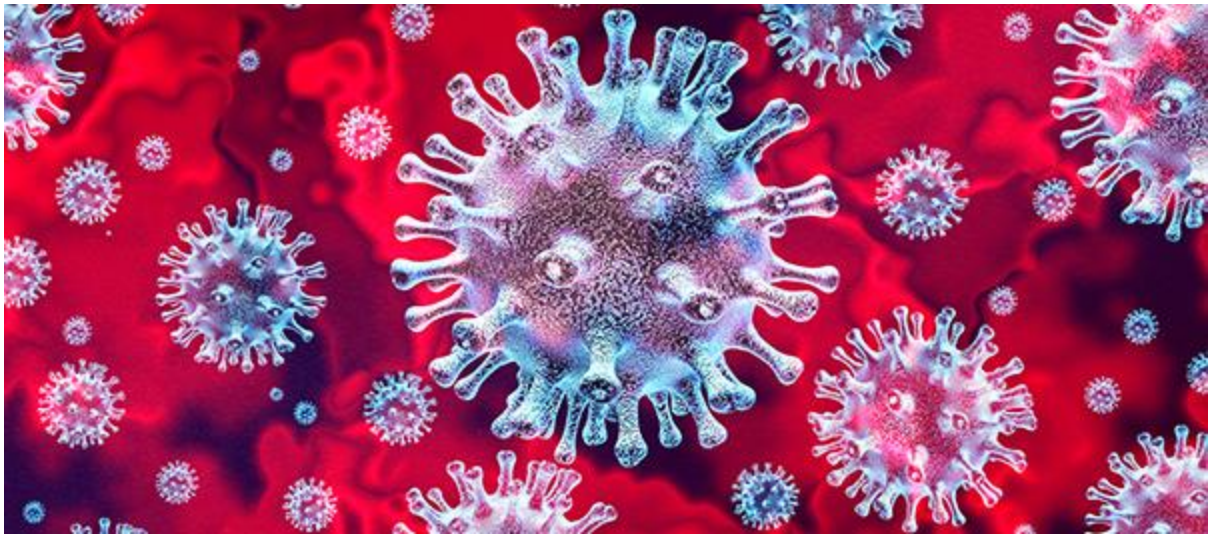
Metro Health & Medical Preparedness Coalition

COVID - 19 Pandemic

January 2020 - July 2020: *Initial Response*



AFTER ACTION REPORT/IMPROVEMENT PLAN

WRITTEN BY THE REGIONAL HOSPITAL RESOURCE CENTER

SEPTEMBER 14, 2020

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EXECUTIVE SUMMARY

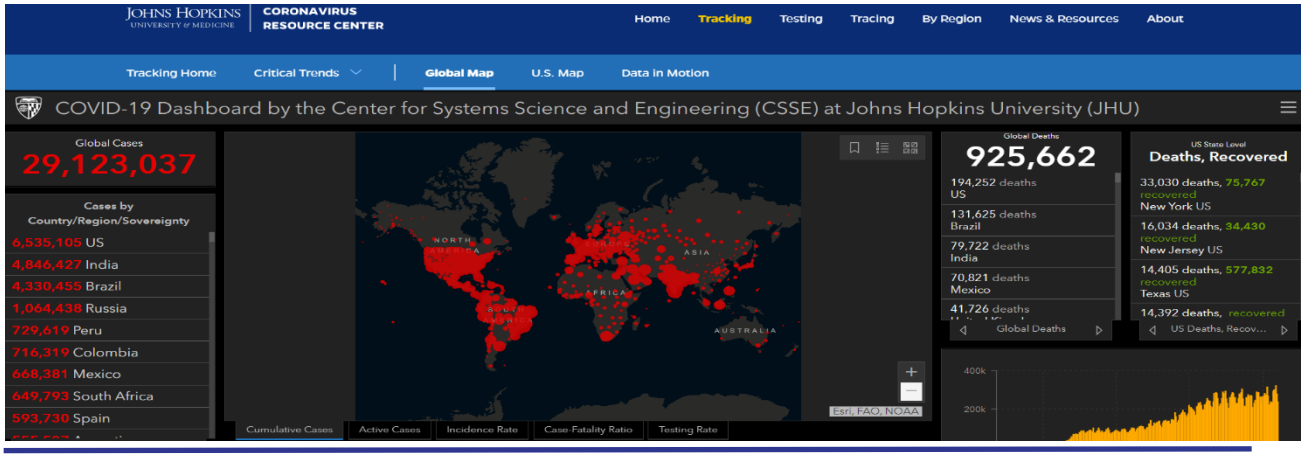
In January 2020, the United States had its first confirmed case of the novel Corona Virus Disease (COVID – 19). The virus that originated in China eventually went on to cause a global pandemic. Minnesota has had to institute several response mechanisms we have not seen in our lifetime to attempt to slow the spread of this virus, such as stay at home orders, wearing protective masks in public, and closing of restaurants, schools, and businesses. This pandemic has caused severe supply chain disruptions, staggering financial losses, and has pushed the healthcare facilities and public health organizations to their limit. This report is focused on our initial response to this virus from January 2020 – July 2020. The response to this pandemic has been complicated, prolonged, and is still on-going as of the date of this report.

Minnesota has eight established Health Care Coalitions (HCCs), each led by a Regional Health Care Preparedness Coordinator (RHPC) and an established advisory committee. Although they function and are governed independently, they collaborate inter-regionally across the State for planning and response purposes. This report is *solely* focused on the mission and functions of the **METRO** Healthcare Coalition, which is comprised of the metropolitan seven counties of the Twin Cities.

