington state's COVID-19 pandemic response.
- On April 10, 2020, the State Public Health Officer released PPE conservation guidance in response to a shortage of available PPE to treat COVID-19 patients. Also released was a tiered prioritization of PPE distribution in order to maximize the use and availability of PPE to hospitals, EMS and LCTFs with COVID-19-positive residents and staff.
- To date, Washington state has:
    - Placed PPE orders totaling $345 million;
    - Received less than 5% of PPE supplies totaling $16.67 million (4.8%);

    - Distributed 68% of PPE supplies totaling $11.46 million, with 27% of supplies totaling $4.52 million awaiting distribution.
- Initial distribution plans for PPE provided delivery of equipment from the state warehouse directly to hospitals and hospital systems. Subsequent distribution plans were altered to provide delivery to county Emergency Management Services with allocation to hospitals by EMS.
- Current distribution data demonstrates that of the PPE delivered to various counties, documentation of PPE allocated to specific hospitals, EMS or other facilities is not available.

Discussion

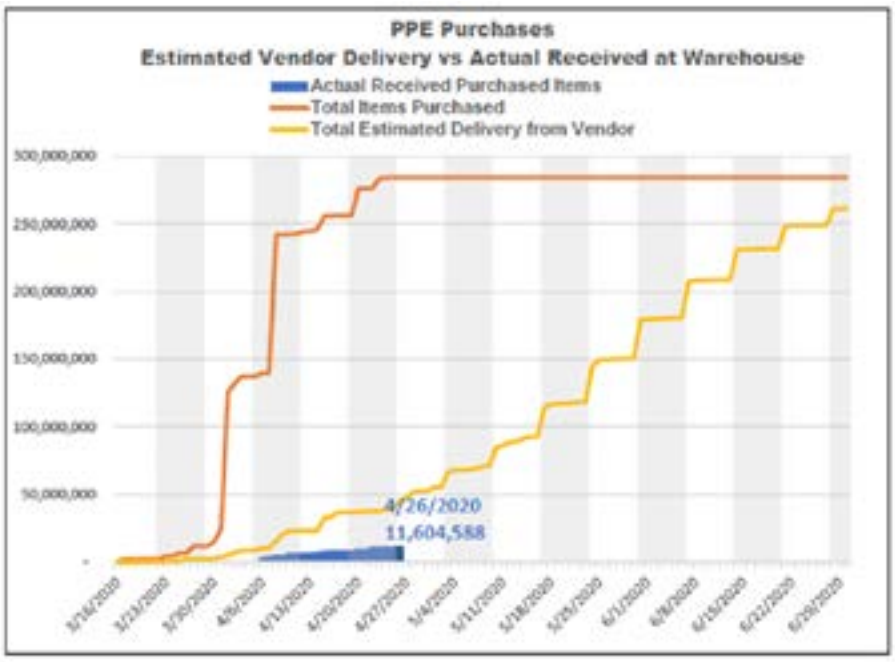
- During visits with hospitals in both Eastern and Western Washington, staff from at least four hospitals and/or systems have shared that the hospitals require extensive re-use of PPE, even in instances where the state's Department of Enterprise Services (DES) data show that PPE has been delivered to the county being visited.
- During visits to the counties, EMS have not been able to provide the allocation plan for PPE after delivery.
- As the Governor evaluates easing non-pharmaceutical interventions (NPI), resuming elective surgery has to be supported with appropriate PPE availability and utilization. Labor unions are expressing reservations regarding the support for elective surgery due to the persistent conservation measures that are imposed on HCW staff, including using the same face mask for multiple shifts or over multiple days.
- The WA HEALTH dashboard, the state-wide common operating picture for hospitals and hospital systems, is collecting data on individual hospitals' PPE availability and burn rates, which provides transparency into available PPE down to the hospital level.

Summary

Although procurement of PPE has improved as evidenced by the increase of PPE purchase orders, only a fraction of the PPE bought has been delivered and even less distributed to hospitals and HCWs. While the PPE that has been delivered can be tracked to the county, allocation to specific facilities and hospitals remain difficult to ascertain. The lack of PPE at the hospitals and for HCWs will continue to challenge the Governor's ability to re-introduce elective surgery, contain COVID-19 outbreaks in LTCFs, support more broad-based testing and surveillance and any efforts toward recovery and easing of NPIs.

Recommendations

- Require an accountable end-to-end supply chain system and record of PPE procurement, acquisition and distribution
- Require hospitals to document PPE stores in WA HEALTH (Complete: DOH, Apr 2, 2020).
- Require EOC to utilize WA HEALTH PPE data to support re-supply of PPE to hospitals.



Current as of 4/27/20
Source: DES

Health Care System Readiness

As measured by:

- Hospital beds
- ICU capacity
- Ventilator numbers
- State PPE procurement

The Data -
protecting public health as we begin our economic recovery

COVID-19 Disease Activity

Health Care System Readiness

Testing Capacity and Availability

Case and Contact Investigations

Risk to Vulnerable Populations

COVID-19 Pandemic Health Response Recommendations

CONTENTS

Appendix

September 15, 2020

Dear Governor Inslee,

I am delighted to provide this playbook in response to your data-driven guidance, the shared commitment of your state agencies and the efforts of multiple private business leaders to make the State of Washington safer during the COVID-19 pandemic.

The recommendations and action items you find here build upon the foundational work articulated in the **COVID-19 Health System Response Management** dossier I presented to you this May. It has been my privilege to lead an equally impressive **COVID-19 Pandemic Health Response** team to develop these iterative, more targeted solutions, using public-private partnerships that synergize an all-of-Washington approach to the ongoing public health emergency.

Our intention with this playbook is to provide you and your cabinet with additional perspectives to consider as you seek to safely balance Washington's economic recovery during the pandemic. I also present you with multiple statewide partnerships that can be developed even further to serve Washington's equity goals in support of our most vulnerable populations.

I would like to express my deepest appreciation to several very impactful individuals whose efforts, contributions and leadership were critical to this playbook. First, I want to recognize Clark Halvorson, who courageously stepped forward to be my chief of staff and helped me redesign a statewide response.

Jill Edgin was assigned as my executive assistant, but quickly demonstrated exceptional networking and team-building capabilities that proved essential to the high-trust, responsive and transparent relationships our team developed with state and non-governmental participants.

In bringing together the content of this playbook, Bill Robertson and Sally Watkins were willing accomplices in all our public-private partnership ventures. I am grateful for their forward-leaning approach across different interest groups and their single-minded focus on keeping all Washingtonians safe from COVID-19.

Finally, a playbook like this would not be possible without the tireless program management, cajoling and communications expertise that Brian Mannion and Susan Woodward brought to our efforts. Heather McCauley joined the team as we went into production and her contributions were quickly incorporated as well.

For all these people and the countless others I haven't singularly mentioned, I am grateful and deeply honored to have had this time with you.

Thank you again for the opportunity to serve.

Very Respectfully,

Raquel "Rocky" Bono, MD

EXECUTIVE SUMMARY

PURPOSE

The purpose of this playbook is to provide Governor Inslee with recommendations and potential action steps for his endorsement that will further the work of the **Washington State COVID-19 Pandemic Health Response** team.

WHAT'S INSIDE

The playbook contains recommendations and next steps that have arisen from health crisis response work undertaken June 1 to September 15, 2020, under the leadership of Vice Admiral Raquel "Rocky" Bono, MD. It is designed to be part of a continuum, building upon the foundational work described in the **COVID-19 Health System Response Management dossier** presented to Governor Inslee on May 29, 2020.[1]

This playbook contains clear recommendations and next steps in five focus areas:

1. Acquisition and equitable distribution of **personal protective equipment (PPE)**;
2. Establishment of timely, statewide **COVID-19 testing**;
3. Preparation for an anticipated **fall surge** of both COVID-19 and influenza infections;
4. Optimization of **WA HEALTH** capabilities; and
5. Leveraging the positive **stakeholder relationships** established with the healthcare sector and other industries.

The following pages contain high-level information that synthesizes multiple work stream efforts. More information about how the work groups arrived at specific recommendations and additional detail on how to implement next steps can be found in the appendix.

BACKGROUND

Three consistent priorities have driven the vice admiral and her pandemic health response team throughout the year:

1. Protect frontline healthcare workers;
2. Optimize Washington state health resources;
3. Keep all Washingtonians safe.

Recommendations and next steps found in this playbook support these priorities and the multiple efforts that have contributed to the team's vision, goals and objectives.

Our vision has been to provide a **unified, statewide picture** of Washington's pandemic response priorities for the next 6 to 18 months. Our goal has been to deliver a **playbook of strategies** to coordinate and synchronize work with partners to further minimize the coronavirus risk for all Washingtonians. We have worked to achieve this by including public

[1] See Washington State COVID-19 Health System Response Management dossier (May 2020).

health, the healthcare system, local public health and private stakeholders to coordinate response efforts statewide. To date, these positive, proactive relationships and several public-private partnerships, have already accomplished some notable successes.

Opportunity abounds to build upon these wins in the fight to get upstream of the COVID-19 pandemic. By further cultivating solution-oriented, public-private partnerships, the State of Washington can move from a crisis management posture to more sustainable urgent pandemic operations and maintain focus on what it does best – successfully lead the people and communities of Washington through this 100-year event and elevate the state's preparedness to take care of the greatest number of Washingtonians when the next medical emergency emerges.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

CURRENT STATE

Washington state's healthcare system and key social safety net organizations do not have adequate supplies of personal protective equipment (PPE) and must use conservation and/or extended use protocols.[2] The global supply chain is disrupted, not all organizations that need PPE have regular access to a supply chain, and there is a shortage of the raw materials required to expand manufacturing.

Hospitals are procuring most of their PPE from the marketplace and not from the state backstop,[3] but other entities and vulnerable populations depend on the state backstop. The state and counties are focused on supplying high-risk long-term care facilities and adult family homes.

In August 2020, approximately 50 individuals from across the state collaborated to address the state's PPE supply shortage and get "upstream" of the COVID-19 infection. By doing so and supporting the PPE needs for vulnerable and high-risk Washingtonians, the second objective was to ameliorate "downstream" strain on the healthcare system, especially in preparation for a projected confluence of influenza and COVID-19 infections in the fall. The PPE work group consisted of members of the healthcare industry, labor unions, state agencies, emergency management and local health jurisdictions, among others. The group focused on four key areas and critical tasks:

1. **Supply Chain**
   - Develop a sourcing strategy for high-quality, acceptable PPE.
   - Develop recommendations for centralized reporting for tiering and distribution.
   - Consider traditional and non-traditional PPE sources.
   - Understand warehousing and distribution capabilities.
   - Forecast and calculate PPE needs and volumes.
   - Develop end-to-end inventory.
   - Include dental and other smaller, decentralized parts of the healthcare system.
2. **Stockpile and Backstop**
   - Understand expectations for stockpile.
   - Understand centralized and decentralized decision environment.
   - Consider mutual aid.
   - Understand readiness of the healthcare system to use stockpiles and what is required to plan for that use.
   - Define "backstop" and make inventory visible to stakeholders who would use backstop.
   - Develop ability to forecast estimated product delivery times.

[2] Using measures to reduce need for PPE, such as reducing exposure of healthcare providers.
[3] Supporting or augmenting but not the primary provider of PPE.

- Develop predictive capability for potential requests for backstop assistance.
- Develop centralized process for requests and dissemination.
- Clarify backstop financial model.

3. Vulnerable Populations

- Identify marginalized and vulnerable groups.
- Consider long-term care sector holistically, including small residential homes.
- Understand context, concerns and factors affecting representations of communities.
- Develop options for data collection required to determine a state-managed, 30-day PPE backstop.
- Project backstop allocation with available data.
- Broaden conversation beyond healthcare system to consider organizations providing services to vulnerable communities to re-establish pre-pandemic service levels.

4. PPE Tiers

- Assess the Washington State Department of Health's (DOH) existing **Guidelines for Prioritization of Allocation of PPE**, which guides state and local emergency management agencies on how to prioritize fulfillment of PPE requests.

DESIRED STATE

All healthcare and other essential workers are protected at all times with adequate PPE and do not need to rely on conservation or reuse protocols. A statewide, public-private consortium sources, procures and distributes PPE through robust supplies from local manufacturers wherever possible. Washington state's PPE supplies are used as a last resort, except for the most vulnerable populations, who are prioritized through a specific state PPE backstop. This collective approach to PPE will help stop the spread of COVID-19 and move Washington upstream of the pandemic.

RECOMMENDATIONS

1	Create a statewide purchasing consortium to source, procure and equitably distribute PPE to a public-private membership.
2	Use Restart Partners (a non-profit) to model data to determine how much PPE is needed under various circumstances so that counties and the state are adequately supplied. (Restart has worked with Department of Enterprise Services since March.)
3	Prioritize vulnerable populations by creating a 30-day backstop of PPE supplies for these groups.[4]
4	Work with Washington manufacturing intermediaries to identify manufacturers that can provide alternative local sources of PPE.

[4] See Appendix C for recommended backstop for each vulnerable population group.

STRATEGY

Supply Chain/Backstop

1. Create a PPE purchasing consortium steering committee.
2. Identify a technology platform.
3. Test purchases.
4. Identify lead organization.
5. Determine governance structure for new entity.
6. Identify up-front costs and identify funding sources.
7. For the alternative source of PPE, deliver an initial curated list to the leadership group.[5]
8. Communicate to EMDs and other entities that may wish to access the state emergency PPE supplies.
9. Identify mechanisms for state to recoup investments in PPE and potentially sell excess supplies through the PPE purchasing consortium.
10. Explore federal, state, local and philanthropic funding sources for PPE acquisition.
11. Establish a subject matter expert steering committee that includes the local health jurisdictions and emergency management; work with the consortium to meet backstop needs.

Vulnerable Populations

1. Continue data collection and projection efforts to determine backstop for identified communities.
2. Decide which option is best to produce the data required to determine backstop supply.
3. Partner in this work with the Washington State Department of Corrections and the Washington State Health Care Authority.
4. Continue PPE distribution to low-income and agricultural communities.
5. Work with State Emergency Operations Center (SEOC) and Department of Enterprise Services (DES) to share projections for operationalizing backstop PPE supplies.
6. Focus on moving PPE upstream to vulnerable communities to prevent the spread of COVID-19.
7. Conduct a benefit analysis for the state to supply PPE to vulnerable populations to justify the financial costs and the proactive approach to preventing the spread of COVID.

PPE Tiers

1. Socialize state's role as a backstop and not the primary provider of PPE with the Office of Financial Management.
2. Fully implement and publish revised PPE Tiers and Allocation Guidelines.[6]

[5] Potential manufacturers will require evaluation by new PPE consortium and Washington State Department of Enterprise Services (DES).
[6] See draft guidelines in Appendix F.

Timeline

Review and publish DOH PPE Tier Guidelines in fall/winter 2020.

Recommended Team

Jason Moulding, Vice President, Strategic Sourcing, MultiCare Health System

Bharat Shyam, Board Member, Restart Partners

Rick Rubin, President and CEO, OneHealthPoint

Kellett Sayre, Director, Maintenance and Operations Division, Washington State Department of Social and Health Services

Nathan Weed, Director, Community Health Systems, Washington State Department of Health

In addition:

Washington state agencies

Physicians

Long-term care facilities

Labor unions

Pharmacies

Nursing leaders

Local health jurisdictions

Emergency management

Coalitions

Businesses

COVID-19 TESTING

CURRENT STATE

COVID-19 testing in Washington state lacks the infrastructure to coordinate widespread community testing for both public and private testing needs. Results are inconsistently provided, remote and smaller communities are challenged by limited equipment and supplies, and payment and orders for testing are determined by multiple, competing health plans. Laboratory systems work independently and the various processes for testing populations, reporting test results and supply management lack alignment.

Public health testing needs and indications differ from those of employers, employees, schools and travelers. Local health and state public health offices do not have the capacity or capability to address these broad and diverse needs independently without quickly expending their constrained resources.

As part of the Pandemic Health Response team's efforts, a multi-sector group of public and private stakeholders was assembled to explore potential solutions for Washington's COVID-19 testing challenges. The partnership approached their work with five goals:

1. Increase **testing capacity**, minimize **turnaround time** and ensure all Washingtonians have access to testing when needed;
2. Delineate **health system roles**;
3. Address **payments** for testing;
4. Optimize statewide **test tracking and reporting**;
5. Validate indicators and **standardize processes** for testing and surveillance.

DESIRED STATE

COVID-19 testing is available to any Washingtonian **within 24 hours** of their request, with results determined and delivered to the patient and relevant regulator **within 48 hours for 95 percent of tests**.

Existing platforms are utilized to maximize test collection, diagnosis and surveillance. Test collection is performed electronically, with results and follow-up guidance that is clear, accurate and consistent across the entire healthcare system.

Public education materials are available in multiple formats and languages to inform communities about the testing actions they can take to minimize COVID-19 transmission.

RECOMMENDATIONS[7]

1	Create a Washington co-operative that oversees all testing capabilities statewide ("WA Co-op") and "load balances" tests between laboratories with capacity, processes results and reports results to patients, providers and regulators.
2	Develop and implement a technology platform that supports the co-op's testing coordination and reporting functions and serves as a management platform for contact tracing and patient support.
3	Differentiate indications for **diagnostic** tests and **screening/surveillance** tests and develop expanded capabilities for both.
4	Require businesses to participate and support screening tests for their employees as a condition of re-opening.

STRATEGY

Increase Testing Capacity, Minimize Turnaround Time, Enhance Access[8]

1. Develop a collaborative "load balancing" approach to optimize testing capabilities/ capacity within Washington state.
2. Develop collaborative approaches to secure the reagents necessary to minimize supply-chain constraints on testing capacity.
3. Identify less costly screening testing methods, such as saliva and paper tests.
4. Develop public health guidelines to inform the appropriate use of screening tests, including recommended frequency.
5. Develop resourcing solutions for screening methods. Consider collaborating with the new public-private PPE consortium to explore opportunities for aggregating supply orders and procurement.[9]
6. Build a 12-month budget to quantify the cost of accomplishing testing, tracking and tracing approaches.

Delineate Roles[10]

1. Care provider organizations (acute and ambulatory care settings) and employers are responsible for diagnostic testing of patients and employees (e.g. clinicians, healthcare workers and first responders) with results available within 48 hours for 95 percent of tests.
2. The state Department of Health (DOH) and local health jurisdictions (LHJs) are responsible for general population surveillance and contact tracing testing.
3. Congregate living organizations (group homes, long-term are facilities, etc.) are responsible for testing of patients, clients and employees.
4. Identify others (churches, community organizations, schools/colleges, etc.) that can participate in specimen collection.

[7] See Appendix O: Synthesis of Testing Work Group Recommendations.
[8] See Appendix H: Testing Capacity, Minimize Turnaround Time and Increase Access Work Group Recommendations.
[9] See PPE recommendations, p. 6 of this playbook.
[10] See Appendix I: Delineate Health System Roles Work Group Recommendations.

Address Payments[11]

1. Payment for necessary diagnostic testing associated with the provision of clinical services should be billed to and paid by payers (insurance, self-funded employer plans, Medicaid, Medicare, etc.).
2. Employers should be responsible for the cost of testing provided to healthcare workers who may be exposed to COVID-19 at work.
3. Surveillance testing ordered by DOH and LHJs will be paid for by the government entity directing the testing activity.
4. Congregate living organizations will pay for their testing.
5. Individuals seeking testing (not related to patient care) will pay for their tests.

Optimize Statewide Test Tracking and Reporting[12]

1. Select and implement a commercially available population-health oriented information system platform, such as Innovaccer[13], for data collection, reporting, tracing coordination and case management.
2. Input test results into this platform and integrate with infection rate reporting, management of tracing and support activities for COVID-19-positive individuals who are not inpatients.
3. To fulfill the public health tracing responsibilities of DOH/LHJs, develop a statewide team of tracers, with work driven by the information system platform described above.

Validate Indicators and Standardized Processes for Testing and Surveillance[14]

1. Develop a screening/surveillance testing prioritization algorithm.

Develop a 12-Month Budget for Washington State

Budget to cover:

- DOH/LHJ surveillance testing costs;
- Implementation and operation of the testing, tracking and tracing information system platform;
- Operation of the tracing platform.

Next Steps

- Develop a project management team to optimize testing capacity, to include lab and pharmacy capacities dashboards, and implement next steps described above.
- Develop and implement a single, unified platform where all results are reported to patients and regulators and provide appropriate access to healthcare providers.
- Create a hierarchy algorithm for diagnostic and screening testing methodologies.

[11] See Appendix J: Address Payment Work Group Recommendations.
[12] See Appendix K: Testing and Reporting Work Group Recommendations.
[13] See Appendix N: Innovaccer Costs for Tracking and Tracking.
[14] See Appendix L: Validate Indicators and Standardized Processes for Testing and Surveillance Recommendations.

Timeline

Within 30–35 days

1. Develop a project management team for testing capacity team strategies and next steps.
2. Create a hierarchy algorithm for diagnostic and screening testing methodologies.
3. Research reagent and consumable purchasing options.
4. Schedule a meeting with county emergency management to take inventory of untapped community resources available to provide test sites, personnel and other resources.
5. Washington State Health Care Authority (HCA) and DOH to update the state's COVID-19 Testing and Contact Tracing Plan.
6. Organize a meeting with The Governor's Office, Office of Insurance Commissioner, DOH, Washington State Health Care Authority, Department of Social and Health Services, health insurers and healthcare employers to determine funding streams for workplace testing, especially for essential employees.
7. Encourage employer coordination to identify how large/well-resourced and small/thin-margin employers can support each other.
8. Identify a subject matter expert to develop a test tracking and reporting workflow.
9. Adopt workflow test tracking and reporting as a Washington state standard operating procedure for all sites performing COVID-19 tests.
10. Align Washington state reporting requirement with federal requirements.
11. Refine and adopt testing table that includes scarcity resource framework.
12. Create a plan for multiplexing. i.e. simultaneous testing for COVID-19 and influenza in the same sample.

Within 3–6 months

1. Develop purchasing contracts based on findings.
2. Develop and implement pharmacy point-of-care testing plan.
3. Develop and implement DOH mobilization testing.
4. Develop a well-defined education program in multiple languages.

Within 6–18 months

1. Develop and implement the Washington co-op testing hub.
2. Launch single unified platform.
3. Implement home-based testing system.

Recommended Team

Cyndee Jones, Director of Laboratory Services, Swedish Medical Center
Jessica Symank, Senior Director, Patient Safety and Quality Partnerships, Washington State Hospital Association
Taya Briley, Executive Vice President and General Counsel, Washington State Hospital Association
Gloria Brigham, Director of Nursing Practice, Washington State Nurses Association Cynthia Bellas, Partner, IRB Advisors

FALL SURGE

CURRENT STATE

Washington state continues to experience ongoing COVID-19 infection, with some regions and communities more impacted by virus transmission than others. While most healthcare systems prefer to keep patients within their own systems for continuity of care, insurance coverage and to preserve market share, some patients must be moved to alternate facilities to optimize bed availability and to receive the most appropriate clinical care.