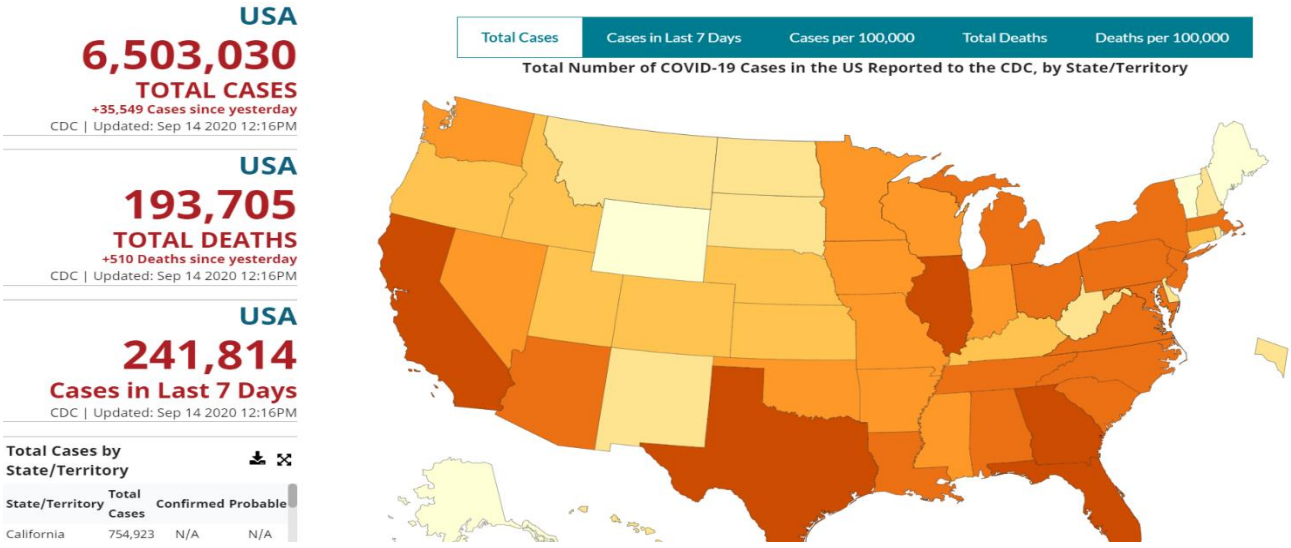
A response of this magnitude and duration requires constant coordination of local, regional, and state response plans and efforts. Coordination is critical to slowing the spread and lessening the impact of this virus. To assist in coordination efforts, the Metro Health & Medical Preparedness Coalition activated its Operations center called the Regional Hospital Resource Center (RHRC). The RHRC stood up its incident command system in January 2020 in response to COVID – 19; and continues to be actively engaged in the response to COVID – 19. The RHRC staff is comprised of two full-time employees, one part-time employee, and one grant manager. Activation of the RHRC now includes three additional part-time contractors supporting the response effort.

The data maps on pages 5 and 6 are the case and death counts from COVID – 19 as of the date of this report. This data, along with the charts and graphs in Appendix D, illustrates just how pervasive and complex the response is to this virus, and the need for an on-going coordinated response within our region, State, nation, and the world.

Johns Hopkins Global Map – *as of 9.14.2020*



CDC Map of USA – *as of 9.14.2020*



The purpose of this report is to assess the ***current*** processes in place for the Metro Health & Medical Preparedness Coalition/Regional Hospital Resource Center's response to the COVID – 19 Pandemic, identify strengths to be maintained and built upon, identify potential areas for further improvement, and support the development of corrective actions to improve the current response needs. This report will also facilitate and support planning efforts for future potential epidemics and pandemics.

Major Strengths

The major strengths identified during the initial phase of this event are as follows:

- Coordination of regional partners
- Communication and Information Sharing with regional partners
- Providing tools, documents, and resources to assist regional partners
- Provide Personal Protective Equipment through state/regional caches and donations
- Staff wellness topics and presentations

Primary Areas for Improvement

Throughout the initial response and feedback garnered from the regional response survey, opportunities for improvement in our planning and response were identified. The primary areas for improvement, including recommendations, are as follows:

- Clarify the roles of the SEOC, SHCC, and the Coalition
- Strengthen support for non-residential facilities (i.e. Homecare, Hospice, Clinics)
- Include additional information regarding metro COVID case counts and positivity rates

as well as Hospitalization/ICU numbers to the Coalition Situation Reports.
- Continue to build an increased understanding of external partner roles and responsibilities.

Overall, the event was well coordinated across our region. What we have learned during the initial phase will be used to strengthen our continued response to this pandemic. Future response improvements should focus on the areas of improvement that are identified in the Corrective Action and Improvement Plan at the end of this report. It is evident that the Metro Healthcare Coalition is committed to all four (4) phases of emergency management (planning, response, recovery, and mitigation) and providing continuity of exceptional service to our regional partners to the best of our ability. Lessons learned from this event will better prepare us for the second phase of this response and future large-scale events and regional coordination efforts.

SECTION 1: EVENT OVERVIEW

Event Details

Event Name
COVID – 19 Pandemic

Type of Event
Real Event – Corona Virus Pandemic

Event Start Date
January 2020

Event End Date
Initial Response Phase: July 31, 2020

**Response is still on-going*

Duration
Initial Response Phase: 7 months

**Response is still on-going*

Location
- Global Pandemic. This report will focus on Minnesota's healthcare response and more specifically, the metro region healthcare response for the 7-county metro area.
- Healthcare facilities include, but not limited to: Hospitals, Long Term Care, Home Health and Hospice, Assisted Living, and Clinics, as well as additional response partners, including local public health, emergency management, and emergency medical services.

Planning and Response Objectives:

1. Maintain and communicate situational awareness to all partners.
2. Align regional coalition response with local and state efforts.
3. Ensure communication of planning and response efforts with regional partners.
4. Aid healthcare facilities to lessen supply chain disruptions.
5. Ensure coordination of efforts among coalition and regional partners.
6. Assist with staffing and testing efforts as assigned.
7. Participate in regional planning efforts with external partners to ensure integrated response efforts.
8. Provide staff support and wellness strategies and information.

Regional Hospital Resource Center (RHRC) Response Team

RHRC Team:

- *Chris Chell*, Regional Healthcare Preparedness Coordinator, Emergency Preparedness
- *Emily Moilanen*, Regional Healthcare Preparedness Coordinator, Emergency Preparedness
- *Tracy Gonser*, Office Specialist Principal, Emergency Preparedness
- *Jonathan Bundt*, Emergency Management & Behavioral Healthcare Consultant
- *Carol Christians*, Emergency Management & Business Continuity Consultant
- *Kris Kaus*, Emergency Management & Business Continuity Consultant

Participating Organizations

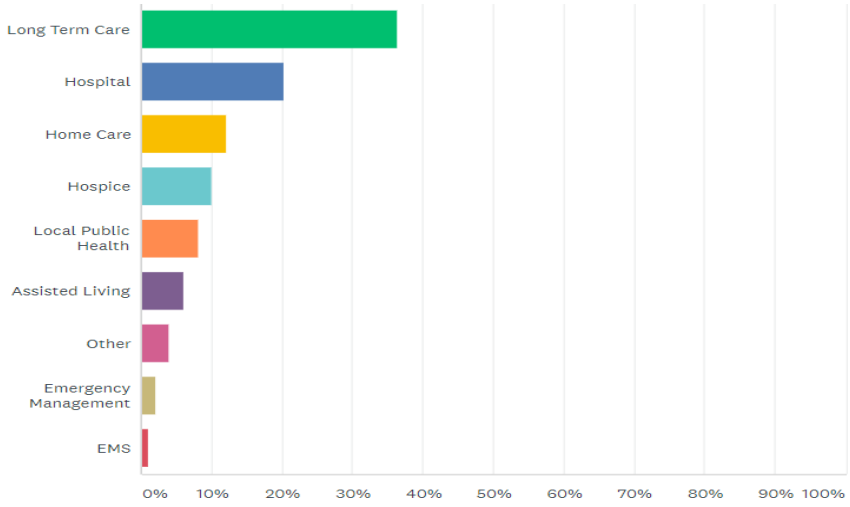
- Abbott Northwestern Hospital
- Children's Minnesota
- Gillette Children's Specialty Care
- HealthPartners - Park Nicollet Health Services, Regions and Methodist
- Hennepin Healthcare System
- Mercy Hospital
- Mercy Hospital – Unity Campus
- MHealth Ridges Hospital
- MHealth Southdale Hospital
- MHealth Bethesda
- MHealth St. Joe's Hospital
- MHealth St. John's Hospital
- MHealth University of Minnesota Children's Hospital (Masonic)
- MHealth University of Minnesota Medical Center – East and West Bank
- MHealth Woodwinds
- Minneapolis VA Healthcare System
- Mayo Clinic Health System – New Prague
- Lakeview Hospital
- North Memorial Health Hospital
- Maple Grove Hospital
- Northfield Hospital and Clinics
- Prairie Care Hospital & Clinics
- Regency Hospital
- Regina Medical Center
- Ridgeview Hospital-Waconia
- St. Francis Regional Medical Center
- Minnesota Department of Health (MDH)
- VAMC Administration
- Long Term Care facilities
- Assisted Living facilities
- Home Health and Hospice Agencies
- Outpatient Clinics
- Emergency Medical Service (EMS)
- County and City Emergency Management
- Local Public Health Agencies

SECTION 2: EVENT SUMMARY

Event Summary

This after-action report is reflective of the **initial response phase**, January – July 2020. The strengths and areas for improvement were identified on an on-going basis throughout our response as well as after action surveys completed by our regional partners. We had 99 respondents to that survey, and feedback crossed nine different disciplines.

Respondent discipline breakdown:



Prior to this event, **85%** of the respondents indicated they were aware of the Metro Health & Medical Coalition/ Regional Healthcare Resource Center (RHRC) and its function.

The Metro Health & Medical Preparedness Coalition and Regional Healthcare Resource Center (RHRC) set objectives at the outset of the initial response, which drove the daily response efforts. As the event progressed, we remained flexible and adjusted our objectives to reflect the changing trends of the virus and response efforts. We worked to coordinate response efforts with our regional, state, and federal partners. *The main focus of this report is based on the RHRC's efforts to meet our mission and ensure coordinated efforts around seven key elements: Communication, Coordination, Staffing, Testing, Supply Chain, Staff Wellness, and providing our partners with Resources and Tools.* This report does not include assessment for the many workgroups participating in patient flow, critical care, alternative care site, infection prevention, staff wellness, or other workgroups lead by individuals outside the Coalition or at the State level.

Listed below are the ***seven*** key elements of our response survey and the summary of the findings in each category.

1) **COMMUNICATION:** The RHRC used several methods of communication during the initial response phase. These methods include phone, email, Teams Meetings/WebEx, Webinars, Coalition Website (COVID page), and weekly situation reports.