The Washington State Department of Health (DOH) has been partnering with the Northwest Healthcare Response Network (NWHRN) and a newly created **Regional Coronavirus Coordination Center (RC3)** at UW Medicine Harborview Medical Center to provide a more coordinated approach to transport and placement of COVID-positive patients on the west side of Washington. These efforts have resulted in a desire to scale the RC3 model statewide and provide similar support to hospitals and patients on the east side of Washington.

DESIRED STATE

The transport and placement of COVID-positive patients who require hospitalization in Washington state is coordinated through a single, centralized system to ensure timely, high-quality healthcare and to prevent strain on individual hospitals. This **Washington State COVID-19 Patient Placement Center** is a patient-centered, clinically focused entity, supported by DOH, NWHRN, RC3 and the DOH Office of Emergency Medical Services (EMS).

The DOH Division of Emergency Preparedness and Response leads the new COVID-19 Patient Placement Center. It relies on a robust **WA HEALTH data platform** to make informed decisions that save patient lives and spread the burden of care across the entire healthcare system.

In the future, the patient placement center model could extend to all other emergency situations, including pandemics and natural disasters.

RECOMMENDATIONS

In preparation for a fall surge ("twindemic"):

1	Expand and formalize the RC3 model to establish a **Washington State COVID-19 Patient Placement Center**, led by DOH, in partnership with RC3 and others.
2	Conduct **pandemic readiness tabletop exercises**, per Federal Emergency Management Agency guidelines.[15]

[15] This is an opportunity to more clearly define roles and responsibilities in a regional approach, as recommended in p. 22 of Washington State COVID-19 Health System Response Management dossier.

STRATEGY

Central COVID-19 Patient Placement Center

For the past several years, Washington state hospitals have worked with DOH and the healthcare coalitions to establish a network of Disaster Medical Coordination Centers (DMCC), including two state DMCCs at Harborview Medical Center in Seattle and Providence Sacred Heart Medical Center in Spokane. Experts in this public-private partnership are best placed to further advise on and develop a Washington State COVID-19 Patient Placement Center.[16] Additionally, it is imperative that relevant preexisting healthcare mechanisms, notably transfer centers, be included in the creation of the new center.

DOH leadership is required to investigate and design a solution that ensures ambulance services have enough capacity and logistical coordination across all counties and local health jurisdictions.

In addition, it will be important for the state to sustain and support the WA HEALTH platform, which has been providing essential data to the new RC3.

Next Steps

The following gaps/risks require urgent attention and analysis:

1. **Transportation capacity:** This is the highest risk identified. Currently, EMS or private ambulances provide transportation for COVID-19 patients, which may impact a locality's ability to provide normal emergency coverage.
2. **Transportation equity:** Certain COVID-19 patients are at risk of deteriorating quickly upon hospitalization and may require urgent air transport to a higher-level care. There is a need to ensure equity for all at-risk populations, i.e. marginalized, elderly, underinsured patients.
3. **Assessment of projected surge data:** An assessment is required to project statewide patient transportation needs to determine what additional transportation capacity is needed.

Pandemic Readiness Tabletop Exercises

The healthcare sector conducts regular readiness exercises to fulfill regulatory compliance requirements and has activated plans for the COVID-19 pandemic. In preparation for the 2020–21 flu season, the healthcare sector has reviewed surge plans and incorporated lessons learned to date from COVID-19.

However, there is opportunity to conduct state-level tabletops with participation from relevant agencies/departments.

[16] This concept aligns with the HHS/ASPR/FEMA Medical Operations Coordination cells (MOCCs).

Next Steps

1. Conduct state-level tabletops to test how agencies and the State Emergency Operations Center have adapted their processes to improve service and communication across all major pandemic response activities, including PPE acquisition and distribution and healthcare waivers.
2. Partner with RC3, healthcare facilities, coalitions and transfer centers to conduct a **patient transport and placement tabletop**, using WA HEALTH data to create scenarios.

Timeline

Recommendations to be operational in time for an expected "twindemic" in fall 2020.

Recommended Team

Co-leads: Washington State Department of Health and Regional Coronavirus Coordination Center (RC3)

Washington State Department of Social and Health Services

Washington State Emergency Management Division

Washington State Health Care Authority

State Emergency Operations Center

Northwest Healthcare Response Network (NWHRN)

REDi

Healthcare organizations (including UW Medicine Harborview Medical Center and Providence Sacred Heart Medical Center)

Local health jurisdictions (including local health officers) Local emergency management

Healthcare organizations and associations

Healthcare labor groups

WA HEALTH DATABASE

CURRENT STATE

The **Washington Healthcare Emergency and Logistics Tracking Hub (WA HEALTH)** is a technology platform that collects key hospital data in a single dashboard to help leaders across the state make timely and informed decisions in response to the COVID-19 pandemic.

A highly collaborative public-private partnership between Microsoft, the Washington State Department of Health (DOH) and the Washington State Hospital Association (WSHA) developed WA HEALTH in less than three weeks in the first quarter of 2020. Over the next six weeks, the team onboarded 500 healthcare workers at every acute care hospital in Washington State to input critical daily data, including counts of available ICU beds, ventilators and personal protective equipment (PPE).[17]

Customer feedback has been adopted into subsequent rapid iterations of the platform, including the ability for users to input data that meets federal reporting requirements. Such responsiveness to end-user need has earned WA HEALTH sustained participation, with healthcare providers and facilities, state agencies and state emergency leaders utilizing the platform to inform their respective response activities.

Importantly, WA HEALTH already informs fruitful conversations between the state and healthcare sector. In addition, the new **Regional Coronavirus Coordination Center (RC3)** at Harborview Medical Center in Seattle is heavily reliant on WA HEALTH as it seeks to create a centralized statewide system for placing every COVID-positive Washingtonians in the right environment for optimal clinical care.[18]

In May 2020, Microsoft fully delivered WA HEALTH system ownership to DOH. However, despite strong positive reception from users, hospitals and state decision-makers, DOH has been challenged to find the dedicated IT and business administration expertise and resources to sustain the platform.

DESIRED STATE

WA HEALTH is the go-to, single source of truth for informing all aspects of Washington's response to COVID-19. The database has been expanded to encompass the state's entire healthcare sector, including outpatient clinics and long-term care facilities, and continuously increases participation of other stakeholders. It provides real-time data update capability and at-a-glance read outs that are openly available and invaluable to all Washington decision-makers with pandemic public health responsibility. Additionally, WA HEALTH is a helpful tool for meeting evolving federal reporting requirements.

[17] See Washington State COVID-19 Health System Response Management dossier, p. 3.
[18] See Fall Surge pages of this playbook for more information about the Washington State COVID-19 Patient Placement Center.

WA HEALTH is sustained with the appropriate state funding, resources and governance structure to respond to its users and the changing regulatory landscape. The team that sustains it retains a nimble and creative approach that embraces additional partners and industries invested in the pandemic response and/or future public health emergencies, including law enforcement, advocacy groups, etc., whose needs may be incorporated into the system of may drive development of similar databases.

RECOMMENDATION

1	Fully adopt WA HEALTH as an integral part of the state's common operating picture and to provide statewide situational awareness.

STRATEGY

Next Steps

- Identify a state executive champion and an operational owner for WA HEALTH to ensure the platform continues to inform decision-makers.
- Identify and empower a key state representative to restart and expand our successful public-private partnership with Microsoft.
- Ensure DOH remains a leading advisor on the platform's future development.
- Develop governance, resourcing and organizational structure strategies that are responsive to the healthcare sector's changing needs and that support a future expanded scope.[19]
    - Reproduce WA HEALTH's aggressive start-up timeline and lessons learned.
- Assemble the broader stakeholders at every level who understand WA HEALTH'S various potential future states and can provide input on the best path forward.
- Expand the public-partnership to include other sectors of the healthcare system.
- Develop state policy and funding strategies to launch the partnership.
    - Involve the State Legislature for investment opportunity.
    - Consider investment from Washington state hospitals.
- Ensure business strategy and objectives drive the platform's future technological development.
- Remain cognizant of the tool's open and inclusive intent; WA HEALTH should never become a regulatory tool.

[19] DOH's Health Systems Quality Assurance division is currently examining approaches to WA HEALTH governance.

Timeline

Immediate

- Identify state or contract resources to support DOH and sustain current user base.

October 1:

- Identify state lead, begin talks with Microsoft and agree to scope of services.
- Assemble broader stakeholders.

October 14:

- Develop strategies with a view to helping manage potential fall surge "twindemic."

Recommended Team

Representative from The Governor's Office
Current DOH owners
Washington State Department of Social and Health Services
Microsoft
Current healthcare workers who input data
Hospital executives
State data users/decision makers (emergency managers, etc.)
State government lead for broader effort
Potential users (representatives from long-term care facilities, ambulatory services, etc.)

STAKEHOLDER RELATIONS

CURRENT STATE

When the Washington state director for COVID-19 Health System Response Management was appointed by Gov. Inslee in late March 2020, the immediate goal was to align and coordinate the care and hospitalization of the COVID-19 patient surge. That early effort was marked by the collective decision of the healthcare system to work collaboratively to avoid any single hospital from straining their operations beyond their capacity. Follow-on efforts to develop a common statewide healthcare operating picture (**WA HEALTH**) and the restoration of elective care (**Proclamation 20-24.1**) drew upon the coordinated efforts of the hospitals, labor unions and numerous clinical, professional associations.

As the pandemic continued across Washington state, there were ongoing challenges to the provision of COVID-19 testing, the availability of PPE and the management of increasing COVID-19 hospitalizations. In mid-June 2020, the director's responsibilities were broadened under the state's new COVID-19 Pandemic Health Response. Building on the earlier accomplishments and recognizing the pandemic's complex impact on Washington state, the Pandemic Health Response team expanded the all-of-Washington approach to include the healthcare system, labor unions, local health jurisdictions, the state legislature, policy advisors and department leaders, as well as many other private sector stakeholders with valuable subject matter expertise to help create multi-sector solutions.

Candid discussions and collaboration with a shared desire to take care of all Washingtonians have created the conditions for continuous dialogue and regular standing meetings with healthcare system leaders, labor unions, local public health, state agencies and business and medical leaders. These ongoing conversations inform all those involved in the pandemic response of the Governor's interest and commitment in the healthcare system's success, while providing key insights and understanding to ongoing challenges and potential opportunities among multi-sector leaders.

A central feature of the current state is stakeholder confidence in Vice Admiral Bono's charge over the pandemic response and her authority as an extension of Gov. Inslee. Key partners are appreciative that their viewpoints are well represented to the Governor and are considered in his related decision-making.

The overall result of the team's approach to stakeholders is a positive atmosphere with multiple public-private partnerships invested in deepening Washington's collective response to the COVID-19 public health crisis. The four key areas of this playbook – PPE, Testing, WA HEALTH and the Fall Surge – contain broad and inclusive solutions that were made possible only by the participation of the stakeholders below.

Current Stakeholders

Washington State Hospital Association (WSHA)
Washington State Nurses Association (WSNA)
Washington State Medical Association
Washington State Dental Association
State health officer
Federal/state representatives
Tribes (health directors and leaders)
Local health jurisdictions
Local health officers
Hospital executive leaders
Long-term care facilities
University of Washington
Washington State University
Pacific Northwest University
The Bill & Melinda Gates Foundation
Policy Advisors to the Governor
Departments of Health, Corrections, and Social and Health Services
Washington State Operations Center
Amazon, Boeing, Costco, Google, Microsoft, Starbucks
Kaiser, MultiCare, Providence, Swedish and Virginia Mason healthcare systems
Kaiser, Molina, Premera medical insurers
Regional coalitions
UFCW 21
SEIU 1199

DESIRED STATE

The Washington State COVID-19 Pandemic Health Response continues to partner with a diverse, ever-growing group of statewide stakeholders. New public-private partnerships are created to address challenges wherever they emerge in the fight to control the COVID-19 pandemic and protect all Washingtonians.

The response is a unified, solution-oriented effort that solicits expertise wherever it exists. The new Washington State Secretary of Health leads the response, acting as neutral arbiter to all parties and greeting all pandemic-related problems as challenges to be solved rather than barriers to forward momentum. The secretary creates forums in which all stakeholders are provided the opportunity to contribute and be heard. Solutions are transformed into well-informed recommendations, which are expedited to the Governor so he and the legislature can quickly act and pivot in response to COVID-19.

All future public health and medical crises are approached through a similar public-private lens.

RECOMMENDATIONS

1	Leverage existing stakeholder relationships with business, the healthcare sector and others to further public-private partnerships.
2	Position the new Secretary of Health to be the executive level liaison with the Washington State Hospital Association and Washington State Nurses Association.
3	Develop a strategic communications plan for articulating pandemic response decisions made at the Governor level, so they can be supported and operationalized.

STRATEGY

Key to sustaining stakeholder relations will be ongoing conversations in which healthcare system leadership and labor unions are able to maintain ongoing dialogue with the Governor through an executive-level liaison who credibly reflects the Governor's intent and provides candid feedback from the healthcare system back to the Governor.

Next Steps

1. Continue to support multi-sector collaboration, especially between the healthcare system and labor union leaders. DOH and other state agencies need to promote the shared decision-making and collaboration of these groups.
2. Empower the new Secretary of Health to assume the vice admiral's leadership role in stakeholder discussions.
3. Consider quarterly conversations between David Postman, Chief of Staff to Gov. Jay Inslee, and Kelly Wicker, Deputy Chief of Staff to Gov. Jay Inslee, with leaders from the healthcare system and labor unions.

Timeline

1. Multi-sector collaboration is ongoing. The incoming WSHA president and the current WSNA president are a good team and appear committed to working with each other and finding shared solutions.
2. Kristen Peterson, Assistant Secretary, Health Systems Quality Assurance, DOH, is beginning her orientation of ongoing public-private partnership efforts. This should be an interim solution until the new Secretary of Health is appointed and can assume this role.
3. Quarterly sessions with Postman and Wicker could begin based on their soonest availability.

Recommended Team

Washington State Health Care Authority
Washington State Department of Social and Health Services
Washington State Department of Labor and Industry
Washington State Department of Commerce
Washington State Department of Corrections
Washington State Hospital Association
Washington State Nurses Association

CONCLUSION

The COVID-19 Pandemic Health Response team has learned that designing solutions to complex problems such as PPE acquisition and COVID-19 testing demands broad, inclusive, statewide collaboration. The pandemic has revealed that individual sectors and government offices are quickly strained when attempting to provide solutions independently. The opportunity, then, is to consider fresh approaches and innovative solutions from multi-sector contributions.

The Vice Admiral, her team and statewide partners, urge the state to act decisively on the recommendations in this playbook. In summary:

1. **Create a statewide purchasing consortium to source, procure and equitably distribute PPE to a public-private membership, to include vulnerable populations;**
2. **Develop a statewide cooperative and distinguish between public health versus private industry testing needs;**
3. **Establish and sustain a Washington State COVID-19 Patient Placement Center and conduct pandemic readiness tabletop exercises to prepare for a fall surge;**
4. **Fully adopt the WA HEALTH database as an integral part of the state's common operating picture;**
5. **Leverage existing stakeholder relationships with business, the healthcare sector and others to provide sustainable public health solutions in Washington state.**

Evident here is the high degree of confidence that Washington state healthcare sector leaders, labor unions and businesses have in working with The Office of the Governor. They are enthusiastic about the opportunity for additional exchanges and stand ready to operationalize public-private recommendations through the various action teams that have been established.

Appendix A

SAFE START ADVISORY GROUPS – INSLEE ANNOUNCEMENT
MAY 5, 2020

Inslee announces three Safe Start advisory groups

Governor Jay Inslee
May 5

Gov. Jay Inslee today announced members of Safe Start advisory groups with focus on health systems readiness, social supports and safe return to work.

“These groups include a diverse group of voices, from community leaders in labor, business, government and nonprofit organizations,” Inslee said during a press conference Tuesday. “They represent a broad cross-section of Washingtonians from east and west of the Cascades, different generations and a focus on different impacts from the pandemic on our state.”

Each advisory group constitutes a forum for the community to consult with the governor’s office and state agencies on next steps as Washington moves forward. The members of these community leader groups are in touch with communities around the state and will inform decision-making.

Public Health and Health Care System Community Leaders Group

The Public Health and Health Care System group will look at broadening testing efforts, preparing for a second wave and preparing for treatment or vaccine distribution.

Members include:

- Brian Cladoosby, Swinomish Tribal Leader, Anacortes (Group Lead)
- Ben Danielson, clinic chief and senior medical director, Odessa Brown Medical Clinic, Seattle Children’s Hospital, Seattle
- David Fleming, vice president, Global Health Programs, PATH, Seattle
- Jane Hopkins, executive vice president, SEIU Healthcare 1199NW, Renton
- Hiroshi Nakano, vice president of value based initiatives, Valley Medical Center, Renton
- Carlos Olivares, CEO, Yakima Valley Farm Workers Clinic, Yakima
- Alison Poulsen, executive director, Better Health Together, Spokane
- Mary Selecky, former Washington state secretary of health, Colville
- Sabine von Preyss-Friedman, medical director, Issaquah Nursing & Rehabilitation Center; president, Washington State Society for Post-Acute and Long-Term Care Medicine, Issaquah

> *“This provides a great opportunity for important perspectives from across the health care industry to come together to discuss the next steps within the health care system and the health of Washingtonians,” said Alison Poulsen, of Better Together, Spokane.*

Safe Work and Economic Recovery Community Leaders Group

The Safe Work and Economic Recovery group will advise on recovery plans, guidance for maintaining health standards during re-opening and assistance to Washington's businesses and workers.

Members include:

- Jesus Alvarez, president, Southeast Central Labor Council; Teamsters Local 839, Kennewick
- Anthony Anton, president and CEO, Washington Hospitality Association, Olympia
- Larry Brown, president, Washington State Labor Council, AFL-CIO, Seattle
- David Giuliani, CEO Washington Business Alliance; Sonicare inventor, Friday Harbor
- Latisha Hill, vice president for community and economic vitality, Avista, Spokane
- Junus Khan, founder, Carbitex, Kennewick
- Dominique "Dom" Morel, director of retail operations, REI, Seattle
- Tina Morrison, secretary-treasurer, Spokane Regional Labor Council; American Federation of Musicians, Spokane
- Mark Riker, president, Washington State Building and Construction Trades Council, Olympia
- Lamont Styles, owner, Life's Styles Barber Academy, Federal Way

> *"We truly appreciate the opportunity to offer our perspective to the Governor regarding the difficult decisions ahead as Washington transitions to a more open economy," said Larry Brown, President of the Washington State Labor Council, AFL-CIO. "Job №1 for the labor movement is to ensure that workers are safe when they return to the workplace."*

Social Supports Community Leaders Group

The Social Supports group will offer perspectives on the increasing need for social services because of the COVID-19 pandemic, including food security and safe shelter and housing. It will look at recovery through an equity lens to defend the state's most vulnerable and make sure that every Washingtonian is part of the recovery.

- Sonya Campion, president, Campion Advocacy Fund, Seattle (Group lead)
- Michael Byun, executive director, Asian Counseling and Referral Service, Seattle
- Jodi Daly, president and CEO, Comprehensive Healthcare, Yakima
- Stacy Dym, executive director, Arc of Washington, Olympia
- Toni Lodge, CEO, The Native Project, Spokane
- Steve Maher, director, Our Valley, Our Future/Nuestro Valle, Nuestro Futuro, Wenatchee
- Estela Ortega, executive director, El Centro de la Raza, Seattle
- Thomas Reynolds, CEO, Northwest Harvest, Seattle
- Loria Yeadon, president and CEO, YMCA of Greater Seattle, Seattle

"Thank you Governor Inslee for your leadership during this unprecedented time of crisis. We are forever changed as a society and I look forward to us finding new ways to think about what is important. I am grateful for the opportunity to approach this recovery effort with boldness and, ironically, a focus on inclusion in this new world of isolation and distancing. Many of us were socially, politically, and economically fragile and excluded before this crisis, and now some issues are more acute. The impact is unevenly felt by many diverse groups on this advisory panel. We look forward to prioritizing a research-based approach to some pressing and enduring social justice issues with a focus on equity," Stacy Dym, Executive Director of The Arc of Washington said. "For many people with disabilities, underlying conditions make them more at risk for the severe consequences of this virus and more vulnerable to the effects of isolation and distancing that cut them from needed services, supports, and personal care to stay healthy and safe. I look forward to some rich conversations about where we go from here, together."

"I'm pleased the governor will be hearing from all parts of the state and from all constituencies and all walks of life. While each community in the state is different, we need to tackle reopening the economy, recovery efforts and the likelihood of a second wave later this year as one united front. We need to be creative, inclusive and collaborative, and mindful of all who are suffering economically and socially." Steve Maher, Director, Our Valley Our Future

The creation of these advisory groups are part of the governor's recovery plan that he first announced last month. The groups will work in tandem with ongoing conversations with local and other state governments, stakeholders and community partners to make sure Washington can re-open safely for everyone.

"I thank each of the members of these groups for helping inform the critical work we are doing to protect our public, economic and social health," Inslee said.

Appendix B

PPE SUPPLY CHAIN, STOCKPILE AND BACKSTOP – WORK GROUP RECOMMENDATIONS

PPE Supply Chain Workgroups 1,2,3

Adequate PPE, Distribution, Stockpiling & Backstopping

PPE Supply Chain

The Problem:

- The health care system and key social safety net organizations do not have adequate PPE to avoid conservation or extended use protocols.
- The global supply chain is disrupted, not all organizations have regular access to the supply chain.
- There is a shortage of raw materials to expand manufacturing.

Desired State:

- All health care providers have access to PPE so that health care can be fully and safely operational, in the context of a green agenda, without the need to utilize PPE conservation/reprocessing protocols and with minimum reliance on state and county EOCs

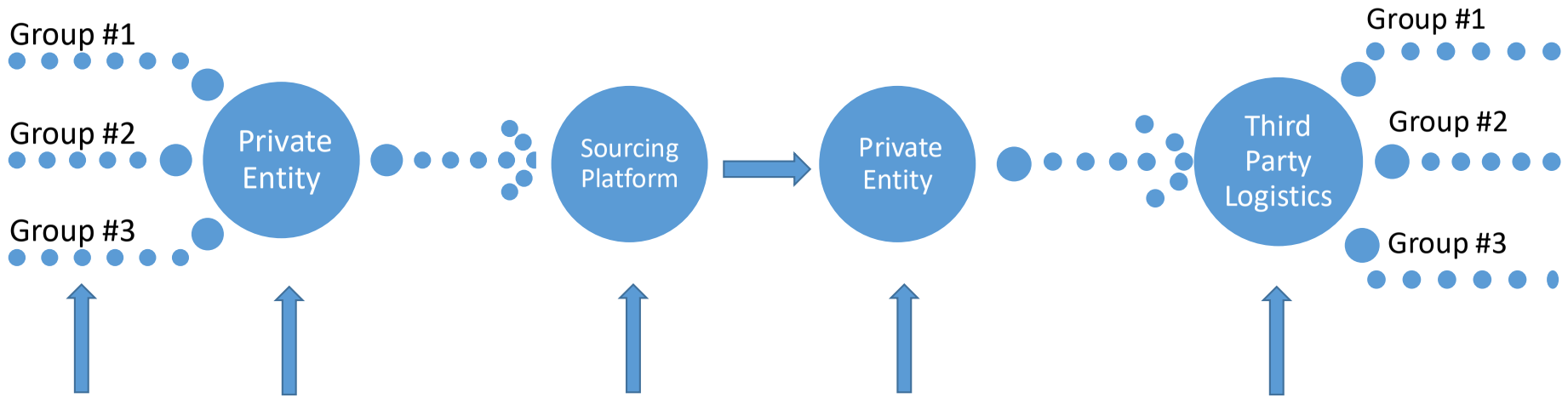
Group Definitions

Group 1	Has a reasonably robust supply chain mechanism in place. This group is well positioned to continue with current procurement practices.
Group 2	Is not as robust and lacks significant impact (influence) in the procurement arena.
Group 3	Does not have influence and is not a participant in the procurement arena.