Over **84%** of the respondents to the survey "strongly agreed" or "agreed" that the RHRC gave timely, helpful, clear, and appropriate information during the response.

Strengths respondents identified that should be maintained through the second phase of this response:

- RHRC was very responsive and accessible.
- Scheduled meetings (Coalition meetings, Hospital meetings, LTC/AL meetings) are very useful to stay up to date and hear what our other partners are doing.
- Email updates were appreciated, and links to resources are always helpful.
- Having separate meetings for Hospitals and LTC/AL/Home Care/Hospice was appropriate and helpful.
- Coalition Situation Reports were appreciated and informative.

It was noted that as the RHRC learned or discovered new guidance, hot topics, or issues additional meetings were called. The meetings were very informative and assisted in collaboration. Meeting agendas and minutes were well organized for LTC and questions and concerns were answered or sent forward to the State.

Along with the strengths to be maintained in communication there were also areas of improvement identified by the respondents.

Areas for Improvement:

- Clarifying roles of the SEOC, SHCC, and the Coalition.
- Share agenda earlier, allowing for SME's to attend and speak to the issue/ask relevant questions.
- At times there seems to be a disconnect between Coalition and SEOC.
- At times hard to identify who owns a process, is it MDH, Coalition, or SHCC.
- Have report outs for Infection prevention, Hospice/HomeCare, and Assisted Living at weekly meeting, this will assist in recognition of current efforts and issues from these partners.
- Continue to build on understanding of external partner roles (i.e. Local Public Health).
- Find a balance between the speed and frequency of information against need for complete single source information.

2) COORDINATION: The goal of the Metro Health & Medical Preparedness Coalition is to facilitate integrated planning, response, and recovery activities critical to an effective response to an event or emergency with public health and medical implications in the metro area. There are four primary disciplines in the Coalition: Healthcare, Emergency Management, EMS, and Local Public Health. The RHRC worked to coordinate and integrate the COVID – 19 response efforts among these groups, and other external partners.

Over **83%** of the respondents to the survey "strongly agreed" or "agreed" that the coordination meetings and their frequency were helpful and appropriate key stakeholders were invited to these meetings. **87%** stated they were informed of local and state processes through these meetings

and hearing partner updates was very helpful.

Strengths respondents identified that should be maintained through the second phase of this response:

- Regularly scheduled Coalition meetings (Hospitals/LTC).
- Use of multiple avenues to connect for meetings.
- Allowing free information sharing among healthcare facilities helped standardize approach.
- CNO meetings were helpful and well-coordinated.
- Open communication among leaders.
- Brought the right coalition partners together right from the start.
- Strong ability to connect regional partners.
- Early coordination rhythm was established.
- RHPCs and Coalition Leadership worked hard to keep up the ever-changing information.
- Aligning Visitor Policies across the region.

It was noted and found helpful to hear about how other agencies handled topics such as DHS infection prevention survey information, email links and meeting recaps. Meetings were a key resource for information.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- Start with SEOC and MDH updates at the beginning of meetings.
- Define expectations from State vs Coalition vs Public Health.
- At times Coalition meetings were focused on hospitals (in-patient) vs other partners (i.e. Local Public Health, LTC).
- Need to support non-residential programs (i.e. clinics, home and hospice care)
- For some healthcare systems, administrators attended meeting in place of primary contact for hospital (EM).
- Some hospital organizations in the meetings seemed to have difficulty providing timely answers

3) TOOLS & RESOURCES: The Coalition and the RHRC worked tirelessly to provide Coalition members with links to resources and critical statewide guidelines as well as providing tools and reference materials to assist members in their planning and response within their facilities. Tools and resources include such items as testing data, hospital bed counts, and the Coalition Webpage (COVID 19 tab) with links to PPE requests, testing requests, staffing requests, staff wellness, and volunteers. In addition, PPE grids and burn rate calculator spreadsheets, tutorials or background documents on data collection, PPE reuse strategies, vendor lists, PPE donning and doffing posters, and several other topics and tools were shared with members via email, coalition website, and/or at the Coalition meetings.

According to the survey, **72%** of the respondents "strongly agreed" or "agreed" that the COVID case count breakdowns were helpful as well as **67%** of respondents stated the Metro Coalition Situation Reports were useful. **57%** stated the Coalition Website was useful, and **56%** stated they used MNTrac during this initial response.

Strengths respondents identified that should be maintained through the second phase of this response:

- RHRC did well in providing tools, resources, and reference materials to its members.
- Providing COVID 19 updates and case counts weekly or as needed.
- Quick to add LTC members to MNTrac.
- Situation reports were timely, useful, and informative.
- Adjusting MNTrac to track ventilator and ICU bed utilization was helpful.

It was noted that tools for the HPP grant invoice and the example invoice were helpful as well as introducing and refreshing members on Crisis Standards of Care documents was useful.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- MNTrac Coordination Room was utilized at the beginning of the event but fell off as the response progressed.
- Add Metro COVID case counts and positivity rates to SitRep (found on MDH site).
- Add hospitalization/ICU/MS utilization numbers to Sit Reps.
- Is it possible to develop a dashboard and central storage location Coalition members can access?
- Provide more tools and resources specific to Home Care and Clinics.
- Work on clarifying common operating picture for the whole Coalition.
- Use MNTrac during the protests (any emergent event that arises in the midst of COVID).
- Consider "EMResource" vs MNTrac for future event management in the metro.

4) SUPPLY CHAIN: The RHRC worked in coordination with the SHCC to distribute PPE to requesting facilities across the region; at other times the SHCC was able to push out batches of PPE directly to Coalitions/RHRC to distribute at the regional level; at other times it was distributed directly from the SHCC (COVID positive facilities). The RHRC developed processes around allocation, distribution, storage, and inventory tracking. In addition, the Coalition accepted donations from local partners and distributed and tracked all items received.

According to the survey, **64%** of the respondents "strongly agreed" or "agreed" that the RedCap survey link was useful to request needed PPE. Between **57 to 59%** of the respondents "strongly agreed" or "agreed" that the distribution process for PPE was timely for the Metro Coalition PPE Cache and the State PPE Cache, while **55%** stated the Coalition Supply chain guidance for PPE was useful.

Strengths respondents identified that should be maintained through the second phase of this response are:

- Communication regarding when Metro Coalition Cache supplies were available.
- RedCap request link on Coalition site was useful.
- Information sharing on how to request supplies and testing.
- Distribution process of PPE worked well in Metro Region (supplies were greatly appreciated).
- Sharing of PPE reuse strategies and vendor lists.

Some of the Coalition members were uncertain of the differences between State cache and Regional cache processes (pick up vs. shipment) and the availability of different items. In addition, it was evident non-hospital facilities did not have robust supply chain plans or vendor connections and relied heavily on State and Regional cache supplies. The process has improved over the months as these facilities began to develop strategies and relationships with vendors and other PPE resource locations.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- RedCap survey is long and time-intensive to complete for PPE.
- RedCap survey is inflexible and lacked clarity on how to complete.
- Home Care was unable to get supplies from the state; considered low priority.
- Quality of some items in PPE cache were mediocre.

5) STAFFING: The RHRC participated in staffing planning groups with state and regional partners. Staffing strategies included volunteer sign up, MDH contracts, and sharing staff between healthcare systems. A link was put on the Coalition website to request staffing assistance. The SHCC handled those requests and worked to assist facilities in need. The RHRC served as a resource for requesting guidance and bringing concerns back to the SHCC as needed.

Over **56%** of the respondents to the survey "strongly agreed" or "agreed" that the RHRC shared relevant staffing updates, and **53%** noted the RHRC shared appropriate staffing resources. Only **24%** stated the RHRC assisted with staffing as needs arose. Low utilization is likely due to many facilities not using this resource, as **44%** indicated the need for staffing resources were "not applicable" to their facility.

Strengths respondents identified that should be maintained through the second phase of this response are:

- Provided a beneficial forum to discuss various approaches to manage staffing surge.
- Provided awareness, education, and updates on staffing concerns across the Metro Region.
- Collaboration between the RHRC and Crisis Staffing Managers for LTC staffing plans.
- Continue collaborative efforts with MDH and Federal partners around staffing plans.

It was noted that sharing staffing continues to be a challenge even within the same healthcare system (union/non-union locations). Hospitals furloughed staff during the early phase of the pandemic while LTC were in crisis staffing. Many LTC facilities did not have a robust staffing plan in place prior to COVID – 19. Alternative sources, such as the Medical Reserve Corp (MRC), proved non-viable in this situation.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- Develop contingency staffing plans tiered to small, independent facilities.
- Staffing efforts mainly focused on LTC, hospital staffing concerns were left to the facility.
- Strengthen the MRC to develop more robust staffing capability.

6) TESTING: The RHRC participated in testing planning groups with State and Regional partners. Strategies were developed, and priority facilities were identified for testing. The National Guard assisted in staffing testing sites, which increased our regional testing capacity. A link was put on the Coalition website for members to request testing at their facility. Testing resources and testing data was shared with Coalition members weekly. The SEOC and MDH led the efforts for scheduling and coordinating resources for testing sites. The RHRC led weekly Coalition Testing meetings to share updates, resources, lessons learned, and brought back any concerns to the SHCC as needed.

Of the respondents who completed the survey, **58%** "strongly agreed" or "agreed" that the RHRC was helpful and answered questions regarding staffing concerns. **43%** indicated the weekly testing data they received was useful, and **40%** stated the weekly testing meeting was useful. It should be noted that not all facilities conducted testing, as **28%** indicated the testing meetings did not apply to their facility.

Strengths respondents identified that should be maintained through the second phase of this response are:

- Information sharing regarding testing processes and updates was invaluable.
- Weekly testing meetings were useful.
- Extremely helpful to have the RHRC/Coalition as another avenue to acquire information.
- Developing testing subgroup was useful.

It was noted that some comments and rankings were not reflective of RHRC/Metro Coalition effort, but more at the lack of testing supplies and conflicting guidance by the State in this area.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- Government and MDH made media statements about testing capability that could not be fulfilled due to lack of testing kits, lab capacity, and other resources added to confusion of expectations.
- Bring PHPCs into the RHRC realm sooner.
- Testing program is frustrating at times, stop, start, change plans, etc.

7) STAFF WELLNESS: Early on in the initial response RHRC staff recognized the lack of knowing when our response will end would have a significant psychological impact on all involved in healthcare and that there was a need to help provide resources for staff. RHRC reached out and invited organizations and facilities to participate in a weekly call. These calls allowed a platform for participants to discuss challenges, share strategies and tactics, and provide support to each other. An outcome of these meetings led to brief trainings, 15 to 20 minutes during weekly coalition meetings, or at workgroup meetings. Presentations were on a range of topics regarding staff wellness. Another element of support was creating one-page information sheets and recorded webinars on a wide range of wellness topics related to the stressors healthcare professionals experienced.