Group Examples

Group 1	Largest hospital providers (with 300 beds or more)
Group 2	Smaller health care providers and first responders (Small and critical access hospitals, long-term care and nursing homes, behavioral health, dental, pharmacies, morticians, FQHCs, public health, tribal clinics, physician practices, ASCs, EMTs, police, fire departments)
Group 3	Underrepresented or vulnerable populations (Homeless shelters, agricultural congregant communities, childcare providers)

Private Entity & Sourcing Platform Flow



Requesting organizations submit PPE requests to Private Entity

Private Entity with public visibility and coordination that aggregates & coordinates group buy with Sourcing Platform

Platform takes demand to market to ensure access, availability and affordability

PPE purchase & shipment confirmed with entity

3PL receives, inventories and distributes PPE purchase out to requesting organizations

Next steps

- Creation of a steering committee
- Identification of technology platform
- Testing purchases with 2-3 organizations (dental, long-term care, rural hospital)
- Identification of lead organization
- Governance structure for new entity
- Identify up front funding needs and identify funders.

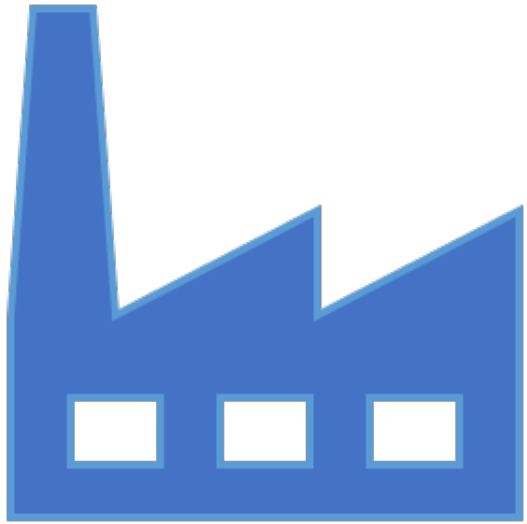
Alternative PPE Resources

The Problem:

- The global supply chain has been disrupted. Dependence on off-shore suppliers has not been reliable.

Desired State:

- Identify and support local manufacturers of PPE



Alternative PPE Sources

- Work with manufacturing intermediaries to identify manufacturers who can provide necessary PPE
- Develop and execute strategies with the intermediaries to bring manufacturers to scale
  - Capital requirements
  - Raw materials
  - Regulatory issues
  - Access to markets

IMPACT WASHINGTON

AWB

Association of Washington Businesses

Washington State Department of Commerce

Next steps

- Initial curated list delivered to the leadership group
- Working with potential manufacturers, Impact WA, AWB, Washington State Department of Commerce to evaluate relationships.

Stockpiles & State Backstop

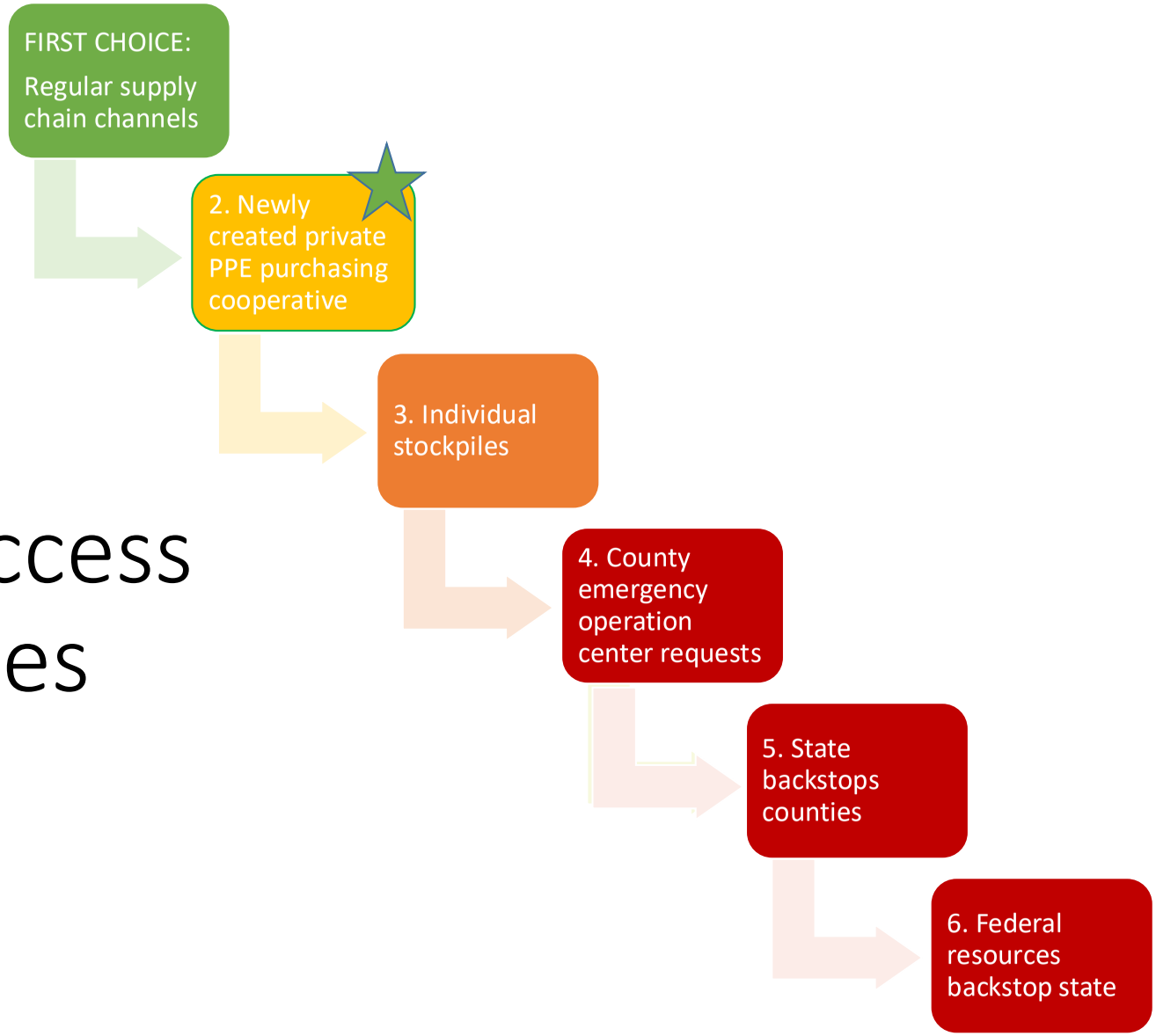
The Problem:

- Local, state and federal stockpiles were unpredictable during the first wave.
- Reserve supplies need to be built up to ensure adequate supply in case of further supply chain disruption.
- Some organizations have become reliant on supplies from federal, state, and county supplies.

Desired State:

- Health care organizations across the spectrum have reserves to minimize dependence on state and county operational staging of resources in the event of a surge.
- State and county operational staging of resources serve as a supplier of last resort.
- Government entities recoup costs from requesting entities
- State and counties have operational staging of resources ready to meet needs for PPE should they arise.

Process to access supply sources



Next steps

- Completion of initial modeling for evaluation by the state/leadership group
- Refinement of the model by stakeholders
- Communication to emergency management agencies, other local and state agencies, and any other entities who may wish to access the state the operationally staged PPE supplies.
- Identify mechanism for the state to recoup investments in PPE and sell excess supplies through the PPE purchasing cooperative.

APPENDIX

Problem statement: The health care system and key social safety net organizations do not have adequate PPE to avoid conservation or extended use protocols. The global supply chain is disrupted, not all organizations who need PPE have regular access to the supply chain and there is a shortage of raw materials to expand manufacturing.	**Desired state:** All health care providers have access to PPE so that health care can be fully and safely operational, in the context of a green agenda, without the need to utilize PPE conservation/reprocessing protocols and with minimum reliance on state and county EOCs

Ideas for reaching success	• Develop a PPE purchasing cooperative to increasing buying power of smaller organizations and possibly secure better pricing. • Test a mutual aid program where a large healthcare organization buys PPE on behalf of a smaller hospital to ensure access, availability and affordability of supplies.
Key interdependencies/ opportunities with other groups	• The cooperative would allow health care and safety net organizations to build their own stockpiles and allow state and county EOCs to truly become suppliers of last resort. • The cooperative would incorporate end-to-end inventory and distribution for all members. Inventory and delivery processes for DES, LHJs, and EMDs would remain the same as they are today. • LHJs, EMDs and DES need to participate in steering committee driving development of the entity
Current risks, issues assumptions, decisions required to move work forward	**Risks:** • Reliability of supply chain. • There is variability in the ability of organization to stockpile. **Assumptions:** • Small organizations can stockpile their own PPE or the need can be filled through philanthropic efforts. • The platform will provide some visibility to government entities about request to avoid duplication of efforts • Steering committee would include representatives from large health care systems, state and local government, smaller health care providers, and social service providers. **Decisions:** Creation of a steering committee to test playbook ideas and guide organizational development
What's next in the sprint?	• Identification of technology platform • Testing purchases with 2-3 organizations (dental, long-term care, rural hospital) • Identification of lead organization • Governance structure for new entity • Identify up front funding needs and identify funders.

Problem statement: The global supply chain has been disrupted. Dependence on off-shore suppliers has not been reliable.	**Desired state:** Identify and support local manufacturers of PPE

Ideas for reaching success	• Curate a list of local manufactures with continued willingness to produce PPE. • Work to secure purchases for locally produced PPE for the state staging of emergency supplies for fall, as well as for sale through the PPE purchasing cooperative.
Key interdependencies/ opportunities with other groups	To meet the overall goal of ensuring sufficient access to PPE to continue regular delivery of health care services across the spectrum, the sources of PPE need to be diversified.
Current risks, issues assumptions, decisions required to move work forward	**Risks:** • Local manufacturers who have switched to PPE production may want/need to return to the items they were manufacturing before the COVID crisis. • Local manufacturers may have challenges getting new products vetted and approve by the federal government to meet the standards of the health care buyers. • Raw materials may not be available to manufacture needed PPE locally. • Costs may be significantly higher for products then what is experienced when supplies are sourced **Assumptions:** • Organizations would purchase supplies from domestic suppliers even if the price was higher then what may be available through the global marketplace.
What's next in the sprint?	• Initial curated list delivered to the leadership group • The manufacturers will need to be evaluated by DES for state purchasing and by the new PPE purchasing cooperative.

Problem statement: Local, state and federal stockpiles were unpredictable during the first wave. Reserve supplies need to be built up to ensure adequate supply in case of further supply chain disruption. Some organizations have become reliant on supplies from federal, state, and county supplies.	**Desired state:** • Health care organizations across the spectrum have reserves to minimize dependence on state and county operational staging of resources in the event of a surge. • State and county operational staging of resources serve as a supplier of last resort. • Government entities recoup costs from requesting entities • State and counties have operational staging of resources ready to meet needs for PPE should they arise.
Ideas for reaching success	Support development of private PPE purchasing cooperative Utilize Restart to develop a model predicting appropriate operationally staged resources for the state and counties. Encourage individual health care providers to build reserves by requiring reporting reserves and conservation measures to access county/state backstop.
Key interdependencies	Access to the state and county resources would be based upon the tiered access determined by the DOH and tier development workgroup.
Current risks, issues assumptions, decisions required to move work forward	**Risks:** • Reporting beyond hospitals has been difficult. Any reporting would need to be relatively low burden. **Assumptions:** • The model works for state and county agencies • State and counties will continue to operate as they have until an alternative PPE purchasing group is up and running and meeting the needs of health care organizations. **Decisions:** • Agreement on Restart modeling and the conditions needed to access any emergency resources staged by the state/counties
What's next in the sprint?	• Completion of initial modeling for evaluation by the group • Acceptance of the model by DES • Communication to EMDs and entities who may wish to access the state emergency PPE supplies. • Identify mechanism for the state to recoup investments in PPE and potential sell excess supplies through the PPE purchasing cooperative.

Appendix C

PPE VULNERABLE POPULATIONS – WORK GROUP RECOMMENDATIONS

Vulnerable Populations Workgroup

08.21.2020

Background and Problem Statement

Background:

- Defining the overall Personal Protective Equipment (PPE) need for WA has been a challenge, esp. for vulnerable populations
- We define vulnerable populations as communities with socioeconomic barriers or pre-existing condition resulting in:
    - an increased risk of contracting severe illness from COVID-19
    - an increased risk of spreading COVID-19 due to the congregate settings they reside or work in

Problem Statement:

- The PPE need across vulnerable populations has not been adequately characterized
- The scope of these communities (in terms of total counts of personnel*) has not been accomplished
- The current reporting mechanisms, which are essential to producing data needed to determine PEE demand and State backstop inventory, have been disparate

*including and not limited to members, facilities/organization, and staff

Desired Outcomes

The desired outcome is to ensure vulnerable populations receive adequate PPE resources without moving to conservation efforts.

Key Objectives:

To recommend strategies on developing standardized PPE reporting mechanisms in order to receive the data needed to ascertain the State backstop supply

To define the scope of each community in terms of number of facilities, members, and staff serving the populations

To establish a projected threshold, based on current data, for each identified vulnerable populations for a State managed 30-day supply of PPE backstop allocations to ensure sufficient supply inventories

Outcomes and Measures of Success

Outcomes and Measures of Success

Fully implemented PPE reporting mechanism in place for each population requesting PPE backstop support with 75% or higher response rate (Long Term Care, Developmentally Disabled, etc.)

Quantifying comprehensive PPE need for each population, including determining the percentage between private vendor supply and public supply

Distribution of PPE from State backstop is successfully delivered to requesting populations within 48 hours

Identified Vulnerable Populations

Aging and Long Term Support Communities

Developmentally Disabled Communities

Low Income and Poverty Communities with Programs, Services and Providers

Child Communities

Behavioral Health Communities

Agricultural Communities

Communities Disproportionately Impacted by COVID-19*

Prison and Jail Communities

*DOH's COVID-19 Morbidity and Mortality by Race, Ethnicity and Language in WA State report: "Native Hawaiian or Other Pacific Islander people (NHOPI) and Hispanic people have age-adjusted rates approx. 8x higher relative to White peoples. Hospitalizations are 7x higher for Hispanics and 11x higher for Native Hawaiian or Other Pacific Islanders relative to Whites. Blacks and American Indian or Alaska Native (AIAN) case and hospitalization rates are 3x higher than those of Whites. Among COVID deaths, we see a similar trend although not as extreme, with rates over 4x higher among Hispanic and NHOPI compared to Whites, 3x higher among AIAN, and over 50% higher among Black and Asian people."

Census

Community Type	Staff	Client / Population
Aging and Long Term Support Communities	116,743	125,214
Developmentally Disabled Communities	14,225	4,927
Low Income and Poverty Communities	4,800	1,838,000
Child Communities	52,757	389,750
Behavioral Health Communities	3,916	1,351
Agricultural Community	160,000	NA
Total	**352,441**	**2,359,242**

Note: Data gap for prisons and disproportionately affected populations; Data gap for community based behavioral health (HCA Data); Agricultural count depicts peak season numbers

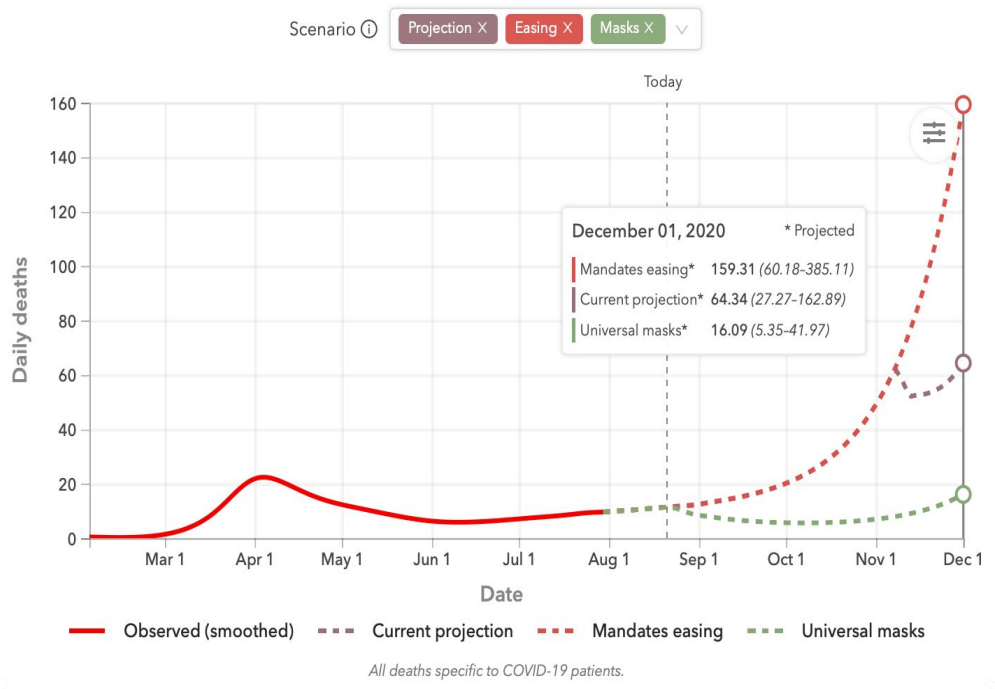
Backstop Analysis

Backstop Projection Summary

- Low income and poverty community (except ESA service staff and agricultural community) are currently being supplied cloth face masks solely by the state.
- Assumptions were used to reach the results for each community and there are large data gaps in each community.
- Projections could be developed for the aging and long-term care community, child community, ESA staff serving the low income and poverty communities
- The Prison population was identified very late and there was not any representation within the group to get data. It was also identified that the disproportionately affected community overlaps with many

Winning at the Upstream, Winning the Frontline

WA Daily Deaths Projection by Mask Wearing Scenarios



- **Current projection** assumes mask use continues at currently observed rates and mandates will be re-imposed for 6 weeks if daily deaths reach 8 per million
- **Mandates easing** assumes mask use continues at currently observed rates and mandates are never re-imposed
- **Universal masks** assumes mask use rises to 95% within 7 days and mandates will be re-imposed for 6 weeks if daily deaths reach 8 per million
- By Dec 1, daily death rates are forecasted to be **159.31 under mandates easing scenario** VS **16.09 under universal masks scenario**

Source: Institute for Health Metrics and Evaluation (IHME)

Recommendations

Market Accessibility:

- The public-private entity (purchasing consortium) developed by the supply chain and backstop groups would allow equitable access and increase buying power to vulnerable populations.

Determining State Backstop:

- Option 1: Let the private-public entity (group 1 and 2s concept) determine the backstop through orders requested by a purchasing entity.
- Option 2: Develop a centralized reporting mechanism focusing on aging and long-term care, child communities, behavioral health, developmentally disabled and prison setting communities in order to determine backstop allocations.
- Others: The State to purchase 20% of the cloth masks and sanitizers from local sources to create and support local jobs.

Community Recommendations

- **Aging and Long Term Support Communities:** Recommend a 30% ~ 50% 30 day backstop of the overall projected need.
- **Low Income and Poverty Communities:** Recommend continuation for distribution of cloth face covering (~3,600,000 units) and 100% backstop for ESA staff providing field services to these communities.
- **Child Communities:** Recommend 100% backstop to staff performing field services to prevent service delivery interruption.
- **Behavioral Health Community:** Further analysis is needed to project backstop. Missing Community Behavioral Health Data.
- **Developmentally Disabled Community:** Further analysis is needed to project backstop. Missing community based developmentally disabled program and facilities.
- **Prison and Jail Settings:** No recommendation at this time. Need stakeholders to be brought into the work into.
- **Communities Disproportionately Impacted:** Further analysis needed.

Next Steps

1. Continue data collection and projection efforts to determine backstop for identified communities.
2. Decide on which option is best to produce the data need to determine backstop supply.
3. Get DOC and HCA involved in this work.
4. Continue distribution to low income and agricultural communities.
5. Work with SEOC and DES to share projections in order to operationalize backstop PPE supplies.
6. Focus on moving the PPE upstream to these communities to in order to prevent the spread of COVID-19
7. Conduct a benefit analysis for the State to supply PPE to certain vulnerable populations in order to justify the financial costs and the proactive approach to preventing the spread of COVID

Appendix D

PPE VULNERABLE POPULATIONS – FINDINGS AND RECOMMENDATIONS

Vulnerable Populations Finding and Recommendations
PPE Public Private Partnership Work Group (PPE P3 WG)

Current State

Background: Defining the overall Personal Protective Equipment (PPE) need for the State of Washington has been a challenge since the onset of the coronavirus pandemic. This includes the vulnerable populations living in the State and the staff members serving these communities. For the purpose of this venture, vulnerable populations are defined as communities with socioeconomic barriers or pre-existing conditions resulting in an increased risk for severe illness after contracting coronavirus or pose an increased risk to spreading the disease due to the congregate settings they reside or work in.

The primary barrier to determining the PPE need is the usage data (quantity and type) for these communities. There is disparate data as to what the burn rates of PPE are for these communities. There is some data in terms of what is being distributed via private vendors versus what the State has distributed to vulnerable populations. This variation makes it difficult to understand the appropriate logistics cycle (manufacturing, transportation, procurement, warehouse/inventory, distribution, and supply) for these populations.

The level of logistical sophistication within these vulnerable populations varies greatly and typically depends on the size of the organization serving these communities. One planning assumption is larger organizations such as nursing homes and psychiatric hospitals have greater logistical resources and buying capabilities, but still struggle to attain PPE and are operating in contingency mode. Within this same planning assumption, smaller organizations such as adult family homes and childcare providers need greater public assistance in attaining and/or managing PPE. From Resource tracking through the State Emergency Operations Center there is some indication there are also communities that may be fully reliant on the State PPE supply. While the larger organization do have greater logistical resource, the reality is State and local emergency management have supplied these organizations on several occasions to meet on-going demand during the pandemic.

Problem Statement: The PPE need has not been adequately characterized across the defined vulnerable populations. An effort to define the scope of these communities in terms of total counts of personnel (including/not limited to members, facilities/organization, and staff) has not been accomplished. There are currently disparate reporting mechanisms in place to produce the data needed to define the PPE need and State backstop inventory for these populations.

Desired Outcome

The desired outcome is to ensure vulnerable populations receive adequate PPE resources without moving to conservation efforts. In order to meet the desired outcome it is critical to determine the comprehensive PPE need for each population including the breakdown between private vendor supply and public supply. This will determine what the State backstop supply should be for each population resulting in adequate inventory to meet the needs without conservation efforts.

Key Objectives:

1. Recommend strategies on developing standardized PPE reporting mechanisms in order to receive the data needed to understand the State backstop supply.

2. Define the scope of each community in terms of number of facilities, members, and staff serving the populations.

3. Establish a projected threshold, based on current data, for each identified vulnerable populations for a State managed 30-day supply of PPE backstop allocations in order to ensure sufficient supply inventories.

4. Conduct a benefit analysis for the State to supply PPE to vulnerable populations in order to justify the financial costs and the proactive approach to preventing the spread of COVID.

Outcomes and Measures of Success

1. Fully implemented PPE reporting mechanism in place for each population requesting PPE backstop support with 75% or higher response rate (Long Term Care, Developmentally Disabled)

2. Quantifying comprehensive PPE need for each population, including determining the percentage between private vendor supply and public supply.

3. Distribution of PPE from State backstop is successfully delivered to requesting populations within 48 hours.

Identified Vulnerable Populations

1. **Aging and Long Term Support Communities**
   - Long Term Care Facilities
     - Nursing homes
     - Assisted Living Facilities
     - Adult Family Homes
     - Individual Providers
   - Adult Protective Services
   - Private Duty Nurse / Nurse Delegators
   - Home Care Aides
   - Case Managers
     - Area Agencies on Aging Case Managers
     - Home and Community Service Case Managers
   - Residential Care Services Investigators, Surveyors and Licensors

2. **Developmentally Disabled Communities**
   - Developmentally Disabled Facilities / Programs
     - Supported living
     - Supported employment
     - Group Homes
     - Group Training Homes
     - State Operated Living Alternatives
     - Licensed Staff Residential
     - Alternative Living

- Adult Companion Homes
- Intermediate Care Facilities for Individuals with Intellectual Disabilities

➢ DSHS/DDA Case Resource Managers
➢ Individual Providers (Same providers as aging and LTC)

3. Low Income and Poverty Communities with Programs, Services and Providers

➢ Homeless Shelters
➢ Economic Service Administration Staff
➢ 200% Below Poverty Level

4. Child Communities

➢ Child Protective Service
➢ Child Care Licensors
➢ Chile Welfare Licensors
➢ Child Welfare Group Homes
➢ State Run Juvenile Rehabilitation Centers
➢ Child Care and early learning providers
➢ Family Time and In-Home Services

5. Behavioral Health Communities

➢ State Behavioral Health Facilities
- Psychiatric Hospitals
- Residential Treatment facilities
- Special Commitment Center
- Pierce and King SCTF
- Child Study and Treatment Center

➢ Forensic Evaluators
➢ Community Behavioral Health

6. Agricultural Community

➢ Agriculture Workers
➢ Food Processing workers

7. Communities Disproportionately Impacted by COVID

8. Prison and Jail Settings

Census

Community Type	Facility Count	Staff	Client / Population
Aging and Long Term Support Communities	4034	116,743	125,214
Developmentally Disabled Communities	301	14,225	4,927
Low Income and Poverty Communities	Unknown	4,800	1,838,000
Child Communities	10,709	52,757	389,750
Behavioral Health Communities	7 (State Run)	3,916	1,351
Agricultural Community	43,000	160,000	NA
Totals	**58,051**	**352,441**	**2,359,242**

Vulnerable Populations Finding and Recommendations
PPE Public Private Partnership Work Group (PPE P3 WG)

*****Data gap for prisons and disproportionately impacted populations
*Facility = Homeless Shelters for low income and poverty communities
*Data gap for community based behavioral health (HCA Data)
*Facility = Farm and food processing plants for agricultural community
*Agricultural count depicts peak season numbers

Impacted Services

Vulnerable populations have also been impacted by the accessibility to in home service since the onset of the pandemic. State and local agencies do provide in-home and field services to vulnerable. Prior to the pandemic staff performing these services did not need PPE, but in the post-pandemic world, they do. Failure to acquire PPE will not allow these services to get back to pre-pandemic levels.

For example, Adult Protective Services within DSHS conducted on average 4,159 in home visits per month pre-pandemic and are now currently operating at 638 visits per post-pandemic. Many of the in-home visits are now being conducted over the telephone. Only the most severe cases are receiving in-home visits. Further analysis needs to be conducted across similar services such Child Protective Services. Further analysis needs to be conducted for agencies performing in-home field services to determine the true impact to vulnerable populations. Similar agencies and providers include (not limited to):

- Child Protective Services
- Residential Care Services Surveyors and Investigators
- Individual Providers
- Home Care Aides
- Economic Service Administration field staff
- Home and Community Services Case Managers
- Area Agencies on Aging Case Managers

Backstop Projection Summary

An attempt was made to determine the overall PPE need and backstop supply for each community based on current data. Projections could be developed for the aging and long-term care community, Behavioral Health Community (state run only), child community, and the developmentally disabled community. The results of these projections can be found in the recommendations section. Assumptions were used to reach the results for each community and there are large data gaps in each community. The low income and poverty community (except ESA service staff) and the agricultural community are being supplied cloth facemasks solely by the state. Hand sanitizer is also being a supplied to the Agricultural Community by the state. Further analysis is need for Prison and Jail settings, Behavioral Health, Developmentally Disabled, and Child Communities in order to determine the overall PPE and State backstop supply. The disproportionately impacted community overlaps with many of the other communities and therefore a projection was not conducted to prevent duplication.

Recommendations

Vulnerable Populations Finding and Recommendations
PPE Public Private Partnership Work Group (PPE P3 WG)

Market Accessibility: Many of the vulnerable populations do not have logistical or procurement means for equitable access of the PPE market. The public-private entity (purchasing consortium) developed by the supply chain and backstop groups would allow equitable access and increase buying power to vulnerable populations. Vulnerable populations will need access to this entity. Dependent on what is developed communication will be key to ensure access to the market.

- Access should be granted to the market by communities' regulating / service agencies or designee: Aging and Long Term Care – Residential Care Services, Behavioral Health – Health Care Authority (HCA). and Behavioral Health Administration (BHA), Child Communities – Department of Child Youth and Families, Developmentally Disabled – Developmental Disabilities Administration (DDA), Prisons – Department of Corrections and County (DOC), Agricultural Community - (WSDA).

Determining State Backstop:

Option 1: Let the private-public entity (group 1 and 2s concept) determine the backstop through orders requested by a purchasing entity. As long as the purchasing entity is identified by community / organization, it should give the appropriate data to maintain appropriate levels of backstop for each community. Accessibility to this private-public entity should focus on the communities mentioned above in the market accessibility recommendation.

Option 2: Develop a centralized reporting mechanism focusing on aging and long-term care, child communities, behavioral health, developmentally disabled and prison setting communities in order to determine backstop allocations.

- Centrally managed reporting mechanism at DES, SEOC, or public-private entity
- Distribute reporting mechanism through regulating agencies to ensure accessibility and participation: Aging and Long Term Care – RCS and HCS, Behavioral Health – HCA and BHA, Child Communities – DCYF, Developmentally Disabled – DDA, Prisons – DOC
- Monthly reporting requirement
- Reporting criteria needs to be easy and simple only seeking information needed to determine backstop: Identification, monthly burn rate by PPE type, percentage of PPE received by a public entity by PPE type, on-hand inventory by period.
- Monthly Reporting Requirement

Aging and Long Term Support Community: The following is the recommended backstop based on projected DOH burn rates and public distributed PPE data for a 30-day period.

Projected Backstop Allocation						
	Projected Backstop	**Gowns**	**N95**	**Facemask**	**Gloves (pairs)**	**Face shields/eye protection**
LTC Facilities	25%	1,480,406	6,432,070	193,704,272	3,831,380	176,843
APS	100%	3,720	3,720	121,050	748,620	3,720
RCS	100%	159	159	1,065	954	159
Case Management	49%	4,131	4,131	133,785	827,492	4,131
PDN/ND	10%	38	38	1,216	7,521	38
Individual Providers	100%	935,190	935,190	30,237,810	187,038,000	935,190
HCA	10%	93,557	93,557	3,024,997	18,711,321	93,557
	Total Backstop Inventory	**2,517,199**	**7,468,864**	**227,224,194**	**211,165,288**	**1,213,637**
		32%	27%	27%	54%	47%

Vulnerable Populations Finding and Recommendations
PPE Public Private Partnership Work Group (PPE P3 WG)

*Assumptions: DOH burn rate for hospitals was reduced to 80% for Nursing Homes, 60% for Assisted Living Facilities and 40% for Adult Family Homes.
* LTC Facilities projected backstop is an assumption considering only one county's data set of PPE distribution to LTCFs was available for analysis.

Low Income and Poverty Communities with Programs, Services and Providers: It was identified the population at 200% below the poverty level is currently being supplied with state procured cloth face coverings at a total of 3.6 million units. Approximately 2 million units have been distributed and the remaining are in the process of being distributed. The estimated cost of this venture is $7.02 million. This will allow for 2 face covering per each person within this population. A cloth face covering is estimated to last 30 washes. The recommendation is to continue this service to this population every 6 months for the next 2 years.

The Economic Service Administration field staff within DSHS perform essential services to low income and poverty communities. In order to perform services at pre-COVID-19 levels the below table depicts the monthly burn rate for these services. The recommendation is to backstop this group at 100% to prevent service delivery interruption for this vulnerable population.

	Staff Needing PPE			PPE Needed for 1-Month[2]			
	High Risk	Medium Risk	Low Risk	High-risk: surgical goggles/etc. (Each)	Medium Risk: FDA-cleared surgical (Each)	Medium Risk: Gloves (Each)	Low Risk: Cloth Masks (Each)
Community Services Division (CSD)[3]	--	870	660	--	38,280	3,000	1,320
Division of Child Support (DCS)	--	100	1,000	--	2,740	2,740	2,000
Disability Determination Services (DDS)	--	25	305	--	426	1,000	610
Division of Finance and Fiscal Resources (DFFR)	--	5	0	--	220	110	0
Division of Program Integrity (DPI)	--	26	60	--	125	125	120
Information Technology Services (ITS)[1]	--	0	250	--	0	0	500
Office of the Assistant Secretary (OAS)	--	0	65	--	0	0	130
Total	**--**	**1,026**	**2,340**	**--**	**41,791**	**6,975**	**4,680**

Child Communities: Childcare is essential to Washington's economic recovery. Many parents and guardians need childcare for children birth through school age, as well as youth development opportunities for children age 13 through high school. In order to support this work, and reduce the transmission of the virus, it is recommended that cloth face coverings is provided for children and providers, so that families may return to work. In order to perform services at pre-COVID-19 levels the below table depicts the monthly burn rate for these services. The recommendation is to backstop this group at 100% to prevent service delivery interruption for this vulnerable population.

	Staff Needing PPE				PPE Need for 1 Month						
Program Area	High Risk	Medium Risk	Low Risk	Total	High-risk: Goggles	High-risk: N95/KN95 Masks	High-risk: Gloves (Pair)	High-risk: Gowns	Medium-risk: Surgical Masks	Medium-risk: Gloves	Low-risk: Cloth Mask
Parole Services	-	-	100	100	-	-	-	-	-	-	100
JR Transportation	10		-	10	300	600	3,000	3,000	-	-	-
Child Protective Services	-	70	-	70	-	-	-	-	2,100	4,200	-
Child Welfare Field Operations	-	1,300	-	1,300	-	-	-	-	39,000	78,000	-
Visitation	-	75	-	75	-	-	-	-	2,250	4,500	-
Licensing-Foster Care (Includes Homes), Group Care, and Child Placing Agencies	-	139	-	139	-	-	-	-	4,170	8,340	-
Licensing-Child Care	-	83	-	83	-	-	-	-	2,490	4,980	-
Juvenile Rehabilitiation Secure Facilities	110	48	492	650	3,300	6,600	33,000	33,000	1,440	2,880	492
Juvenile Rehabilitiation Community Facilities	-	300	-	300	-	-	-	-	9,000	18,000	-
Child Care and Early Learning Servies	-	-	50,000	50,000	-	-	-	-	-	-	50,000

Behavioral Health Communities and Developmentally Disabilities Communities: The data collected was specific to State run 24/7 facilities and does not include community behavioral health or community based developmentally disabled programs and facilities. Further analysis is need to project what the

backstop should be. The following table depicts the projected monthly burn rate for State run facilities run by the Department of Social and Health Services.

Facility	Iso/Surg Procedure masks total	Face shields total	Gowns total	N-95	Gloves
WSH Response Warehouse	**500,000**	**100,000**	**100,000**	**50,000**	**3,000**
WSH Central Services	50000	20000	20000	10000	1200
Ft. Steilacoom	5000	5000	1000	1000	250
CSTC	10000	10000	5000	5000	500
Maple Lane	5000	5000	1000	1000	250
SCC	50000	20000	20000	10000	1200
Rainier (DDA)	50000 (all staff)	20000	20000	10000	1200
Fircrest (DDA)	50000 (all staff)	20000	20000	10000	1200
CSS	**200,000**	**20000 (storage limit)**	**100000**	**50000**	**2000**
ESH	50000	20000	20000	10000	1200
Lakeland Village (DDA)	50000 (all staff)	20000	20000	10000	1200
Yakima Valley School (DDA)	25,000 (all staff)	10000 (storage limit)	10000	5000	500
Yakima CRP	5000	5000	1000	1000	250
Totals	**1,050,000**	**275,000**	**338,000**	**173,000**	**13,950**

Agricultural Community Recommendation: It was identified the agricultural worker community is currently being supplied with federally donated cloth face coverings and state purchased hand sanitizer through the State Emergency

Operation Center. It is anticipated that the current stock of coverings and hand sanitizer will cover agricultural and food-processing sector needs through approximately February 2021. It is assumed that the state will continue to distribute federally donated supplies until they are depleted. It is also assumed that PPE needs fluctuate significantly based on season, with June-October exhibiting the highest demand due to increased number of agricultural workers.

A state-managed 30-day supply of cloth face coverings and/or KN95 respirators is recommended to provide back stock support for the agricultural and food processing sectors, estimated at approximately 300,000 total units. The estimated cost of this 30-day face covering supply is $900,000.00. It is at the discretion of OFM and/or DOH as to how this and other costs should be covered and which cost-sharing arrangements need to be developed between the state and industry (if any).

Communities Disproportionately Impacted by COVID-19: It is important to identify the communities disproportionally impacted by COVID-19. According to DOH's COVID-19 Morbidity and Mortality by Race, Ethnicity and Language in Washington State report:

> "Native Hawaiian or Other Pacific Islander people (NHOPI) and Hispanic people have age-adjusted rates approximately eight times higher relative to White peoples. Hospitalizations are seven times higher for Hispanics and eleven times higher for Native Hawaiian or Other Pacific Islanders relative to Whites. Blacks and American Indian or Alaska Native (AIAN) case and hospitalization rates are three times higher than those of Whites. Among COVID deaths, we see a similar trend although not as extreme, with rates over four times higher among Hispanic and NHOPI compared to Whites, three times higher among AIAN, and over 50% higher among Black and Asian people."

For this community it was identified demographics overlapped within other identified populations. It is likely the PPE (cloth face coverings) needed for this community is being distributed through ongoing efforts. However, it is recommended to continue explore what efforts can be done to reduce the impact

of the virus on these communities, such as community outreach programs and collaborating with private organizations serving these communities.

Prison and Jail Communities: No recommendations can be made until data is received.

Next Steps

1. Continue data collection and projection efforts to determine backstop for identified communities.
2. Decide on which option is best to produce the data need to determine backstop supply.
3. Get DOC and HCA involved in this work.
4. Continue distribution to low income and agricultural communities.
5. Work with SEOC and DES to share projections in order to operationalize backstop PPE supplies.
6. Focus on moving the PPE upstream to these communities to in order to prevent the spread of COVID-19.
7. Conduct a benefit analysis for the State to supply PPE to certain vulnerable populations in order to justify the financial costs and the proactive approach to preventing the spread of COVID

Appendix E

PPE TIERS – WORK GROUP RECOMMENDATIONS

Prioritization Tiering for Allocation of PPE

Public and Private Partnerships (P3) PPE Workgroup 5

August 21, 2020

Problem Statement

- Personal Protective Equipment (PPE), in the context of COVID-19 is a scarce response resource.
- Optimizing the safety of healthcare providers and first responders, in this pandemic, requires a mechanism for identifying groups that should be supported with government supplied PPE above others.
- Washington has a decentralized structure for public health and emergency management and the system requires consistency in responding to the COVID-19 pandemic.
- There are many healthcare and social services organizations who serve critical roles in the COVID-19 pandemic and who are in competition for this scarce resource.

Purpose of PPE Allocation Tier Document

This document is intended to guide state and local emergency management agencies (EMAs) on how to prioritize the fulfillment of emergency protective measures, specifically personal protective equipment (PPE), requests to meet the needs of the response to COVID-19.

Public and Private Roles

- **The state's role in PPE:** The state enterprise serves a role in the acquisition, storage, and distribution of PPE to state agencies and to Tiered stakeholders in emergent circumstances where the normal supply chain cannot meet demand.
  - This is the role as a back-stop for emergent needs
- **Non-governmental response partners' role in PPE**: Working with the public sector organizations, and key stakeholders to build systems for providing PPE to key organizations that require access to PPE.
- Additionally, non-governmental response partners connect PPE distribution channels to organizations that help reduce the likelihood of patient surge in our hospitals, to reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19.

Definitions

- Back-stop: Supporting or augmenting, but not the primary provider of PPE to entities in the Tiered prioritization guidelines.
- Response: Actively engaging with patient populations or community populations to identify and treat persons with suspected or confirmed COVID-19, protect the people in our communities who are most at risk of infection and may face disproportional impacts from the disease, and to control the spread of COVID-19.
- Operational Cache: A staged supply of equipment or supplies that is available for rapid deployment to organizations responding to the impacts of COVID-19.
- Urgent and Emergent Care: Care provided to a patient for which a delay would result in worsening a life-threatening or debilitating prognosis.

Factors in defining prioritization Tiers

- Requirements to treat patients in need of significant medical care and protect the healthcare providers treating urgent and emergent patients with known or suspected COVID-19, in this COVID-19 pandemic response.
- Requirements to control the spread of disease and “box in the virus”.
- Protecting those most vulnerable to COVID-19 and those who are disproportionally impacted by COVID-19
- Ability to access PPE through normal supply chains that are limited/ degraded

Allocation Strategies

- Steady-state COVID-19 operational staging strategy: All governmental entities requesting state provided PPE should first attempt to procure PPE through normal channels or access the current master contracts available through the State of Washington Department of Enterprise Services (DES). If those channels are exhausted or not able to meet the requirement, entities should submit a resource request to the SEOC.
- Steady-state COVID-19 disease control strategy: Governmental agencies, healthcare facilities, and non-governmental organizations will collaborate to increase access to PPE for key organizations. These organizations must maintain their operational effectiveness in order to reduce the likelihood of patient surge in our state's healthcare system, detect cases of COVID-19, reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19. Universal masking is the most proven approach for stemming the spread of COVID in LTCFs and within other congregate living facilities. Surgical masks and cloth face coverings must always be available to congregate living facilities that serve vulnerable populations.
- Emergent needs COVID-19 strategy: When facilities use their operational cache and have less than 7 -14 day supply (depending on the facility) on hand and/or face a surge in COVID cases. They may request an emergent shipment of PPE to meet their needs for up to 7 days. – the state recommends that all healthcare facilities maintain at least a 7 day supply of necessary PPE): the state and county EMAs will aim for short, rapid deployment of supplies; state response goal from request to shipment: <24 hours (dependent on type of PPE and availability in the warehouse, quantities requested, and shipping location in the state). Healthcare organizations may receive PPE that is not their normal type/brand therefore they need to ensure they have a mechanism to re-fit test staff. Noting the fit testing process will also reduce the back stock available .

Tier 1
Confirmed/suspected COVID-19 case(s) with limited ability to social distance and apply engineering controls.
	• Hospitals
	• Outpatient facilities providing care of an urgent or emergent nature. (Including but not limited to ASCs, Urgent Care Centers, Dental Clinics, etc.)
	• EMS Services licensed or recognized in Washington
	• Long term care facilities/home health/home care/hospice/hospice care centers and supported living agencies Alternate care facilities and COVID-19 Isolation facilities workers
	• Medical examiners, coroners
	• Behavioral Health Residential Programs including, but not limited to:
	  ○ Children's Long Term Inpatient Programs
	  ○ Secure withdrawal Management Facilities
	  ○ Evaluation and treatment facilities
	• Regulatory agencies required to complete onsite inspections and investigations in facilities with residents and patients with COVID-19.

Tier 2
Confirmed/suspected COVID-19 case(s) but able to implement social distance and apply engineering controls.
	• All public health agencies for outbreak investigations and testing/lab operations
	• Outpatient clinics providing routine care without conducting aerosolizing procedures, including jail health
	• COVID-19 test sites
	• Law enforcement agencies not licensed or recognized as EMS services
	• Designated crisis responders
	• Congregate living facilities with confirmed/suspected COVID patients
	  ○ Domestic violence shelters
	  ○ Homeless Outreach Programs
	• Quarantine facilities with asymptomatic but exposed individuals
	• Immunization / Vaccination clinics serving asymptomatic populations

Tier 3 Facilities	• Licensed pharmacies not providing testing or immunization services • Families of patients with confirmed COVID-19 who are at home • Adult day health, Adult day care providers, and Community based providers (serving individuals w/developmental disabilities) • Childcare centers / facilities (including those entities providing childcare services to medical professionals, first responders, critical infrastructure employees, etc) • Opioid treatment programs • Funeral homes • Mental health promotion, substance abuse, domestic violence and child abuse prevention programs (or similar social service prevention provider)

Participation in state PPE distribution

- Facilities need to adhere to the DOH and CDC infection control recommendations.
- Facilities need to adhere to PPE Conservation Strategies, typically published by the CDC
- Facilities Emergency Management plans (CMS required) should reference DOH/CDC conservation strategies to standardize approaches across the state.
- Hospitals should continue to enter PPE daily into WA Health.
- To assist the state with prioritizing orders, all PPE requests submitted through emergency management need to include data on the current burden that treating COVID-19 patients is creating.
  - Factors including the acuity of a patient increases burn rate and this may be easier for the larger hospitals to handle. The smaller hospitals handle fewer patients with less resources lower par levels and less stockpile. Not always about the number, but about what % of patients have COVID/Suspected COVID.

Considerations for moving forward

- Vetting with the Disaster Medical Advisory Committee
- As plans for a private sector hub for PPE distribution emerge, a non-governmental allocation approach may need to develop to meet emerging requirements
- Payment for PPE may need to be defined

Appendix F

PPE TIERS – DRAFT REVISED DOH GUIDELINES

Prioritization Guidelines for Allocation of Personal Protective Equipment when Supplies are Severely Limited

Washington State | September 2, 2020

DRAFT

Introduction:
The increased need for Personal Protective Equipment (PPE) caused by the COVID-19 pandemic has caused world-wide shortages of PPE, which has posed a tremendous challenge to the healthcare system, congregate living facilities, and many other patient-care facilities. Since the beginning of Washington State's response to COVID-19, requests to the State Emergency Management Division (EMD) for PPE has far outpaced the ability to source and fulfill orders given the lack of product availability.