Of the respondents who completed the survey, **75%** "strongly agreed" or "agreed" that the staff wellness information/presentations shared at the Coalition meetings have been useful, and **68%** went on to share that information with others in their organization. **54%** indicated they would like their organizations to be more involved with staff wellness initiatives.

Strengths respondents identified that should be maintained through the second phase of this response are:

- Continue to include staff wellness topics on the Coalition meeting agendas.
- Great resources (one-pagers) provided.
- Helpful and informative information during stressful times.

It was requested by some respondents that topics such as stress relief and burnout be addressed as well as a focused presentation for LTC facilities be developed.

Along with the strengths to be maintained in coordination efforts, there were also areas of improvement identified by the respondents.

Areas for Improvement:

- Ensure other existing and anticipated priority items are covered first (i.e. vaccines, influenza) during the Coalition meetings.
- Consider strategies to provide staff wellness to a mobile workforce.
- Consider having other psyche-based institutions chip in on this effort.
- Share best practices and success stories.

SECTION 3: CONCLUSION

The years of working on the development of the Metro Health & Medical Coalition have made a positive impact in response capability to the most complicated incident that this region has seen in its history. With the addition of weather-related emergencies and civil unrest, the region has been especially challenged. In emergency management, we speak of exchanging business cards in training and exercise, because the **response** is all about relationships, communication, and collaboration.

The immense challenge of our response is not having the ability to navigate the timeline of the response. We know that having the fall and winter season ahead of us includes seasonal influenza, which will impact response resources and capabilities. The metro region RHRC and the Coalition have set up a coordination and communication process that supports regional needs as indicated in our survey. While communication and coordination needs are being met, there is still work to be done. Staffing and testing response strategies are always a challenge and an on-going focus of the RHRC staff. There is a clear recognition that there will be more work with critical care resources and, at some point, readiness for distribution of vaccine to the community.

The work of the RHRC will continue to be a hub for the metro region by maintaining situational awareness for state levels of response along with informing the state of regional needs. Ensuring that all healthcare institutions, including the non-residential, are part of communication pathways will be important for future response needs.

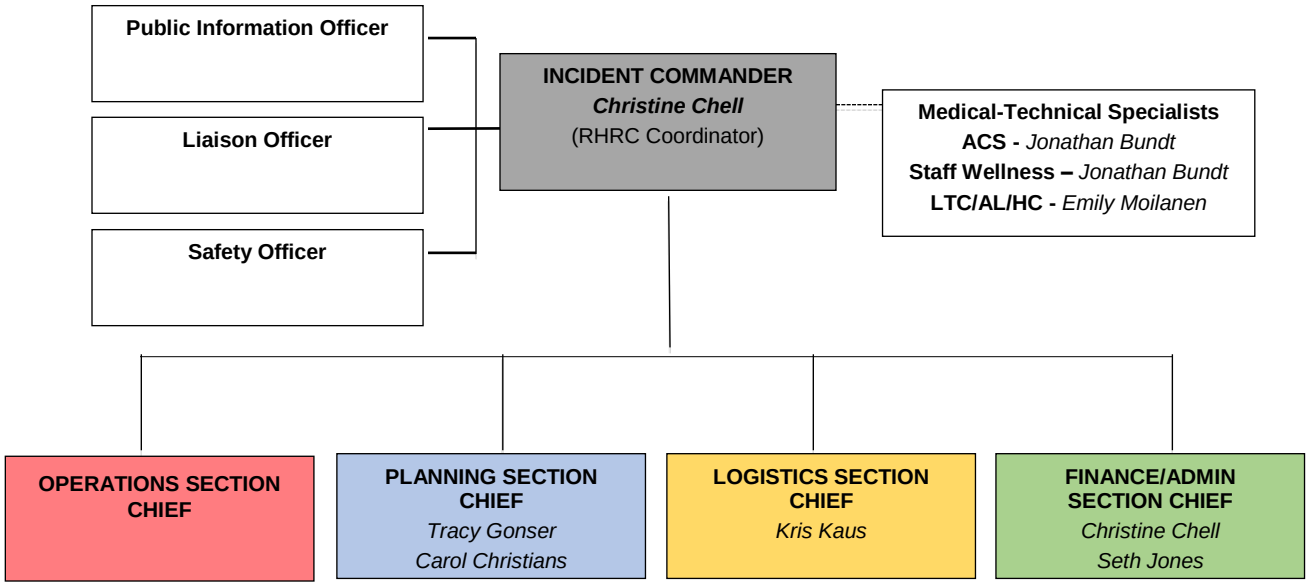
The emergency management cycle of mitigation, preparedness, response, recovery, and repeat takes on a different progression when you are continuously responding. This survey, along with the improvement plan, will give a brief time out for the direction of improvement along with our response assumptions. There will be an on-going need for all levels of responders and healthcare providers to find pathways to help maintain one's wellness and strength to be resilient in the long-term response needs.