While PPE continues to be a scarce resource and difficult for some agencies to source across the country, and internationally, the situation is not as bleak as the spring. This document is intended to guide state and local emergency management agencies (EMAs) on how to prioritize the fulfillment of personal protective equipment (PPE) in an extreme shortage of PPE supplies.

Purpose:
This document will be used as a decision-making tool in the event that PPE becomes an extreme scarcity. This prioritization document does not guarantee fulfillment of every order that meets priority criteria, nor does it ensure fulfillment of complete orders. Orders may be partially filled due to limited stock. It also does not guaranteed that the healthcare organizations will receive PPE that is their normal type/brand therefore they need to ensure they have a mechanism to re-fit test staff. The fit testing process will also reduce the back stock available

Scope:
This document is specific to PPE in the context of the COVID-19 pandemic to ensure good infection prevention control practices and disease containment. This document will be used in times of extreme scarcity.

The state's role in PPE:
As operationally required, the state enterprise serves a role in the acquisition, storage, and distribution of PPE to state agencies and to tiered stakeholders in emergent circumstances where the normal supply chain cannot meet demand. The state enterprise does NOT play a lead role in providing PPE to counties (for tiered entity stakeholders) and tribes, except as a back-stop for emergent needs for government or tribal operations.

Note: These tiers may not capture all facilities or individuals that request or need access to PPE. Emergency management agencies need to use their best judgement around how to prioritize other facilities and individuals not listed.

Non-Governmental Response Partners' Role in PPE:
Non-governmental response partners include partners such as dental clinics, ASFs, and behavioral health organizations, etc. These organizations are to work with the state of Washington, local EMAs, and key stakeholders to build systems for providing certain PPE to key healthcare and social service organizations that require PPE but are not traditional users or have very limited access to require PPE. Additionally, non-governmental response partners can connect PPE distribution channels to organizations or healthcare providers that must maintain their operational effectiveness in order to reduce the likelihood of patient surge in our hospitals, to reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19.

Prioritization and Allocation Strategies:
All entities, including governmental (city, county, state, and tribal) requesting state provided PPE will pursue all available options to obtain PPE on their own, including if it is part of a larger health system and regular ordering and procurement process. Have been practicing PPE conversation strategies per Center for Disease Control and Prevention (CDC) strategies[1], contacted your regional Healthcare Coalition (Northwest Healthcare Response Network and REDi Healthcare Coalition), and/or contacted the local EMA. Organizations may also access current master contracts available through the State of Washington Department of Enterprise Services (DES). If ALL of those channels are exhausted or not able to meet the requirement, entities should submit a resource request to the Local EMA. Facilities must also comply with the Division of Occupational Safety and Health (DOSH), Labor and Industry (L&I), CDC, and healthcare requirements for treating patients in order to request PPE.

Prioritization Protocol:

1. ***Conventional (steady state):*** Organizations are able to order/maintain levels of PPE for current operations, and have enough on hand for a possible surge event. Current facility strategies are in place as part of general infection prevention and control. Organizations can maintain a 30-day supply of PPE.
2. ***Contingency:*** Organizations have anticipated PPE shortages and/or have 7-14 days of PPE supplies on hand. Those organizations begin to implement strategies to obtain additional PPE through available channels and prepare for conserving PPE.
3. ***Crisis (Emergency):*** When demand is exceeding supply, and facilities use their operations cache and have less than 7-14 days of PPE on hand on hand and/or face a surge in COVID-19 cases. In crisis facilities and organizations have implemented PPE conservation strategies as appropriate.
    a. Organizations may request an emergent shipment of PPE to meet their needs for up to 7 days.

Note: The state recommends that all healthcare facilities maintain at least a 7 day supply of necessary PPE. State and county EMAs will aim for short, rapid deployment of supplies [(state response goal from request to shipment: <24 hours) dependent on type of PPE and availability in the warehouse, quantities requested, and shipping location in the state].

[1] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

COVID-19 disease control strategy: Governmental agencies, healthcare facilities, and non-governmental organizations managing congregate living facilities serving vulnerable populations must maintain their operational effectiveness in order to reduce the likelihood of patient surge in our state's healthcare system, detect cases of COVID-19, reduce the spread of COVID-19 in our communities, and protect groups of people most vulnerable to COVID-19. Universal masking is the most proven approach for stemming the spread of COVID in LTCFs and within other congregate living facilities.

Face cloth coverings will be will be available to other congregate living facilities.

Factors to consider in defining the prioritization of PPE:

1. Protecting healthcare providers treating urgent and emergent patients with known or suspected COVID-19.
    a. Ability of healthcare professional to comply with the Division of Occupational Safety and Health (DOSH), Labor and Industries (L&I) and CDC recommendations and healthcare requirements for treating patients.
    b. Likelihood of performing aerosol generating procedures (highest priority for N95s).
    c. Degree of contact between staff and patients, ability to implement engineering controls and social distancing, and the likelihood that patients are infected with COVID-19.
2. Controlling the spread of the disease and "boxing in the virus" particularly among vulnerable populations living in congregate settings (e.g. long term care facilities, homeless shelters, etc.).
    a. Surgical masks will be available to all long term care facilities, home health, homecare, hospice, hospice care, and supported living agencies as part of the universal masking mandate in order to prevent the spread of COVID-19 within these settings.
    b. PPE required as a public health emergency protective measure to prevent and mitigate the spread of the disease for populations where spread of the disease will place an increased burden on the healthcare system.
    c. Need for PPE in testing and containment operations.
    d. Sufficient and appropriate PPE for facilities that are providing vaccinations.
3. Protecting those that are disproportionately impacted by COVID-19 (e.g. essential workers).
    a. Risk of disease spread to other vulnerable people in a congregate setting, or from setting to setting by healthcare workers and others.
    b. Role of asymptomatic spread in severe outbreaks.
    c. Essential nature of the service or support provided by the requesting organization.
4. Organizations having limited ability to access PPE through normal supply chains.
    a. Availability of PPE in the global and US marketplace to entities/requesters.

Definitions:

Back-stop: Supporting or augmenting, but not the primary provider of PPE to entities in the Tiered prioritization guidelines.

Response: Actively engaging with patient populations or community populations to identify and treat persons with suspected or confirmed COVID-19, protect the people in our communities who are most at risk of infection and may face disproportional impacts from the disease, and to control the spread of COVID-19.

Operational Cache: A staged supply of equipment or supplies that is available for rapid deployment to organizations responding to the impacts of COVID-19.

Urgent and Emergent Care: Care provided to a patient for which a delay would result in worsening a life-threatening or debilitating prognosis.

Tiers for PPE Allocation:

Tiers	Organizations	Type of PPE

Tier 1 – Facilities with confirmed/suspected COVID-19 case(s) with limited ability to social distance and apply engineering controls and are unable to maintain a 30-day operational supply of PPE.
 	
Note: Facilities in this tier with confirmed cases, no PPE, and those practicing extreme CDC's PPE conservation strategies[2] will be recognized as a higher priority
	• Hospitals
	• Outpatient facilities providing care of an urgent or emergent nature. (Including but not limited to ASCs, Urgent Care Centers, Dental Clinics, etc.)
	• EMS Services licensed or recognized in Washington
	• Long term care facilities/home health/home care/hospice/hospice care centers and supported living agencies Alternate care facilities and COVID-19 Isolation facilities workers
	
	- Surgical masks will be available to all long term care facilities, home care providers, and supported living agencies in support of the universal masking mandate
	
	• Medical examiners, coroners
	• Behavioral Health Residential Programs including, but not limited to:
	  ○ Children's Long Term Inpatient Programs
	  ○ Secure withdrawal Management Facilities
	  ○ Evaluation and treatment facilities
	• Regulatory agencies required to complete onsite inspections and investigations in facilities with residents and patients with COVID-19.
		• N95 Respirators
		• Surgical Masks

Tier 2 – Facilities with confirmed/suspected COVID-19 case(s) but able to implement social distance and apply engineering controls. Can request PPE from Emergency Management Agencies when they become unable to maintain a 14-day operational supply of PPE.
 	
Note: Fit tested respirators are less likely to be required but surgical masks, gloves, gowns, and other PPE are often necessary.
	• All public health agencies for outbreak investigations and testing/lab operations
	• Outpatient clinics providing routine care without conducting aerosolizing procedures, including jail health
	• COVID-19 test sites
	• Law enforcement agencies not licensed or recognized as EMS services
	• Designated crisis responders
	• Congregate living facilities with confirmed/suspected COVID patients
	  ○ Domestic violence shelters
	  ○ Homeless Outreach Programs
	• Quarantine facilities with asymptomatic but exposed individuals
	• Immunization / Vaccination clinics serving asymptomatic populations
		• Surgical masks
		• Cloth face coverings

[2] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Tier 3 – Facilities that are critical for providing social and behavioral health services to vulnerable populations and must encounter people suspected of having or confirmed to have COVID-19. • *Can request PPE from Emergency Management Agencies when they become unable to maintain a 14-day operational supply of PPE.*	• Licensed pharmacies providing testing or immunization services • Families of patients with confirmed COVID-19 who are at home • Adult day health, Adult day care providers, and Community based providers (serving individuals w/developmental disabilities) • Childcare centers / facilities (including those entities providing childcare services to medical professionals, first responders, critical infrastructure employees, etc.) • Opioid treatment programs • Funeral homes • Mental health promotion, substance abuse, domestic violence and child abuse prevention programs (or similar social service prevention provider)	• Cloth face coverings

Note: These tiers may not capture all facilities or individuals that request or need access to PPE. Emergency management agencies need to use their best judgement around how to prioritize other facilities and individuals not listed.

*Many adult family homes and skilled nursing facilities have connections to local pharmacies. Pharmacies, in some communities could serve as a hub or connecting point for these types of facilities.

**General practice medical offices or medical specialists should attempt to use their healthcare network(s) for PPE. In the event that a healthcare network cannot meet requirements, they should submit a resource request to their local emergency management agency and it will be evaluated on a case-by-case basis.

Appendix G

PPE PUBLIC-PRIVATE WORK GROUPS – PARTICIPANTS

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Appendix H

TESTING CAPACITY TURNAROUND TIME AND ACCESS – WORK GROUP RECOMMENDATIONS

P3 TESTING WORK GROUP – TEAM 1

CURRENT STATE: WHERE ARE WE NOW?

HISTORY

At the onset of the COVID-19 outbreak the demand for testing outweighed the availability of tests. In order to meet the demand, independent laboratories, university labs and governmental agencies developed non-waived high throughput and specialty PCR methods to detect the presence of the COVID SARS-Co2 viral RNA. Once testing became more widely available, consumable supplies for the collection and testing became limited. Manufacturers and researchers pivoted their focus to the development of alternative collection kits and validations of alternative sample sources, swab materials and transport media types. Next, manufacturers focused their attention on the respiratory season of 2020/2021 and determined that the test method of single testing of COVID-19 would usurp supplies for collection, increase turnaround times of results and overwhelm testing laboratories. To address these concerns, manufacturers have focused on non-waived combination multiplex respiratory pathogen testing and waived testing such as home testing and rapid point of care testing (POCT).

SITUATION/BACKGROUND DESCRIPTION

There are three stages in performing clinical tests: pre-analytic, analytic and post-analytic. All steps must be addressed in order to successfully provide accurate results which can be used to assess status of infection:

1. **General Considerations:**
    - Non-local testing takes 2-5 days to receive results which limits their efficacy in prompt identification of cases and subsequent activities that could reduce spread and support care.
    - Test results are only indicative of the current status of the patient at the time the specimen was collected (i.e. not predictive of whether someone will become infective in the future).
    - Cost of testing frequently exceeds the level of allowable Medicare reimbursement rates.
    - Sample collection supplies were initially a significant supply constraint but are now less constrained
    - Staff constrictions is a significant constraint for clinical laboratories.
        - Accessioning capacity is typically fixed based on the number of staff available and the mode of orders (paper vs. electronic)
        - Number of trained licensed personnel who can perform testing
    - Laboratory capacity is dependent on sample intake, accessioning, and processing as well as analytical capacity, and potential reporting limits based on the laboratory's current capabilities.
    - Overall lab capacity is not transparent to entities who may need centralized testing resources.
    - Overall costs for supporting the total testing process, including investment in infrastructure for new testing platforms and interfaces, may exceed the reimbursement from expected tested volumes for many laboratories.

- Possible supply management impacts due to the DOD and CMS redirection of supplies to high prevalence areas in the country or for other means resulting in delay or cancellation of receipt of prior ordered supplies.

- **Pre-analytical**

  Test Orders:

  - A licensed provider must provide orders for most clinical laboratories to perform testing.
  - While legally tests may be ordered without a physician order, reimbursement for testing is uncertain if not ordered by a traditional ordering provider
  - Without an ordering provider there is no set pathway of responsibility to inform about the results and what medical care or behavior changes are needed.
  - Some localities that are running testing sites or collection events have established standing orders from public health physicians to ensure a valid order is available.
  - The default mechanism for ordering testing at a remote/reference laboratory location is a paper requisition, which presents a relatively low barrier to ordering but increases the likelihood important information (patient address and phone number) will not be captured. It also makes data more difficult to track, increases error risk and is time and expense intensive.
  - The standard communication mechanism for laboratory orders and results is HL7. HL7 interface projects typically require expertise that some laboratories who are new to clinical testing or test at smaller volumes are not familiar with. These projects are typically executed in the time frame of weeks to months rather than days.
  - Specific laboratories may have electronic ordering options (e.g. physician portals) that can better capture the information we need, but these are currently laboratory specific.
  - More generalized electronic ordering interfaces are under development (e.g. Epic OCHIN system) but present overhead and barriers to use in the field (e.g. using a patient encounter/visit centric system for high-throughput sample collection workflows).
  - Other hybrid approaches such as the QRP form system developed by the Public Health Laboratory (enter data electronically that is printed on paper on a QR code) are difficult to generalize across laboratory information systems.

  Sample Collection

  - Sample collection for COVID-19 testing is currently being performed by a wide variety of different entities outside of traditional healthcare systems: high-throughput public collection sites, mobile collection teams, long term facilities, pharmacy facilities.
  - Availability of easy access sample collection sites varies in different localities/counties.
  - Permanent high-throughput collection sites require significant overhead for facilities and staffing, with uncertain funding sources.
  - Respiratory samples continue to be the predominant sample type that is allowable on a broad number of testing platforms, with nasopharyngeal (NP) samples continuing to be the gold standard sample type and requires licensure for sample collection.

- Alternative samples types that are easier to collect such as nasal or saliva have either poorer sensitivity (nasal) or high failure rates (saliva viscosity variability is a challenge for automated liquid handling), etc.

- **Analytical**
  - Different testing methods have variable levels of quality and reliability (rapid tests need a high viral load in order to produce a positive result)

Polymerase Chain Reaction (PCR):

- **High Throughput: High Complexity Testing**
  - PCR testing continues to be the primary methodology for detecting infections due to its combination of sensitivity and specificity.
  - Demand for PCR testing with appropriate turnaround time has been higher than supply at multiples times throughout pandemic, particularly when positivity rates are high
  - Operating high-throughput PCR platforms, whether automated or laboratory developed, generally requires a high complexity CLIA license.
  - There are limited automated high-throughput PCR testing platforms and their supplies/reagents that are more accessible for existing clinical laboratories to run.
  - Large commercial laboratories have more testing supplies for automated PCR platforms but have increased transport time and are subject to increased demands from other parts of the country.
  - Other Impacts: Testing supplies required for COVID-19 PCR testing are disrupting supply chains for non-COVID-19 testing and decreasing the ability of labs to perform other testing.
  - High Throughput sites are expensive to operate and have associated high fixed and variable costs (site leasing, traffic control regulations (e.g. signage), labor (e.g. traffic control, registration, swabbers, supervisors).

- **Lower Throughput: Medium to high complexity testing**
  - Lower throughput (single sample or small batch) PCR platforms are more widely available in clinical laboratories and in clinics but those platforms also have significant supply/reagent constraints.
  - Point of care or small batch PCR platforms are not easily scalable to large scale collection. As an example, the number of samples that can be performed in a point of care setting is dependent on the number of devices times the amount of time the analyte detection requires.
  - Supply constraints for testing on non-automated PCR platforms are not as severe but there are more significant personnel constraints. Infectious disease molecular testing is a specialized field and many laboratories are competing for the same labor force.

Antigen testing/Point of Care Testing (POCT)

- Antigen testing is becoming more widely available with specific “readers” or card-based options for output. However, there are likely to be continued supply chain limitations as governments distribute this supply across a wide range of settings.
- The sensitivity and specificity for antigen testing are lower, with expected performance of 80% sensitivity and 95% specificity (based on EUA data,

published data for COVID-19, and past known performance for analogous influenza technologies).
- Thus far antigen testing has been evaluated and approved on symptomatic populations and its performance in screening asymptomatic individuals is unclear. At low prevalence a less than 99.9% specificity will result in a large number of false positives (low positive predictive value).
- Antigen testing is dependent on the capture antibody and the readout mechanism, varies from manufacturer to manufacturer, unlike laboratory based RTPCR, thus you cannot assume the sensitivity and specificity of an antigen test will be similar between two different manufacturers.
- CLIA lab licenses are required to perform any laboratory testing which limits the widespread deployment of point of care testing (CLIA has requirements for quality oversight, training and competency related to performing testing)

Post-analytical

Results

- Evaluation and interpretation of the results requires a licensed medical director to determine parameters for reporting (i.e. Does a negative on a low sensitivity analyzer truly mean someone does not have COVID-19? Does a repeated positive result from a PCR test two to five weeks after onset mean someone is still infective? Does a positive antibody test mean a person is sick now, was sick in the past, or has immunity? What is the pretest probability that the person is infected (was there a known exposure)?)
- The communication of results and associated patient data to ordering provider/entity and the state/county is critical to identifying cases, contact tracing, and containing the virus.
- Performing testing in existing clinical laboratories utilizes existing mechanisms for reporting to the state in a timely fashion (typically via real time electronic HL7 interface).
- Point of care and antigen testing solutions require additional steps & manual effort to ensure that results are communicated to the healthcare organization and to public health.
- Convenient mechanisms for patients to access their test results also play an important role in ensuring patients are aware of their status and continue to isolate themselves.

Payment

- Payment for testing may be more diverse than typical healthcare laboratory testing: in addition to payment by insurers, there are federal, state, and employer sources of payment that can add complexity to the billing workflows.
- Current regulations insulate patients from charges from COVID-19 testing, but it is unclear whether this will persist throughout the pandemic and could be a barrier to patients seeking testing.
- Insurance carriers do not currently have significant restrictions on covering testing but have expressed the desire to limit their coverage outside of specific symptomatic populations. These restrictions will increase financial risk for laboratories performing the testing (with high reagent & labor costs).

- Inadequate funding (including private and foundational) to support public health initiatives to manage emerging infections to include testing large populations, symptomatic or not

PROBLEM SUMMATION

Due to multiple pre-analytic, analytic and post analytic factors that are involved there has been an ongoing struggle to meet the demands of testing in a timely manner statewide.

There is no consensus among regulatory bodies (CDC, WHO, or IDSA) or laboratory consortiums on result interpretation. Laboratory systems work independent of one another with various overlaps regarding their tested populations, testing methods and supply management. In addition, there is no one single testing system that imparts a single interpretation with reliable understanding of positivity or negativity other than the PCR test method, nor is there a single method to communicate results to various organizations or populations within the state. The inconsistent supply and testing demands makes it difficult to reliably meet expected turnaround times and comply with expectations of the state to test all populations.

DESIRED STATE: WHAT DOES SUCCESS LOOK LIKE?

Desired state description

1. Have an outline of which testing methods should be available for defined population (i.e. Hospital, Ambulatory Care, Long Term Care Homes, Nursing Homes, Congregate Homes, Businesses, General Population or Outbreak Screening)
2. Have a clearly defined algorithm for the critical need to test
3. Have plans for supply chain stabilization for Washington State (reagent co-op, Washington state dedicated manufacturing plant-likely will only work for antigen testing, structure of courier support for transport of remotely collected specimens to testing lab)
4. Have mobile testing capabilities (i.e. Create mobile testing labs with rapid antigen testing availability, expand on mobile testing deployment groups for specimen collection partnered with performing lab with capacity)
5. Have a laboratory, POCT and home-based testing co-op which can mobilize to attend to emergent outbreaks

GOALS AND OBJECTIVES

Perform COVID-19 testing at scale–early, equitably, and urgently in order to detect acute infection early, to aggressively reduce secondary transmission, and inform surveillance and modeling

1. Link all defined populations and contacts to public health interventions (isolation, contact tracing & quarantine and connect at risk populations to resources)
2. Perform the correct test with optimal sample type for the specific setting with the shortest turnaround time (including time from sample acquisition to result notification) to provide actionable interventions
3. Identify which test modality is best in each setting (e.g. high throughput, small clinical setting, surveillance screening of at-risk populations, etc.)

4. Create a hierarchy of testing modalities for these settings that also could flex based on testing supply or testing logistic limitations and can accommodate surges

OUTCOMES AND MEASURES OF SUCCESS

1. Achieve turnaround time for all results to under 48 hours for 95% of all testing.
2. Lower number of exposures per outbreak due to quick reporting. Target a specific Reproductive Number (RO) of <1
3. Achieve a stabilized operation with uptime of 90% statewide.

STRATEGIES TO ACHIEVE SUCCESS

RECOMMENDED STRATEGIES

Recommendations to Increase testing Capacity/Volume:

To maintain operational uptime of 90% statewide

1. Define an oversite board to support operational processes
2. Map testing labs for capacity
   - Utilize existing DOH map of testing sites
   - Currently there are 4 high throughput labs including UW all who have capacity/ growing their capacity
   - Implement a dynamic Central database to divert testing and manage utilization
   - Involve all labs within the state to participate
3. Develop plan for pharmacies to be an access point for community members (ubiquitous access)
   - Pharmacies are a great access point because you have the pharmacist who can order tests, many pharmacies already have or can easily obtain CLIA waivers for POC, most nursing homes and other LTCF contract with pharmacies to get meds delivered so pharmacies could serve as a chain of distribution to get test kits to facilities, most people live close to one or multiple pharmacies.
   - ~~o~~ If testing positive at a pharmacy or other location where there is no provider, how is the information handled, is there a need for advice as to the medical care needs? Will they be referred to public health, urgent care or the ED if they have a specific level of symptoms**?**
   - Pharmacies as testing site: Will need to develop payment model, reporting ability (likely flat file), how do the specimens get to the lab for quickest possible turnaround? Access to POC tests, Develop CDTA protocols
   - It is important that if pharmacies are to be a testing site that the logistics of post-test result actions are clearly outlined with clear accountabilities
   - Reporting requirements to DOH/WDRS, local public health should be automated.
     - Develop an electronic method for data entry over manual entry methods to reduce undue delay and financial burdens
   - Pharmacies as testing site: Will need to develop payment model, results notification and follow up requirements clearly outlined (e.g. link to Public Health interventions such isolation/quarantine, contact tracing, health and financial resources/referrals, reporting ability (likely flat file), how do the specimens get to the lab for quickest possible turnaround?

Access to POC tests, Develop CDTA protocols Educational materials will need to be available in many languages. At healthcare sites we are required to have translation available real time.

- Increase funding sources (including private and foundational) to support public health to manage emerging infections to include testing large populations, symptomatic or not

4. Develop Home Based Collection/Testing Process
   - Currently exists: Example: Everlywell Homebased Testing in Texas 24-48-hour TAT. Limit capacity could recommend for general screening – asymptomatic grp more utilization serving under insured/ limit factor: Speak English…local jurisdiction. – Contact tracing.
   - It would be helpful for LTC facilities (NH). New CMS requirements for NH testing require a 48-hour time frame for NH using PCR testing.
   - Need to develop method to route samples to in-state laboratories.
   - Recommend use at public institutes such as schools and universities and childcare locations
5. Develop plans for the work of testing: Who will do it? When will they do it? Where will they do it?
   - Mobile units go to hotspots, EMS units out in community, community pharmacies can offer drive-up testing
6. Develop a database to limit testing to in clinically appropriate repeat testing
   - Provide specific guidelines for repeat testing
7. Develop an algorithm for testing that reduces the need to test and increase quarantine to lower costs of tests and low risk populations
8. Develop home based non-diagnostic screening tests which can be widespread, inexpensive and used frequently for routine self-screening
9. Stay flexible with the following considerations:
   - High prevalence will cause higher testing, costs and longer TAT.
   - Increased rate of contamination
   - Increased labor costs

Testing Reagent Supply Strategies:

1. Develop a WA entity to manufacture Antigen testing reagents
2. Partner with bulk buyers for supplies for POCT
3. Multistate approach…
   - Source international or partner neighboring states to increase priority pool of supplies Example: Contract limit buy for so many kits

Testing Recommendations:

1. State facilitate the distribution of Antigen testing used for asymptomatic people
   - E.g.: sports teams are Antigen testing every 2 days
2. Provide funding and resources to build additional capacity for PCR testing in existing laboratories that utilized custom sample processing and testing platforms that are not impacted by supply chain limitations independent PCR testing development
3. Develop until such time as there are unlimited reagents testing should be performed on high risk populations
   - DOH should clearly define hierarchy to avoid differences in LHJs, Health Depts, Clinical Settings, HealthCare Organizations

4. Develop a dashboard to run tests at labs that have capacity for a TAT of 24 hours
5. Develop WA Co-Op to oversee process
6. Create "flow chart" of available test options and when to use each test in order to preserve and plan a robust supply chain to ensure capacity exists
    - Need to touch on test and reagent supply chain

Testing Methodologies Available:

1. High Throughput PCR I. Clinically Symptomatic – Diagnostic Testing -Close contacts; care givers; admission to LTCF; hospital procedure screening II. For outbreak at a localized location: III. High numbers of testing (1000s of people) IV. Centralized PCR Testing: Most sensitive V. Large batch VI. Non-Waived VII. TAT dependent on demand (2-5 days) 2. Lower-Throughput PCR I. Clinically Symptomatic – Diagnostic Testing -Close contacts; care givers; admission to LTCF; hospital procedure screening II. Onsite PCR Testing: Table Top Cepheid/Diasorin/BD Max etc III. For outbreak at a localized location: IV. Low numbers of testing (100s of people) V. Centralized PCR Testing: Most sensitive VI. Large batch VII. Non-Waived VIII. TAT dependent on demand (24-48 hours)	3. Antigen Testing I. Asymptomatic -low risk screening II. POCT: Individual III. Specialized Reader: Alere BinaxNOW IV. Equipment Vs. No Instrument V. Waived VI. Many locations: pharmacy; drug stores; home based kits;

4. Have a joint statement from the local laboratories/Public Health/ID providers about the predictive value of the testing platforms and sample types.
5. Escalation of testing
    - POCT for low numbers of exposures to Lower Throughput PCR
    - High Throughput PCR: Expected high numbers. Perform swab to centralized testing location - Reference lab (state – not at site of patient)
6. Future Methodologies
    - Breathalyzers
    - Pooled Testing – needs to be validated- EUA or LDT
        - Requires robotics and is limited to low prevalence – usually above 5-6% pooled testing will not save reagents
    - Unknown – waived EUA approved assays
    - Unknown – non waived EUA approved assays: novel testing such as paper strip testing
    - Consider leveraging agricultures PCR testing labs for COVID-19 molecular testing
    - Develop newer technologies that are not molecular NAAT tests or Antigen Lateral Flow Assay methodologies
    - Create a process for home-based self-screening tests which can be purchased easily and used frequently

      Continued evaluation of Antibody testing for population management and pre vaccine trial, how much of the population has been infected.

WHEN SHOULD THE WORK BE DONE?

WHAT'S THE NEXT MOVE?

WITHIN 30-45 DAYS

1. Create a Project Management Team
    - Select overarching project manager for global oversight
    - Select multiple project managers to oversee individual components of the project
    - Oversee and prioritize the individual projects to ensure the larger project is successful
    - Bridge relationships between the entities
    - Define the larger strategy
    - Help ensure there is resource and funding for each step
    - Determine timeline for implementation
    - Create onboarding strategies

2. Create a laboratory capacity dashboard
    - Utilize existing DOH map of testing sites
    - Provide survey of testing capacity, sample types and available testing methodologies

3. Create hierarchy algorithm for testing methodologies
    - Sensitivities/Specificity
    - Platforms and Turnaround Times utilizing real-time laboratory capacity dashboard
    - Best testing recommendations per population
    - Emergent escalation recommendations

4. Create a Pharmacy testing capacity dashboard
    - POCT testing
    - Sample collections for laboratory testing

5. Research reagent and consumable purchasing options
    - Bulk buy
    - Interstate partnerships
    - WA manufacturing options

6. Start advocacy for the state to increase Public Health funding and have a state infrastructure to respond to emerging infections in a structured way.

3-6 MONTHS (BREAKTHROUGH)

1. Develop purchasing contracts based on findings
2. Develop Interface portal for order and result pool
    - Develop ordering and resulting protocols
        - Define ordering protocols:
            - Standardized pre-testing questions for testing
            - Standardize contact tracing questions to facilitate ability to analyze trends/sources of infection spread, needs of positive patients, etc.
            - Standing order options and associated payment issues.
                - Require all LTC to have standing orders from attending providers or ordering providers Have a mechanism for LTC pharmacies to manage and distribute testing supplies to contracted facilities in a timely manner
            - Manage the COVID-19 results as they would any other lab notification that they usually receive. Through required consultation with MD/practitioner.
        - Create mechanism to report back to appropriate organization
        - Create secure site for tested persons to look up their results that does not require account generation (e.g. secure QR code look up).
        - Determine billing/reimbursement structure based on ordering protocol
3. Pharmacy POCT testing plan developed and implemented
4. DOH mobilization testing developed and implemented
5. Develop a well-defined education program in multiple languages
    - Very clear standardized instructions on how to handle ordering
    - Very clear standardized instructions on how to handle sample flow
    - Very clear standardized instructions on how to handle result management
    - Patient education/population education materials – DOH/Public Health

4-18 MONTHS (REACH)

1. Develop and implement a WA Co-Op Testing Hub
2. Develop and implement a single unified platform where all results are reported which DOH, patients and healthcare providers have access
3. Home based testing managed system developed and implemented

Appendix I

TESTING HEALTH SYSTEM ROLES DELINEATION – WORK GROUP RECOMMENDATIONS

TESTING P3 WORK GROUP – DELINEATE HEALTH SYSTEM ROLES

CURRENT STATE: WHERE ARE WE NOW?

The term healthcare system represents hospitals, clinics, long-term care, pharmacy, local and public health, and the community setting. COVID-19 testing is a function of many of these entities. Some of them are collecting specimens to be tested and others are both performing collection and testing. There are variable workflows and accessibility to testing in private and community settings. Efforts are sometimes uncoordinated, under resourced and delayed. Vulnerable populations and rural areas may not have equal access to testing. There are opportunities to level load testing and create access and capacity across the healthcare system through standardization, coordination and utilization of untapped resources and existing innovation.

Barriers and challenges:

- There is limited visibility into who is testing or has testing capabilities contributing to missed opportunities for public access and a statewide view to testing.
- Identification of COVID-19 positive individuals, subsequent treatment, tracking and contact tracing continues to be fragmented resulting in delays that likely contribute to increased spread of disease and disparities in treatment and outcomes.
- Connecting individuals to testing sites is a challenge which delays identification, treatment and follow-up.
- There are staffing resources who can perform specimen collection under current waivers that are not guaranteed to be in effect long-term. Other disciplines could support specimen collection if allowed by local and state government.
- Rural healthcare systems lack the resources to provide the same level of support that larger community and urban areas can provide. This includes adequate public transportation for vulnerable populations to commute to testing sites or the lack of smart devices to register and receive test results.
- Reporting is required to multiple places creating burden on testing sites.
- Clinics require appointments which delays quick access to testing.
- A lack of adequate contact tracing support leads to hospitals and clinics to fill some of the gap.
- Provider and CLIA coverage are barriers to standing up test sites.
- Test sites collecting specimens do not always interface with labs that are running the tests. This leads to a need for increased resources and delays in results.

Examples of but not limited to current test collection sites include: Hospitals, long-term care facilities (LTC)[1], pharmacies, clinics, shelters, public health departments, self-administered tests, HHS testing sites, correctional facilities, coroners and public health deployed targeted testing sites (i.e. hot spots).

[1] LTC encompasses post-acute, skilled nursing facilities, assisted living, adult family homes, home health agencies and adult day health.

Problem statement: To detect and decrease transmission of COVID-19 in Washington state, a coordinated consistent approach to increased testing capacity is required across the state. Currently there are not adequate resources, guidelines and testing sites for surveillance, detection, reporting and contact tracing. By allowing entities to function at their highest COIVD-19 support capabilities, we can increase access to timely testing, reporting and contact tracing.

DESIRED STATE: WHAT DOES SUCCESS LOOK LIKE?

- For equitable timely testing and surveillance to occur, all patients, healthcare workers and community members will have accessible timely (within 24 hours of request) test collection, results and follow up. Guidance is clear and consistent to all healthcare and testing entities.
- Infrastructure and coordination with local and state public health to support Tier 2 and 3[2] test sites is clear and consistent.
- Existing platforms are utilized to maximize test collection, diagnosis, and surveillance and to match the community member with appropriate resources.
- Use of untapped resources in the community maximizes testing, follow up and education of vulnerable populations. These resources increase capacity in a time of surge or where testing sites have reached maximum capacity.
- Increased mobile testing capabilities are deployed to central locations where they are needed just in time to level load test collection.
- Tier 1 test sites relieve some of the testing, follow up and education burden from other health system entities to perform other duties.
- Testing process (patient intake through contact tracing) can be done electronically to reduce waste and burden associated with paper test process.
- All test results are funneled to the right place at the right time for the right follow up care.

Examples of resources that can be further utilized also referred to here as Tier 2 and 3 sites: Fire stations, schools, community centers, social service programs, free health centers, daycares, blood banks, lab draw stations and more. See Appendix A.

Goals and objectives

- Identify existing platforms to streamline accessible testing, data flows and support the connection of community members with resources.
- Develop standard processes to support testing and follow up workflows for vulnerable populations using untapped and existing resources.
- Understand what is needed to support untapped resources to maximize testing.
- Create a prioritization matrix of potential testing sites that can support long and short-term, surge and backstop[3] testing.
- Delineate the roles and function of hospitals and Public Health in contact tracing.

[2] Test site tiers: Tier 1-most capable with ready throughput capacity
Tier 2- mostly capable but still has a few needs
Tier 3-very untapped resources and will need the most infrastructure

[3]

Outcomes and measures of success

- Testing, reporting and follow up will be level loaded across healthcare systems as identified by:
    - Testing and follow up education is accessible to all Washingtonians within 24 hours of identified need or test request
    - Test TATs are < 48 hours
    - Testing is accessible at all testing sites
    - Surge and backstop criteria is defined
    - Testing sites are prioritized

STRATEGIES TO ACHIEVE SUCCESS

Describe recommended strategies:

- Explore a single population health tool and repository that can accept information from multiple sources (EMR's, labs, etc.) and automate notification to providers, care managers and health officials can reduce the duplicate work efforts and improve the turnaround time for contact tracing.
- An automated tool that screens individuals for testing necessity and directs them to convenient tests sites can help address this problem.
- Clear infrastructure and coordination is provided by local and state health officials for test ordering, reporting, follow up and contact tracing.
- Guarantee current waivers or make permanent the ability for test collectors under waivers to continue the practice of collecting specimens.
- Expand Tier 1 collection sites such as pharmacies where registration, education and follow up can be readily implemented.
- Utilize healthcare students for specimen collection with appropriate oversight.
- Utilize non-medical personnel to perform all non-medical functions for specimen collection at Tier 1-3 test sites.
- Include experts such as but not limited to local emergency management in detailed planning, communication and relationship building of community Tier 2 and 3 collection sites.
- Utilize mobile testing units for centralized specimen collection in communities and not in a limited capacity. Throughput and safe in/out logistics (e.g. crowd control) should be considered when using this service.
- Create a value stream for contact tracing with multidisciplinary team members, take inventory of resources required to perform duties and delineate roles and responsibilities matched with adequate funding. Include lay community representation (Somali Health Board, Community Health Board, tribal councils, International Community Health Services, faith-based organization, National Asian Pacific Center on Aging, etc.)
- Define payment models and/or funding streams for Tier 1-3 test sites.

- Consider:
    - Tier 2 medical facilities such as lab draw stations, dialysis centers and blood drives for registration and specimen collection (See Appendix A). Standard education materials and information on next steps should be made available.
    - Specimen collection sites with non-medical personnel to provide home test kits
    - Home test kit delivery by hospital or other healthcare system volunteers, community outreach programs or visiting partnerships and home health agencies
    - Consider employing home health nurses or other capable providers to collect specimens for those unable to get to a collection site (i.e. EverlyWell)
    - Approach Amazon to consider opening their health clinics (Crossover Health) to community for testing
    - Deployment of Medical reserve corps to collect specimens at Tier 2 and 3 sites or in homes in times of surge.
    - Connect with Nursing Commission to activate and deploy retired nurse
    - Consider veterinarian clinical personnel for specimen collection
    - Use of Dispatch Health services to collect in home specimens (house calls).
    - Maximize short term drive thru testing by hospitals and LHJ using untapped resources to assist.
    - Community CERT[4] program (community emergency response program) to assist in surge testing in Tier 2 and 3 sites.
    - Repurpose mobile dental teams in conjunction with Medical Teams International for specimen collection
    - Consider National Guard resources to be deployed to test sites

WHEN SHOULD THE WORK BE DONE?

- Work should begin immediately to:
    - Identify a population health platform that can be scaled across WA.
    - Explore existing technology to guide individuals to appropriate testing sites.
    - Identify available data resources that indicate where test collection and testing is being done throughout the state through Emergency Operations Center (DOH), RHINO data (DOH), WA Health, DSHS data. Explore if testing data elements can be added to WAHealth to indicate testing and test collection at sites submitting data.
    - Look at current waivers to see what change can be made to make them more long-term.
    - Explore what, if any, legislative changes need to occur to allow non-medical personnel to collect specimens (i.e. nare swabs in which the person being tested swabs themselves).
    - Connect with county Emergency Management to identify community outreach programs and resources that have the infrastructure to deliver home test kits.
    - Identify facilities listed here that have registration and specimen collection capabilities and what gaps need to be filled in order to get them to a tier 1 collection site.

[4] CERT Program: Working through local emergency management to partner with community groups Communication and bldg. relationships https://www.cert-la.com/cert-washington/

WHAT'S THE NEXT MOVE?

Recommend some specific, time-bound actions to move the recommendations forward as soon as possible

- September 28, 2020-Meeting with David Carlson MD to discuss population health platforms and existing technology to connect testing needs with accessible test sites.
- A meeting is being set up with multidisciplinary group to look at existing gaps in pharmacies' ability to streamline testing, follow up and education.
- Schedule a meeting with county emergency management to take inventory of community untapped resources available to provide test sites, personnel and other resources. (Who leads?)
- Inquire with DOH and Charissa Fotinos about what data is collected that indicates inventory of test sites across the state as indicated above.
- Meet with Taya Briley to understand what steps can be taken to ensure waivers are extended and what legislative changes are required to include other personnel to collect test specimens (Jessica).
- Explore medical reserve corps readiness and capabilities in counties where there are increased testing needs (Who?)
- Continue the process of assigning prioritization (Tier 1-3) to test sites (Who?)
- Continue the work to prioritize when and how test sites will be utilized. (Who?)

Appendix A

Test collection site	Tiers 1-3	Long-term	Short-term	Surge	Provider Coverage and CLIA Coverage (internal testing)	F/U	Contact Tracing	Mobile testing relief	Coordination	Internal testing	Public	Private
Pharmacies	1	X			Y /Y	X	PH	X	Pharm may need a CDTA for giving results		X	X
Hospitals	1	X			Y /Y	X	Varies		Support diagnostic testing for others	X	Varies	X
Clinics	1	X	X		Y /Y	X	Varies			X	Varies	X
Employer sites	1-3	X	X		N/N	Varies	PH		Need Coverage to test	X		X
Public Health	1	X	X	X	Y /Y	X	X	X		X	X	
LTCFs	1	X		X-not for comm.	Y /Y	X	Internal/PH		Within their own communs.	X		X
Comm. Centers	3		X	X	N/N	PH	PH	X	Appts and SD, crowd control		X	
Community testing sites	1	X	X	X	Varies	PH	PH		Finding right venues and throughput		X	
Schools (Unopened)	3		X	X	N/N	PH	PH	X			X	
University	1	X			Varies	Varies	Varies	X	F/U from DOH HSQA	X	X	X
Daycare	3		X		N/N		PH		Need coverage to test	X		X
Social Service Programs	3	X	X	X	N/N	PH	PH	X	Need coverage to test		X	
Faith-based Programs	3		X		N/N	PH	PH	X	Need coverage to test	X	X	

Blood banks	2		X	X	Y /Y if they use own lab	PH or hosp	PH		Blood bank could be longer term		X	X
Fire Stations	2		X	X	Y /N	PH	PH	X	Supplies and Prescriber coverage (PH)		X	
Cultural Centers	3		X		N/N	PH	PH		Need Coverage to test	X	X	
Free Health Centers	1-3	X	X	X	Varies	PH	PH			X	X	

Note: For centers that do not have provider coverage or CLIA cert/waiver consider home based testing kits
Tier 1-most capable with ready throughout, has throughout capabilities
Tier 2- mostly capable but still has needs, has some throughput capabilities
Tier 3-very untapped resources and will need the most infrastructure

Appendix J

TESTING PAYMENTS – WORK GROUP RECOMMENDATIONS

TEAM 3: PAYMENT

Submitted September 11, 2020

CURRENT STATE: WHERE ARE WE NOW?

Payment for COVID-19 testing and contact tracing is currently a patchwork, with gaps in understanding and availability of payment for these services. In some cases testing and contact tracing are occurring based on where resources are available from federal, state, or local government funding, insurers, and employers, or they are not happening at all. While coverage of medically appropriate diagnostic COVID-19 testing for individual and group health plan enrollees is required by federal and state law, payment for public health surveillance and return to work testing is a major challenge. As a result, testing and contact tracing are not deployed as broadly as necessary to be effective or to give priority to those with the highest needs. This is exacerbated by unreliable availability of resources (especially tests, supplies and staff) and lack of clear prioritization regarding who should be tested or where contact tracing should be used.

Unsustainable costs

- **Pharmacies:** HHS has partnered with some local pharmacies to provide testing in the short term, but the pharmacies are not getting reimbursed for staff time– making it unsustainable for the long run. (Question: If pharmacies receive separate reimbursement for staff time should that mean that other diagnostic labs are receiving this reimbursement?)
- **Hospitals:** Especially in rural areas, lack of public health resources for surveillance testing and contact tracing means the burden falls on the hospitals:
    - Hospitals are then understaffed and under-resourced for routine work
    - Outbreaks are not caught as quickly as they should be and can get out of control (Yakima and North Central/Wenatchee)
    - For a hospital based clinic, Medicaid may pay nothing in terms of increased fees for a COVID test, since the hospital is paid a set bundle which includes labs, but the payment hasn't been rebased to consider the addition of a COVID test
- **Long Term Care:** Cost of testing goes beyond cost of lab or equipment. Staff is a key need to, in the absence of a standing order, order testing, or to authorize testing consistent with a standing order, especially for Medicaid-only facilities and assisted living facilities that do not have a medical director.
    - For nursing homes/skilled nursing facilities, as of September 2, 2020 the CMS interim final rule on testing goes into effect. Testing begins on September 7, 2020. CMS's QSO memo (QSO 20-38-NH) https://www.cms.gov/files/document/qso-20-38-nh.pdf
    - Each test after the first test requires a physician order for Medicare coverage
- **State:** Model for state-sponsored contact tracers is not sustainable:
    - National guard and DOL staff turnover
    - Contact tracers do not have a connection to their communities
    - Newer contracts with Comagine and others may help remedy this

Lack of clarity and consistency

- Patchwork of testing and ambiguity about reimbursement based on testing purpose, i.e., diagnostic, public health surveillance, or workplace safety.

- If an employer can pay for workplace testing for surveillance purposes, should it pay? Will it be taking needed testing resources out of the system for diagnostic testing or testing for high priority populations or settings?
- Federal and state guidance on payment diagnostic testing for persons who are symptomatic, or asymptomatic with known or recent suspected exposure to COVID-19:
    - Federal Tri-agency FAQ's re FFCRA/CARES Act, April 11: https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf
    - Federal Tri-agency FAQs re FFCRA/CARES Act, June 23: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf
    - OIC COVID testing emergency orders: 20-01: https://www.insurance.wa.gov/sites/default/files/documents/emergency-order-number-20-01.pdf
    - 20-02: https://www.insurance.wa.gov/sites/default/files/documents/emergency-order-20-02_3.pdf
    - OIC COVID testing FAQ, July 2020: https://www.insurance.wa.gov/sites/default/files/2020-07/faq-covid-19-testing-07-20-2020.pdf
- Lack of consistency on who is going to pay for tests (LHJ)
- Rapid tests are about to become available – how will they be paid for?
    - Rapid antigen tests are less sensitive and may miss individuals who have COVID. Most infected, and many or most infectious asymptomatic people will test negative.
    - Rapid antigen tests are less specific than RT-PCR, and at asymptomatic population infection prevalence <0.1%, essentially all positive results will be false positives.
    - The US Department of Health and Human Services (HHS) announced that the federal government plans to ship rapid COVID-19 tests to assisted living communities across the country. The tests will come from a supply of 150 million ordered from test maker Abbott Laboratories are expected to be delivered in the coming two to three weeks. The test will be used to monitor asymptomatic people and then co-locate infected individuals. There are concerns with this approach – see the point about test specificity above. With the rapid antigen tests, most positive tests will be false, resulting in co-location of non-infected individuals with individuals who are actually infected. Given the vulnerability of the long-term care population this approach could result in harm to patients.
- Lack of clarity regarding prioritization of essential worker testing e.g. healthcare workers v. other essential workers such as those in childcare, schools, juvenile rehabilitation facilities, group care and congregate settings essential to economic recovery
- Payment for testing can be made difficult by scope of practice issues and the lack of a standing order
    - Payment may be dependent on who is ordering the test
    - Having a more limited scope provider (RN) instead of an MD, ARNP, etc. can affect payment, especially if test is negative
- OIC is coordinating with HCA and DOH to in implementing the FFCRA/CARES Act testing provision and testing prioritization
- Pharmacists have ability to bill medical claims for private payers but barriers to Medicare billing remain

- Lack of consistency in timing of testing results as well as costs for labs. Are more lab resources needed? More consistency in costs of tests across all payers?