Appreciation and Acknowledgement

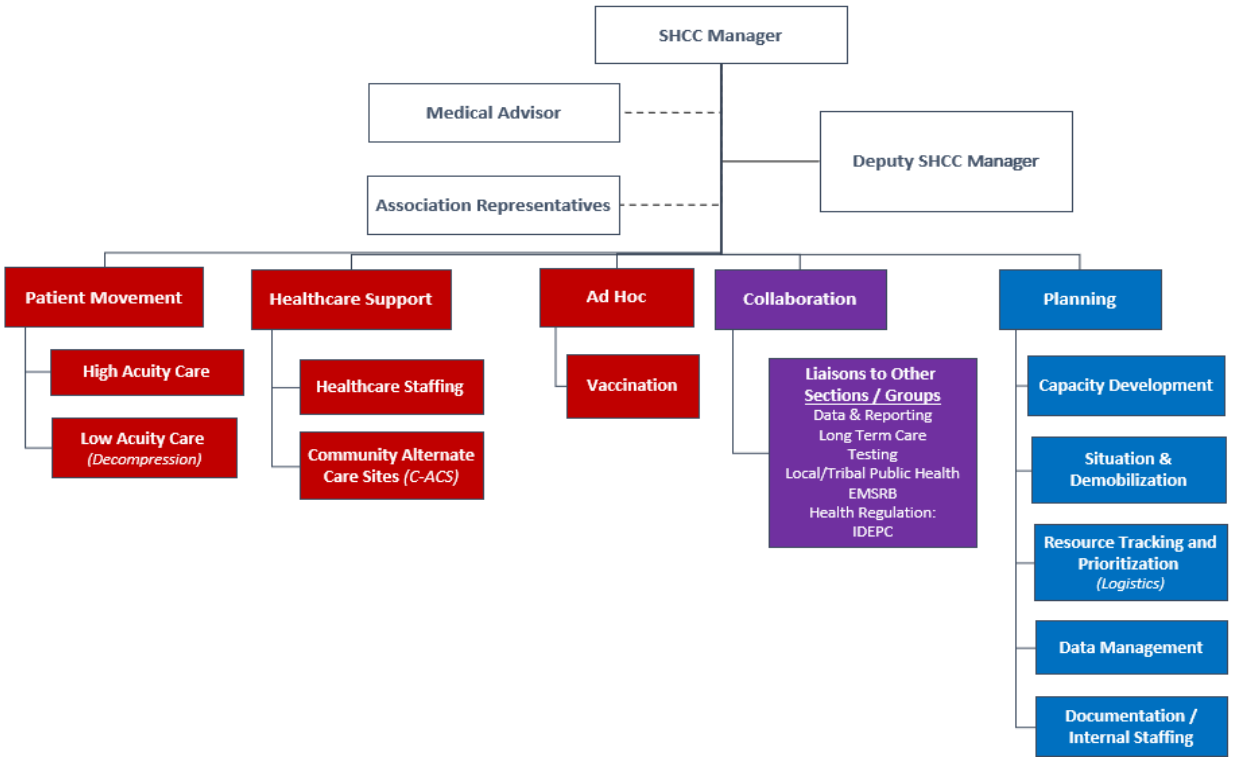
While this report is limited to addressing the initial response to COVID-19 in the metro region, it would be remiss to not acknowledge and express appreciation for all the facilities, services, agencies, organizations, first responders, and others that ensured the safety and well-being of the citizens of the seven county metro area in Minnesota. It would be virtually impossible to individually list every organization that deserves acknowledgment and the sincere appreciation of everyone who lives and works in the Metropolitan area. They continue to provide countless hours of support to their communities and find a way to serve in their primary response role. It is their dedication and selfless commitment to the betterment of their communities that creates and sustains a culture of safety and the support system that drives effective emergency responses. On behalf of the Metro Health & Medical Preparedness Coalition, **thank you** to everyone working to minimize the effects of COVID-19.