DESIRED STATE: WHAT DOES SUCCESS LOOK LIKE?

The roles of the private sector and government in testing and contact tracing payment are clearly defined, adequately and sustainably resourced, and align with strategies that will most effectively combat COVID-19. Payment structures are consistent, reducing variability in costs for payers. Payment reflects the entire spectrum of care or services required to conduct the test and contact trace. Payment is not affected by how the test was ordered.

PROPOSED PAYMENT PRINCIPLES

- A full range of public and private sector participants should contribute to meeting state-wide testing and contact tracing needs. Public and private sector organizations are interdependent members of the same ecosystem. A high level of engagement by all is necessary for successful testing and contract tracing efforts that will curb COVID-19 activity and allow our state to reopen.
- Given resource limitations, well-resourced entities in the private sector, especially large employers with non-essential workers that engage in return to work testing, should consider providing a commensurate amount of financial support or testing resources to support small employers and the community.
- Recognizing resources are limited, funds allocated to the state (including public funds, those potentially raised through the private sector, and philanthropic resources) should be used to support state-adopted testing and contact tracing priorities.
- Where state-allocated funds are used to support increased needs in a certain sector – for example enhanced surveillance testing in long term care facilities, or congregate settings - maintenance of effort requirements should be included to ensure funds are used to their greatest effect.
- Knowing that additional resources are required to address testing and contact tracing needs is not enough. The need must be quantified so potential solutions can be sized and deployed most effectively

STRATEGIES TO ACHIEVE SUCCESS

RECOMMENDATIONS AND NEXT STEPS:

1. **Funds Allocated to the Government Are Used to Support the State's Testing and Contact Tracing Plan**

   Recommendation:

   - Prioritize populations to be tested and where contact tracing should be concentrated using clinical indications and public health principles. Funds allocated to the state, whether government funds, funds potentially raised from the private sector in conjunction with its own testing efforts, or philanthropic contributions, should support that prioritization.
   - Testing and payment models for long term care facilities, childcare facilities (centers and family homes), schools, youth development settings, group care, juvenile rehabilitation

facilities and congregate settings like correctional facilities, and shelters are developed and prioritized based on the State's Testing and Contact Tracing Plan.

Next Steps:

- By the end of September, the Health Care Authority and Department of Health update the state's COVID-19 Testing and Contact Tracking Plan to establish clear priorities for populations to be tested and where contact tracing should be concentrated.
- By the end of September the Health Care Authority, the Department of Social and Health Services, representatives from congregate settings, the Office of the Superintendent for Public Instruction, the Department of Children, Youth, and Families, and staff from the Governor's Office should engage in conversations about how to approach funding for these populations. For example, adjust reimbursement rates to reflect costs associated with COVID-19 testing, authorize the state's federal CARES Act funds to cover the full spectrum of care involved in testing and contact tracing, or identify private sector funds to support these needs.
    - Engage in conversations with the private sector, especially large employers about serving as a funding source. They may be incentivized to assist the children of their workers returning to school.
    - To aid this work, the size of the financial ask must be estimated.
    - To develop a credible estimate, we must know the number of people who will require testing (surveillance, long term care facilities, congregate settings, child care, juvenile rehabilitation, and schools) the frequency for the populations to be tested, the cost of the test and the cost of administering the test.
    - Information about school reopening can be found here: https://tableau.ospi.k12.wa.us/t/Public/views/AESDRe-Opening/Dashboard1?:isGuestRedirectFromVizportal=y&:embed=y
    - Information about child care, youth development, and day camps can be found here: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/DOH-OSPI-DYCF-SchoolsChildCareGuidance.pdf

2. Private Sector Testing for Non-Essential Workers is Informed by State Testing Guidance, is Not Constrained by State Testing Priorities, and Could Potentially Help Support Community Testing Needs

Recommendations:

- The state should issue guidance for private sector return to work testing for non-essential workers and circulates it to employers and other affected organizations.
- Private sector testing of non-essential workers is held to the same standards of results reporting, i.e. reporting positive test results to public health entities, as public sector testing.
- Options for securing private sector support of broader community testing needs should be identified and implemented. This is especially important because private sector testing, unconstrained by state testing priorities, will likely remove testing

resources from the supply chain. This has implications for equity and accessibility for other community members.

Next steps:

- State experts convene with employers and other private sector organizations to discuss and develop guidance.
- See recommendations for employers below regarding private sector support of community testing needs.

3. Non-Traditional Testing Sites are Used Where Necessary and Adequately Resourced

Recommendation:

When testing must be conducted at non-traditional testing sites, payment should support additional costs necessary to run the testing. This includes all activity necessary to conduct the testing such as courier service, staffing costs for collection, and case management/follow up. Health plans should follow the billing and payment guidelines utilized by Medicare.

Next Steps:

- Determine where and to what extent testing at non-traditional sites is required.
- Identify the main sources of payment for most test sites (health insurer, employer, government, self-pay) and evaluate whether additional government or philanthropic resources should be applied to support overhead costs.
- Rely on the recommendations of other P3 COVID-19 Testing Groups engaged in this exercise to address the challenge of provider types authorized to order testing and any impact on reimbursement for tests.

4. Payment for Workplace Testing is Supported by Varied, But Clearly Identified, Sources

Recommendations:

- Well-resourced large employers should cover all workplace surveillance testing and may be positioned to help support testing for small/thin-margin business and/or the community at large.
- Determine how to support small employers or employers with thin margins that may need assistance covering workplace surveillance testing. Not providing assistance may impact small employer ability to continue offering health insurance or could cause small businesses to close.
    - Work with large employers to identify opportunities to support smaller employer return to work testing.
    - For small/thin margin businesses, when local public health directs there be testing, local public health should pay, including covering couriers or other ancillary services necessary to accelerate testing.
    - Any state-financed or state-supported (via test kits, etc.) workplace testing should follow the state testing priorities.

- Medicaid reimbursement rates for long term care facilities (nursing homes, assisted living, adult family homes, residential and supported living services, enhanced service facilities) should be updated to reflect unexpected administrative and clinical costs resulting from resident and staff testing expenses necessary to maintain a safe environment for a vulnerable population. Maintenance of effort requirements should be applied.
- Continue to support worker's compensation coverage for employees who experience a workplace exposure
- Define the role that can be played by private health plans, but from a practical standpoint recognize they cannot be the only source of this coverage due to health insurance premium impacts, lack of consistent coverage for employed populations, and the requirement for tests to be medically appropriate – a standard that surveillance testing does not meet – for coverage to apply: http://chirblog.org/imposing-the-cost-of-workplace-coronavirus-testing-on-group-health-plans/

Next Steps:

- By the end of September, the Governor's Office, OIC, HCA, DSHS, health insurer, employers and DOH have met to determine funding streams for workplace testing, especially for essential employees.
    - Any government resources should be deployed according to the state's testing priorities.
    - An estimate of the cost necessary to determine the state's approach going forward. The state's Employment Security Department can help inform this effort by providing number of workers by industry: https://esd.wa.gov/labormarketinfo/employment-estimates. The Medicare rate of $100/test is one estimate for cost of the test and additional estimates can be found here: https://www.ahip.org/new-study-covid-19-testing-costs/.
- Request the employer community coordinate to identify the extent to which large/well resourced and small/thin-margin employers can support each other on testing needs. See the work of Challenge Seattle for an example: https://www.challengeseattle.com/
- Consider having professional sports teams and other wealthy employers conducting intensive testing in order to open non-essential services make an equivalent number of tests or equivalent financial assistance available to support community testing needs. This could potentially be accomplished through a surcharge on tests purchased by these groups. Also consider other sources of private funds that could help support community testing.

5. Develop a Funding Strategy to Support the Recommendations

Recommendations.

- Secure a steady stream of funding, prioritized according to the state's testing priorities, for:
    - Testing for uninsured and undocumented patients
    - Testing mandated by public health (i.e. schools, congregate settings, and others)
    - Contact tracing

- Reduce variability in testing charges so the state can leverage its purchasing power.

Next Steps.

- The Governor's Office will prepare a package relying on expenditures of federal CARES funds allocated to Washington State, legislative requests, and philanthropic opportunities especially targeting larger employers.
- The Governor's Office will engage in a conversation with federal officials at HHS and the state's congressional delegation regarding the challenges of variability in testing charges. This is a national challenge requiring a national approach. States rely on purchasing power to keep costs of tests and other healthcare expenses down.

OUTCOME MEASURES

- All testing and contract tracing identified by the State's Plan as necessary to control community outbreaks and support safe reopening of publicly funded programs, schools or care settings is readily available and resourced.
- Individuals who are symptomatic, have a known exposure or a suspected recent exposure have ready access to testing
- There is no differential access to testing and contact tracing for vulnerable or underserved populations compared to other populations.
- Non-traditional testing sites are used in a targeted and efficient manner to support community testing needs and are adequately resourced when used.
- The private sector can conduct the testing necessary to reopen businesses in accordance with state public health guidance.
- Testing and contact tracing improvements are the result of efforts made by a range of public and private sector participants, reflecting their interdependence and cooperative work in solving the problem.

EXHIBIT: AN APPROCH TO QUANTIFYING PAYMENT FOR TESTING

See attached.

GROUP PARTICIPANTS

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Appendix K

TESTING, TRACKING AND REPORTING – WORK GROUP RECOMMENDATIONS

P3 OPTIMIZE STATE-WIDE TEST TRACKING AND REPORTING

CURRENT STATE: WHERE ARE WE NOW?

- Situation/background description
    - Reporting to Department of Health
        - Reportable disease tracking/reporting built on pre-pandemic systems focused on positive cases
        - Current reporting information available here: https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/ReportingTestResults
            - Laboratories are required to report all COVID-19 results (positives and negatives) to local health jurisdiction or DOH
                - Standard option is electronic lab reporting (ELR) HL7 interface
                - Electronic lab flat file (ELFF) has been recently added
                - Requirement applies to CLIA-waived labs conducting point of care or rapid screening testing
            - Healthcare workers and/or facilities are also required to report COVID-19 cases
                - Reporting traditionally done by fax form
                - Electronic case reporting is currently under development but not yet available
        - Larger laboratories have existing ELR interfaces with DOH
            - When reporting requirements change, not only must interfaces with DOH be modified, any existing interfaces that laboratories have with entities sending them testing also must be modified
        - Laboratories not previously required to report reportable diseases to the state are performing COVID-19 testing and require resources to either build ELR or ELFF solutions to be able to report
            - Most laboratories do not have resources for custom IT development if existing commercial solutions do not have out of the box solutions
        - Testing performed in point of care settings, inside or outside of traditional healthcare systems, requires additional process steps for reporting
            - Many settings using point of care instruments will not have the resources to set up automated reporting solutions
            - Data entered into electronic health records (EHRs) often does not follow automated reporting pathways used by laboratories
            - ELFF may be an option for reporting via a manual process
            - Some instruments have the capability to report anonymized data to states/LHJs but this does not meet reporting requirements as currently written
        - Required reporting requirements have changed over time and include a growing list of data elements
            - Data rules and collection information keeps changing related to what needs to be reported; there are 18 data elements/6 demographics

        - Patients are hesitant to share personal information and may provide fake names/addresses since no reassurance that there will not be an untoward outcome
    - Washington state has more stringent requirements than the federal government
        - Race and ethnicity categories are more granular than commonly used in healthcare IT standards
            - Existing information systems and interfaces need to be revised to accommodate more granular definitions
            - Any entity reporting separate to both state and federal bodies will have to reconcile split reporting
            - As the list of categories for a field increases, the responses are less likely to be accurate (a patient having to pick race/ethnicity from a list of 10 vs. 30)
        - Fields such as emergency contact number and preferred language do not exist in all information systems
        - Ask at order entry question fields (e.g. is patient pregnant) add overhead to processes with electronic orders and present tradeoffs for maximizing number of patients tested with fixed number of staff available for collection and test processing (when sent to off-site lab)
    - Federal Government has related (and sometimes independent) reporting requirements.
        - Test reporting is completed manually (on a daily basis) and is sent to the Federal Government.
- Reporting results to providers & patients
    - Traditional healthcare organizations generally have existing electronic workflows to distribute results to both providers (EHRs) and patients (patient portals).
    - Outside of large commercial laboratories, newer or smaller laboratories often do not have portals for reporting results directly to patients (since providers/healthcare facilities typically manage that communication)
    - Testing performed in non-traditional settings may not have the resources to perform result notification, either by phone or through patient portal
    - In point of care settings, documentation of test results for patients is more challenging if the test setting is not using an EHR that can communicate results to other providers and patients.
- Problem statement
    - Test tracking/reporting is complex with multiple requirements across federal, state, and county. There is inconsistency of test tracking and reporting workflow across COVID-19 testing entities to meet established and changing data requirements.

DESIRED STATE: WHAT DOES SUCCESS LOOK LIKE?

- Desired state description: Reduce Reporting Burden

All COVID-19 test results are consistently reported to the WA DOH/Public Health Jurisdiction and to the individual tested using an efficient and streamlined process that includes all data elements necessary to support the public health response.

- Goals and objectives

  Short Term Goals (implementation less than 90 days):
  - COVID-19 testing sites adhere to standardized workflow to report test results from a lab and test results at the point of testing
  - COVID-19 test results include identified demographics/data elements to support the public health response
  - COVID-19 testing sites trace (audit) 10 out of the first 100 tests administered and periodically thereafter to verify that test result reporting to the WA DOH and to the tested individual is occurring as intended

  Long Term Goals:
  - Develop a streamlined and standardized state-wide test tracking and reporting system
    - Demographics and data elements for Washington state align with federal

- Outcomes and measures of success

  Short Term Goals (implementation less than 90 days):
  - 100% of testing sites submit a signed attestation of agreement to WA DOH
  - 100% of COVID-19 diagnostic and screening test results are reported to the WA DOH and to the individual tested.
  - 100% of COVID-19 test results reported include required demographics/data elements to support the public health response

  Long Term Goals:
  - 100% of entities providing diagnostic and screening test results have access to and use a standardized state-wide tracking and reporting system

STRATEGIES TO ACHIEVE SUCCESS

- Describe recommended strategies

  Immediate Interventions:
  - Identify a SME(S) to develop a test tracking and reporting workflow for:
    - COVID-19 tests that are resulted in a lab
    - COVID-19 tests that are resulted at the point of testing (refer to sample provided)
  - Adopt workflow test tracking and reporting as a Washington state standard operating procedure for all sites performing COVID-19 tests
    - Prior to initiating testing, every testing entity submits a signed attestation of understanding to WA DOH agreeing to follow established test tracking/reporting workflow including a tracer audit of 10 of the first 100 tests performed and associated remediation (as needed)
  - Identify a SME(S) to develop a standardized tracer audit process for COVID-19 testing
  - Use electronic registration processes whenever possible to reduce data entry burden and spread of infection
  - Align Washington state reporting requirement with federal requirements

Long Term Interventions:

- Implement a standardized, state-wide test tracking and reporting system for use by all entities in Washington state
    - Address the reporting gap for point of care testing with an electronic "requisition" system that is laboratory data focused (rather than clinical electronic case reporting)
    - Workflow analogous to a clinic point of care workflow: at the time of sample collection, the information is filled out and resulted into the electronic system.
    - Complimentary to current reporting to reach testing sites not currently using existing electronic submission methods
- Provide resources for laboratories not already integrated into existing reporting systems, (e.g., ELR or ELFF) to decrease reporting barriers for laboratories with appropriate expertise to contribute capacity
    - **IDEA**: Pharmacies already use the PDMP system for reporting to Washington state. Consider building a model similar to what already exists
    - **IDEA**: Washington state has an immunization database – fewer pharmacies have integrated this database; however, this database is structured to collect the information needed to track COVID tests
    - **IDEA:** Consider third party systems/support

Benefits and Barriers

Short Term

- Benefits include low cost, low tech solution that will increase standardization of COVID-19 test tracking/reporting and decrease missed reporting. This is a timely short-term intervention.
- Barriers remaining include different electronic/manual systems maintained by entities performing COVID-19 tests across Washington state. Manual administration is required with associated work burden. Risk of double/erroneous data entry remains. Centralized ownership required to support standard workflow compliance and tracing audits.

Long Term

- Benefits of developing and implementing an electronic/automated test tracking and reporting platform include automated submission, increased standardization across Washington state, and a decrease in missed reporting. Overall, this will reduce error and build for the future.
- Barriers associated with this platform build include the cost of system build and dedicated resourcing for system administration and maintenance. Some data entry will be required even with an electronic system.

WHEN SHOULD THE WORK BE DONE?

- Short term interventions implemented in less than 90 days

WHAT'S THE NEXT MOVE?

- Recommend some specific, time-bound actions to move the recommendations forward as soon as possible
    - Immediate interventions described above

Appendix L

VALIDATE INDICATORS AND STANDARDIZED PROCESSES FOR TESTING AND SURVEILLANCE – WORK GROUP RECOMMENDATIONS

VALIDATE INDICATORS AND STANDARDIZED PROCESSES FOR TESTING AND SURVEILLANCE

CURRENT STATE: WHERE ARE WE NOW?

SITUATION/BACKGROUND DESCRIPTION:

- Ambiguous instruction for each type of test with varying sensitivity/specificity brings the necessity of a general public guidance on the utilization of specific testing under specific condition, such as who uses which type of testing in which situation.
- Under the general resource constraint, it is critical to strategize how to optimize existing resources to maximize the efficacy of testing
  - Resource constraints include but not limit to consumable (pipettes, reagents), testing system (instruments), or support system (courier to deliver specimen, uneven distribution of testing sites – more in west side than east side)
- Lack of unified testing guidance in Washington between health jurisdictions
- Ability for testing facilities to meet regulatory requirements is challenged (ex. extensive federal reporting requirement of laboratories with a short notice)
- Avoidance on testing by vulnerable population (ex. Testing avoidance due to immigration status and negative experiences with authorities)
- Results are not always available in a timely manner, especially when specimen was sent to laboratories outside of State
- Access to technology cannot be assumed – not everyone has smartphones, internet

Problem Statement:

- Washingtonians do not have equal access to appropriate type of COVID-19 tests with rapid turnaround time to minimize spread of disease, minimize morbidity from disease and maximize socio-economic function. Even among healthcare personnel there is confusion about the optimum application of specific tests for specific situations. Outside of a traditional healthcare system many Washingtonians cannot access testing. There is lack of consistency around how to test the right people at the right time with the right test.
- In response to upcoming flu season, it is important to have a clear guidance to allow for multiplexing for FluA/FluB/COVID-19. We do not currently have enough testing and enough clarity to apply testing to groups appropriately. The solution must try to create a system that looks at lab testing capacity real time with respect to turnaround time.

DESIRED STATE: WHAT DOES SUCCESS LOOK LIKE?

Desired state description:

- Sufficient testing access for the appropriate population with the appropriate test to minimize risk of disease and maximize societal function. Our solutions should meet the needs of historically marginalized populations.
- Assure education materials are available in multiple formats and languages.
- Balance testing needs of public health (surveillance testing) vs patient (clinical testing). It's important to reduce inappropriate testing while maximizing appropriate use.

GOALS AND OBJECTIVES:

- Uniform testing guidance (Indications for when to test and when not to test and timing of appropriate testing)
- Clarity on appropriate testing modality and standardized interpretation of test results
- Clarity on strategy to minimize morbidity and maximize societal function
- Clarity on shift of plan/re-prioritization under surge conditions
- Interpreting results and next steps - patient tools for both individual actions and public health actions
- Clarify distinction for pathway for diagnosis and pathway for screening

OUTCOMES AND MEASURES OF SUCCESS:

- Suppression of spread of virus (R Value/contagiousness goal, new positive COVID-19)
- Equitable access to testing among high risk/historically marginalized or underserved subgroups
- Equitable geographic distribution of testing statewide
- Understandable and usable tools to help stakeholders with contextual communication to ensure buy in

STRATEGIES TO ACHIEVE SUCCESS

Strategy # 1 - Establish clear testing algorithm

Priority for scarcity	**Use Case**	**Epidemiologic risk**	**Best testing (Mol, Ag, Ab)**	**Conventional**	**Contingent**	**Crisis**	**Notes**
High	**COVID-like Illness requiring hospitalization**	High or low risk setting.	Mol	Mol	Mol	Mol	Priority 1
	Asymptomatic positive exposure	High risk setting	Mol	Mol	Mol	Mol	
	Test based screening asymptomatic essential long-term care worker	High risk setting	Mol	Mol	Mol	Mol, Ag	Regulatory requirements for Skilled Long-Term Facility apply.
Medium	**Disproportionately affected populations**	High risk setting	Mol	Mol	Mol	Ag	Populations with higher proportion of community affected with severe disease (e.g. Black, Hispanic, Hawaiian Pacific Islander, etc)

	COVID-like Illness ambulatory	Low Risk setting	Mol	Mol	Mol	Ag	May move to symptom if significant constraint and community efforts
	Surgical screening in higher risk surgeries	High risk setting	Mol	Mol	Mol	Ag	High risk setting = high baseline disease prevalence OR higher risk surgery balancing urgency of surgery with potential adverse outcomes if undiagnosed COVID-19 infection. Also if higher community prevalence.
	Asymptomatic positive exposure	Low risk setting	Mol	Mol	Mol	Ag	
	Test based screening asymptomatic essential worker staff – Other healthcare workers, other non-health care essential workers per DOH guidance or policies	Low risk setting	Mol, Ag with availability	Mol	Mol	Ag	Per DOH guidance and testing policies by organization for screening on non-long-term care health workers and other essential workers
	Test based screening asymptomatic patients (OB, skilled facilities)	High risk setting	Mol, Ag	Mol	Mol	Ag	
	Visitors for skilled nursing facilities	High	Mol (POC), Ag (POC)	Mol (POC), Ag	Ag	Ag	Consider POC testing for these facilities
	Donation for convalescent plasma therapies	High or Low risk setting	Ab	Ab	Ab	Ab	
Low	**Underserved populations**	Low risk	Mol	Mol	Ag	Ag	

	Community test based screening for lower risk settings (e.g. childcare centers, schools, non-healthcare workplaces)	Low Risk	Mol	Mol	Ag	Ag	
	Surgical pre-screening, low community prevalence	Low Risk setting	Mol, Ag	Mol	Ag or no testing	No testing necessary	
	Special situation visitors to healthcare or congregate facilities (non-SNF)	Low or High Risk	Mol, Ag	Mol (POC)	Ag	Ag	Consider POC testing to cover visitors to these facilities
	Serologic prevalence studies	High or Low settings	Ab	Ab	Ab	Don't test	

*Glossary –

Congregate facilities – areas with congregation of at-risk individuals either from epi risk of spread OR higher risk for complications (e.g., SNF, LTAC, shelters for people who suffer from homelessness, correction facilities etc.

Supply constraint definitions (align with CDC definitions)

Conventional – No constraints on "best" type of testing, markets and supply chains operating in Pre-COVID state with no meaningful disruptions or limitations in testing supplies, reagents or reporting times. As of Sept 2020 in contingency.

Contingent - Limitations on any use case for the specific test types. These are broken down to Molecular, Antigen, and antibody testing (understanding there are a variety of tests in each category).

Crisis – Inability to equitably perform recommending testing to prioritized groups

Epidemiologic settings

Low risk – no exposure to at risk individuals for complications of COVID or congregate settings

High risk – prolonged exposure to higher risk individual (e.g. household) or congregate setting

Priority group – High Value, Moderate Value, Low value testing

What will it take to make the strategy successful?

An expert panel that incorporates all health jurisdictions should meet regularly to work towards a uniform standard.

What are the blockers/potholes/risks and how do we get past them?

Traditionally, experts work in silos across many care settings. There are different testing needs in health jurisdictions and potential conflicts among affected populations. (Who has priority?) Also, we need the perspectives of people affected by the virus to be amplified (long term care, minority populations, etc..) in order to establish a work team outside of traditional healthcare settings. how do they access?

How does work relate to other current efforts? Opportunities/Conflicts?

Each health jurisdiction has moved forward with their own testing plan which will make it challenging to have compliance with a statewide algorithm.

Any lessons learned to apply from response so far? How do we apply them?
We have many resources in the professional and public sector, but they have not always collaborated well. This is improving (with current initiative as example) and this initiative could work as a template moving forward.

Who are the stakeholders and how are they involved?
Local health jurisdictions, public school administration and other affected communities (child care centers, long term care, clinics, ageing organizations, public schools)

Who is the ideal team to make it happen?
Government office and Washington DOH or designee

Who should be on the team?
Healthcare and Community organizations that are most affected and can have the most impact

What's the best way to work together?
Take the testing chart, gather input from key stakeholders and gain consensus approval from key stakeholders and then publish as a standard.

Strategy # 2 Resource and Procure Testing Supplies (crossover with WORK AREA 1)

What will it take to make the strategy successful?
Perhaps model on PPE supply playbook strategy

W*hat are the blockers/potholes/risks and how do we get past them?*
Not being prepared for a pandemic, over reliance to resource from out of the country

How does work relate to other current efforts? Opportunities/Conflicts?
PPE efforts that are underway could be a model

Any lessons learned to apply from response so far? How do we apply them?
Federally restricted supplies per hospital beds: Needs to be expanded to population served, the general principle appears to be that of fairness/equity and is good (find out what this means)

Who are the stakeholders and how are they involved?
Labs, healthcare systems, local health jurisdictions, CMS (Centers for Medicare & Medicaid Services) and other federal agencies

Who is the ideal team to make it happen?
State procurement and support for manufacturing, private-public partnership

Who should be the lead agency/organization?
Washington State government and legislature

Who should be on the team?
Gov/legislature/health systems/health organizations/private business expertise (Amazon, MSFT)

What's the best way to work together?
Set common goals, divide responsibilities, lower cost lower sensitivity testing

WHEN SHOULD THE WORK BE DONE?

Internal state milestones/drivers – see below

External milestones/drivers – see below

WHAT'S THE NEXT MOVE?

Testing strategy needs to be coherent across situation and testing modality.

1. Refinement and adoption of testing table that includes scarcity resource framework. Incorporate "Scarce Resource Management and Crisis Standards of Care" materials. (30–45 days) This structure is critical for societal function.
    - Population and prioritization hierarchy
    - Testing resource allocation matrix with emphasis on priorities, use case, epidemiologic risk, best testing, conventional, contingent, and crisis

2. Development of standardized education materials for consumer on indication, timing, interpretation of results (including limitation of test results) and follow up recommendations. Education materials need to represent demographic languages and demonstrate cultural understanding. (30– 45 days pending availability of reagents)

3. As testing shifts to multiplexing for both Flu and COVID tests, (end of September 30–45 days)
    - Interpretation of these tests relative to next actions need to be clarified
    - Payment for multiplex for this season needs clarification
    - CPT code for the inclusion for four respiratory targets (before middle of October 30–45 days)
    - Because this will be more expensive for consumers, we recommend that the automatic multiplex be covered by insurance (recommendation to CMS via HHS)

4. Widespread alternative method testing approach should be considered but in the context of FDA approval, population prevalence, cost effectiveness and overall combined strategy. (3–6 Months) contingent on approvals and distribution plans.

Appendix M

TESTING PAYMENT GROUP APPROACH

AN APPROACH TO QUANTIFYING PAYMENT NEED FOR TESTING

Draft Priority Order for Testing (subject to refinement/modification)	**Payment Sources**	**Barriers**	**Strategies to Remove Barriers**	**Estimated Unfunded Population**	**Additional Funds Needed (Estimated unfunded population times Medicare test fee)**
Diagnostic for symptomatic patients or patients with probable exposure	Health plans Medicaid Medicare Federal payment for uninsured	Lack of health coverage and/or lack of testing sites	Enabling testing at non-traditional sites and easing requirements on who can order tests Consider revising Medicaid outpatient payments	Insert OFM estimate of uninsured –	
Public health surveillance	Public health	LPHJ may lack funds	Increased support for local public health	Estimate of unfunded testing needed by LPHJ	
Workplace safety for essential workers (State development of guidance for which groups should be tested and minimum frequencies)	Employers	Some employers unable to afford based on marginal earnings	Creation of regional funding pools, asking employers with resources to contribute	OFM for categories for essential workers	
Testing in congregate settings (State development of guidance for testing at each type of setting, and frequency. Includes:					
• LTC facilities	Medicaid Medicare Self-pay	Medicaid rates need to be updated to reflect increased testing expenses	Increase Medicaid rates for LTC facilities engaged in testing	Medicaid patients in LTC facilities	

• Schools		Not in school budgets	Direct state funds to school support for testing	295 school districts across the state representing WA children, Need estimates of in-person school attendance during upcoming year	
• Shelters	LHJ				
• Childcare	Private employers	These employers do not have the resources			
• Group Care	If group care is children in DCYF system, then state via provider rates. Also DCYF contracts with private entities.	DCYF does not have funds in its budget to pay for this in provider rates.			
• Juvenile Rehabilitation Facilities	State funding,	None of the cost related to testing is in any of these facilities operating budgets			
• Jails/prisons	State or local funding, depending upon which jurisdiction is operating the facility				
• Food processing					
Return to work for non-essential workers	Employers	Some employers unable to afford			
Total Estimated Needs				TBD	TBD

AN APPROACH TO QUANTIFYING PAYMENT NEED FOR TESTING

Additional information for completing grid:

Community Type	Healthcare	Facility Count	Staff Count	Client Count
Parole Services	**No**	NA	100	270
JR Transportation Services	**No**	NA	10	1,200
Child Protective Services	No	NA	70	Varies
Child welfare field operations	No	NA	1300	Varies
Licensing - foster care, includes homes, group care, and child placing agencies	No	5,316	139	11,610
Licensing - child care	No	5,393	83	186,980
Juvenile Rehabilitation Secure Facilities	Yes	3	650	344
Juvenile Rehabilitation Community Facilities	No	8	330	116
Child Care and Early Learning Services	No	5,393	50,000	186,980

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Appendix N

INNOVACCER COSTS FOR TRACKING AND TRACING

INNOVACCER COSTS FOR TRACKING AND TRACING

Innovaccer is a healthcare data platform that can be used for COVID-19 tracking and tracing. The information below about costs associated with the use of Innovaccer and the contact tracing approach was taken from a proposal made by Innovaccer to the State of Washington:

Innovaccer Costs for Covid-19 Tracking and Tracing						
Only Loading Positive Test Results						
No. of cases per day	200	400	600	800	1,000	1,200
No. of respective contact investigations per day (3-4) per day	800	1,600	2,400	3,200	4,000	4,800
Total Records /Month	30,000	60,000	90,000	120,000	150,000	180,000
Rate	$ 2.67	$ 1.33	$ 1.11	$ 0.83	$ 0.80	$ 0.67
Platform Cost/Month inlcudes Cloud cost	$ 80,100	$ 79,800	$ 99,900	$ 99,600	$ 120,000	$ 120,600
12 Months	$ 961,200	$ 957,600	$ 1,198,800	$ 1,195,200	$ 1,440,000	$ 1,447,200
5 Integrations included						
Each Additional feed Inetgration	$ 20,000					
Innovaccer Costs for Covid-19 Tracking and Tracing						
Loading All (Positive and Negative) Test Results						
No. of tests per day	5,000	10,000	15,000	20,000	25,000	30,000
Conversion Rate	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
No. of cases per day	200	400	600	800	1,000	1,200
No. of respective contact investigations per day (3-4) per day	800	1,600	2,400	3,200	4,000	4,800
Total Records /Month	174,000	348,000	522,000	696,000	870,000	1,044,000
Total Records /Year	2,088,000	4,176,000	6,264,000	8,352,000	10,440,000	12,528,000
Rate	$ 0.67	$ 0.67	$ 0.67	$ 0.67	$ 0.67	$ 0.67
Platform Cost/Month inlcudes Cloud cost	$ 116,580	$ 233,160	$ 349,740	$ 466,320	$ 582,900	$ 699,480
12 Months	$ 1,398,960	$ 2,797,920	$ 4,196,880	$ 5,595,840	$ 6,994,800	$ 8,393,760
5 Integrations included						
Each Additional feed Inetgration	$ 20,000					

The first analysis describes a range of cost if only people who test positive are loaded into the data system. This would allow for tracking of patients with COVID-19 but would limit the type of population analytics we could get from the platform. At the high end of 1,200 positive cases per day, the system would cost $1,447,200 per year.

The second analysis in the chart above describes a range of cost if the information for everyone tested is loaded into the system. This would allow for both tracking of COVID-positive patients and for extensive population analytics. At the high end, loading data for 12.5 million people (more than the population of the state), the annual cost of the platform is about $8.4 million.

The table below describes an approach to staffing for contact tracing. This approach presumes that for every positive test, there will be four contacts to trace. With this as an assumption and 1,000 new positive cases per day, the staffing required would be 323 (the far right column.) Using 323 FTEs for 12 months, a rough order of magnitude cost for contact tracing is calculated as follows:

323 x 2080 hours/year/FTE = 671,840 hours worked x $50 per hour = $33,592,000 x (1 + 25% benefit load) = $41,990,000.

Staff Numbers for Case Investigation and Contact Tracing Per Day					
Multiplier	**Current Capacity**	**2x**	**3x**	**4x**	**5x**
No. of cases per day	200	400	600	800	1000
No. of respective contact investigations per day (3-4) per day	800	1600	2400	3200	4000
Case investigation staff	29	57	86	114	143
Contact tracing staff	19	38	57	76	95
Supervisors	5	10	15	20	25
Administrative support	8	12	16	20	24
Drop team Nursing Staff	12	18	24	30	36
Total Staff	**73**	**135**	**198**	**260**	**323**

Appendix O

SYNTHESIS OF TESTING WORK GROUP RECOMMENDATIONS

Stay Open, Stay Safe

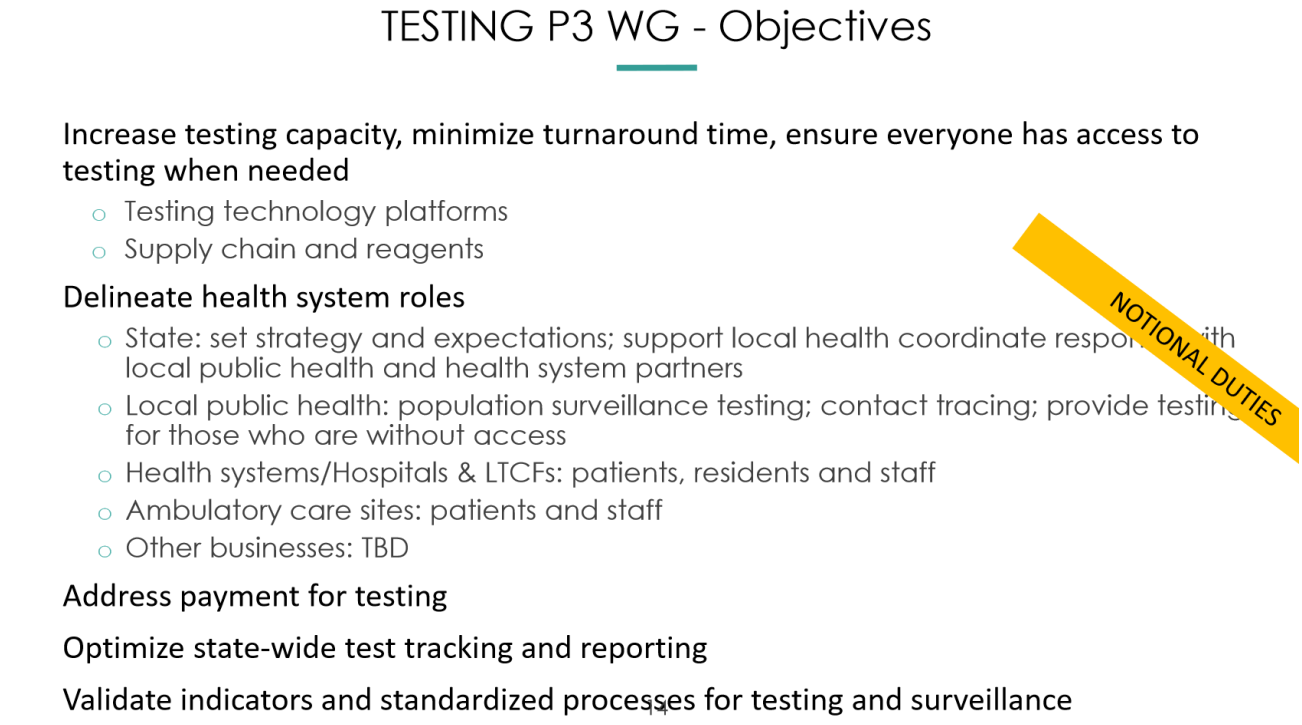
A Public-Private Collaboration to Develop Approaches to Address Critical COVID-19 Practices and Infrastructures to Ensure that Washington State Can Stay Open and Stay Safe

A Synthesis of the COVID-19 Testing, Tracking, and Tracing Workgroup Recommendations

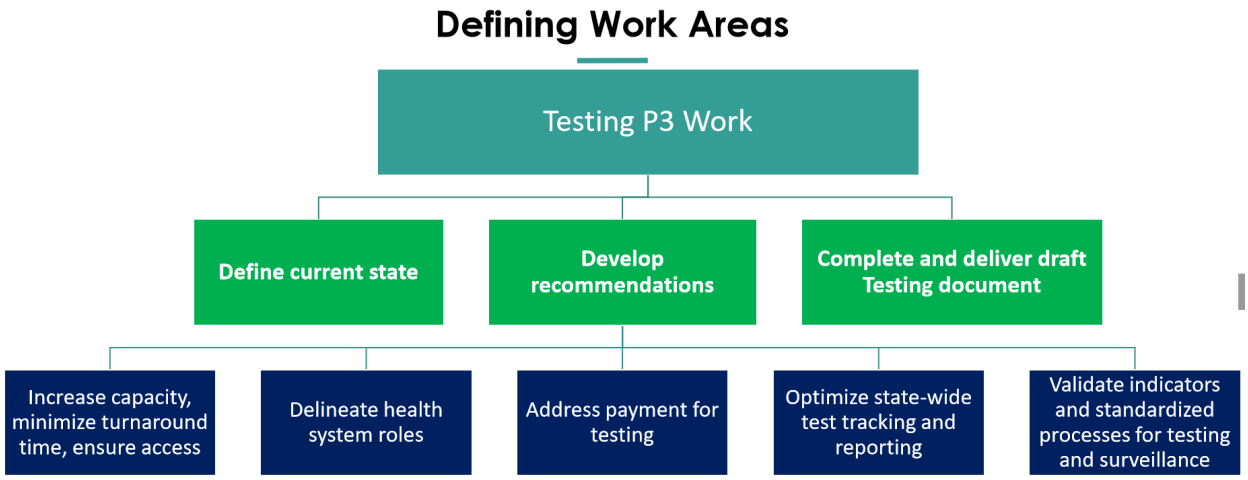
Prepared by Vice Admiral Raquel Bono, Sally Watkins and Bill Robertson
September 12, 2020

Background

The COVID-19 Testing, Tracking, and Tracing Workgroup was convened on Friday, August 28, 2020 by Vice Admiral Raquel Bono as Executive Sponsor and Sally Watkins and Bill Robertson as Co-Leaders. The Workgroup, whose members are subject matter experts from across the continuum of Washington State healthcare provider organizations, labor, governments and government agencies, associations, and other interested parties, was charged with, over a 14-day sprint, developing a set of recommendations that would, if implemented, achieve the following outcomes:



To accomplish the work set out for the Workgroup, five teams were formed which, over the next 14 days, met extensively to identify the current state and desired future state for their assigned topics, and to develop a set of recommendations to achieve the desired future state. These teams were structured as shown below:



To facilitate collaboration and focus, a cadence of brief check-in meetings between the team leaders and the authors of this synthesis document were held throughout the 14 days of workgroup activities.

On Friday, September 11, 2020, the entire workgroup team met, and the comprehensive and thoughtful work product of each team was presented. We are grateful for the passion, engagement, and comprehensive work of the workgroup team members. They have brought the best of themselves to this effort and the citizens of Washington State will be better for their efforts.

A Synthesis

Given the comprehensive nature of the workgroup teams' work product and the intersection between the various recommendations, the following synthesis seeks to extract from the teams' recommendations a framework on which action can be taken to achieve the objectives, articulated above, that were initially set out for the workgroup.

The synthesis begins with the "insight" that there are two basic reasons for testing:

1. Diagnostic testing related to patient care and protection of care givers
2. Surveillance testing related to disease burden modeling, public health interventions including the prevention of hot spots in at-risk populations, and the operation of businesses (reopening and staying open)

Using this insight as the basis, the synthesis flows as described in the following table:

Synthesis Table

Objective	Diagnostic Testing	Surveillance Testing
Increase Testing Capacity, Minimize Turnaround Time, Enhance Access	• Recognize that highly sensitive testing methods are necessary, and that this type of testing is more expensive than less sensitive methods of testing. (Currently PCR is the most common type of high sensitivity testing.) • Develop a collaborative "load balancing" approach to optimize utilization of the testing capabilities/capacity within Washington State • Develop collaborative approaches to secure necessary reagents in order to minimize supply-chain constraints on testing capacity	• Recognize that less sensitive and less costly testing methods may be an acceptable approach to surveillance testing. • Identify a range of less costly testing methods, such as simple or complex antigen tests that employ saliva or nasal samples. • Develop guidelines for appropriate use of these various testing methods to include indications for and frequency of testing. • Develop sourcing approaches for these less sensitive and less costly testing methods. Consider a connection with the PPE sourcing team. • This surveillance testing approach presumes that reporting of non-CLIA testing results will likely not be reported to the statewide tracking system. And, that for this non-CLIA testing, guidance will be included with the test for follow-up in the event of a positive test.
	Note: A key issue is how to deal with scarce testing resources in the now and near time frame and design an appropriate mix of high sensitivity and lower sensitivity testing approaches for a possible fall surge.	
Delineate Roles	• Diagnostic testing for patients being cared for within acute and ambulatory care settings is the responsibility of care provider organizations. • Testing of care providers is the responsibility of care provider organizations with the expectation that resulting of tests for Covid-19 exposures will, 95% of the time, occur within 48 hours of specimen collection. • Testing of first responders (EMS, police, etc.) is the responsibility of the organization that employs them.	• The State DOH and LHJs are responsible for general population surveillance testing • Employers seeking to test their workforce are responsible for providing necessary testing. • Congregate living organizations (LTC, Group Homes, etc.) are responsible for providing any necessary testing. (Note, there are important surveillance and clinical reasons for testing LTC/SNF staff and employees.) • Identify others (Churches, Community Organizations, Educational Institutions, etc.) that can participate in specimen collection.
Address Payment	• Payment for necessary testing associated with the provision of clinical services should be billed to and paid by payers (insurance, self-funded employer plans, Medicaid, Medicare, etc.) • The cost of testing for employees related to exposures/potential exposures at work will be carried by their employer or workers compensation.	• Surveillance testing done by DOH/LHJs will be paid for by government entity directing the testing activity. • Wealthy employers testing their employees will pay for the testing. They will also be strongly encouraged to partner with less wealthy employers (example is Challenge Seattle: https://www.challengeseattle.com/) and communities to support surveillance testing. This helps address equity issues and support for vulnerable populations.

		• Private and well-resourced congregate living organizations will pay for the testing but may bill their residents for the testing. Testing in congregate settings operated by government or that are under-resourced may paid for in whole or subsidized by resources identified in state-allocated CARES funding, a legislative request, or through engagement of wealthy employers. • Individuals seeking testing (not related to patient care – example, travel) will pay for their own tests.
Optimize State-Wide Test Tracking and Reporting	• Select and implement a commercially available population-health oriented information system platform, such as Innovaccer, for data collection, reporting, tracing coordination, and case management. • Develop processes to standardize platform use across entities. • Broadly integrate results reporting into this platform. • Use this platform for all infection rate reporting. • Use this platform to manage all tracing activities. • Use this platform to manage support activities for COVID-positive individuals who are not being cared for in inpatient care settings.	
Develop Effective Platform for an Approach to Tracing	• Tracing for caregivers exposed in work settings is the responsibility of the healthcare organization in which they are employed. • Tracing for patients is the responsibility of DOH/LHJs.	• Tracing for all positive patients is the responsibility of the DOH/LHJs
	• To fulfill the public health tracing responsibilities of the DOH/LHJs, develop a statewide team of tracers whose work is driven by the information and tools available within the information system platform described above.	
Validate Indicators and Standardized Processes for Testing and Surveillance	• For diagnostic testing, the protocols utilized to determine test indications and approaches are the responsibility of each healthcare organization	• Develop a surveillance testing prioritization algorithm.

Budgets	• The budgets for diagnostic testing are the responsibility of healthcare organizations	• Develop a 12-month budget for Washington State regarding:
		  ○ DOH/LHJ surveillance testing costs
		  ○ Implementation and operation of the testing, tracking, and tracing information system platform
		  ○ Operation of the tracing platform
		  ○ Identification of potential revenue sources:
		  ▪ federal CARES funds allocated to Washington State,
		  ▪ legislative requests, and
		  ○ resources from large wealthy employers

Appendix P

TESTING WORK GROUPS – PARTICIPANTS

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Appendix Q

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