APPENDIX A: ORGANIZATIONAL CHARTS

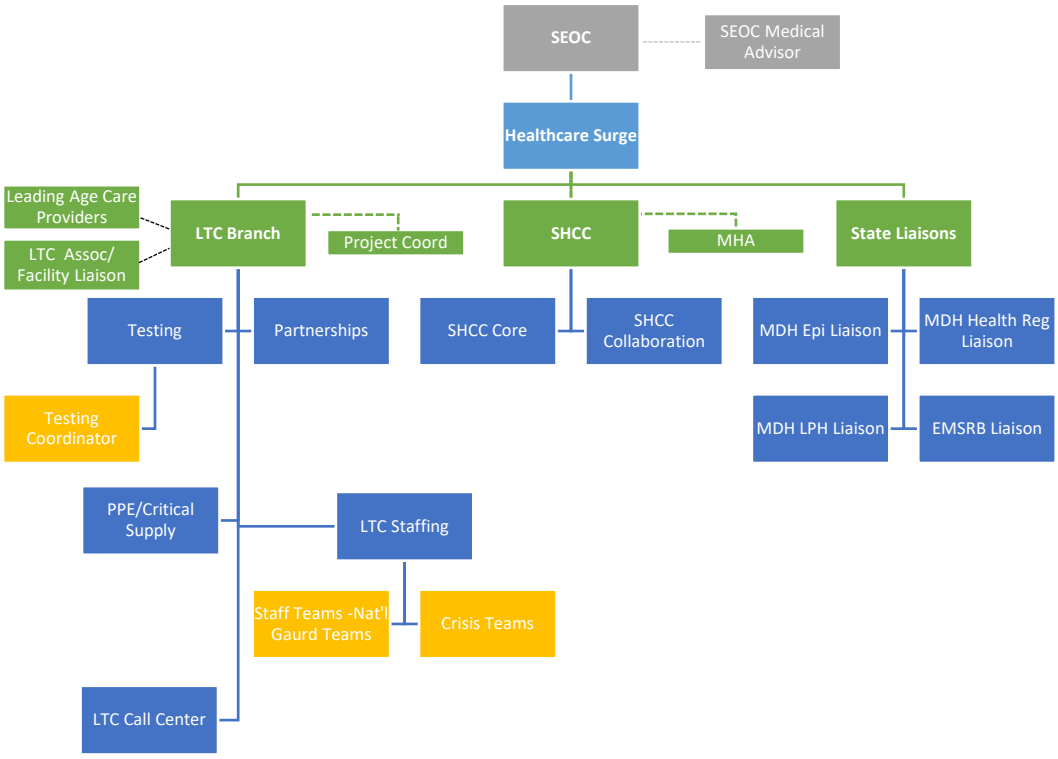
RHRC Organizational Chart



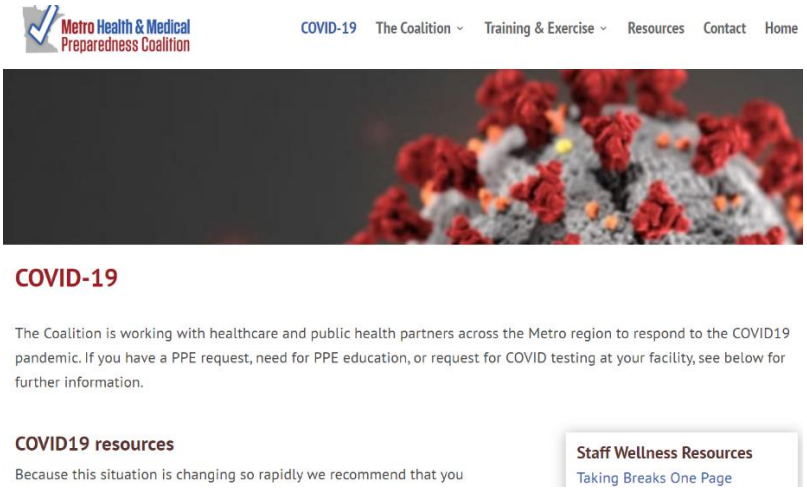
SHCC Organizational Chart



SEOC Organizational Chart



Appendix B: Metro Coalition Website



APPENDIX C: Document Examples

Metro Health & Medical Preparedness Coalition

INTENDED FOR COALITION PARTNERS ONLY
NOT FOR EXTERNAL DISTRIBUTION

Metro Health & Medical Preparedness Coalition Situation Report

Incident Name: COVID-19	**Coalition Contact Information**
Date of Report: 04/28/2020	**Name:** Chris Chell
Time of Report: 0900	**Phone:** 612-743-8414
Compiled By: Tracy Gonser	**Email:** Christine.chell@hcmed.org

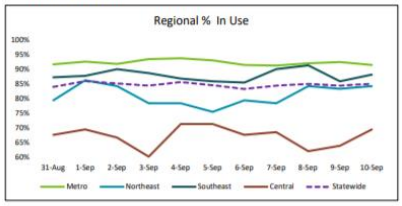
Situation Summary:

	Confirmed	Deaths
Global	3,167,448	224,562
US	1,027,295	59,392
Minnesota	4,644	301

Source: Johns Hopkins (4/29/2020)

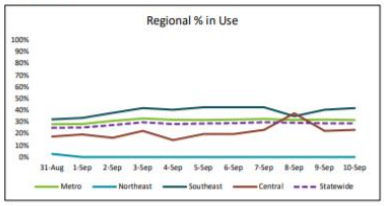
9/10/2020

Critical Care Beds



Last 10 days	Net Δ	1.06%			In Use	1,040			
	High	86%							
	Low	83%							
	Cent	Met	NE	NW	SC	SE	SW	WC
% In Use	69%	91%	84%	63%	48%	88%	43%	45%
In Use 10 day % pt Change	2%	0%	5%	25%	-12%	1%	0%	5%
# Avail	33	59	16	12	13	26	12	11
Avail. Change over 10 days	-2	2	-5	-8	3	-2	0	-1

Ventilators



Last 10 days	Net Δ	3.84%			In Use	406			
	High	30%							
	Low	25%							
	Cent	Met	NE	NW	SC	SE	SW	WC
% In Use	23%	32%	0%	9%	29%	42%	1%	0%
In Use 10 day % pt Change	6%	4%	-3%	0%	4%	10%	0%	0%
# Avail	82	656	72	31	32	83	31	14
Avail. Change over 10 days	-3	-34	2	0	-2	-14	0	0

STATE OF MINNESOTA
Executive Department

Governor Tim Walz

Emergency Executive Order 20-81

Requiring Minnesotans to Wear a Face Covering in Certain Settings to Prevent the Spread of COVID-19

I, Tim Walz, Governor of the State of Minnesota, by the authority vested in me by the Constitution and applicable statutes, issue the following Executive Order:

The COVID-19 pandemic continues to present an unprecedented and rapidly evolving challenge to our State. Since the World Health Organization characterized the COVID-19 outbreak as a pandemic on March 11, 2020, confirmed cases of COVID-19 in Minnesota have rapidly increased. On March 15, 2020, Minnesota detected the first confirmed cases caused by "community spread"—infections not epidemiologically linked to overseas travel. By March 17, 2020, all fifty states had reported a confirmed case of COVID-19, and on March 21, 2020, the

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Notification Letter to Minnesota Hospitals Regarding Reporting of Situational Awareness Data to Support COVID-19/SAR-CoV-2 Surveillance Efforts

April 2, 2020

Dear Hospital / Health System,

This letter is to inform you that the Minnesota Department of Health (MDH) is collecting additional data to support MDH's surveillance efforts for COVID-19. MDH has the authority to conduct this surveillance under Minnesota Statutes, section 144.05, subdivision 1. Specifically, it says:

"The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens. This authority shall include but not be limited to the following:

Record ID	Testing Team	Reason for completing this survey	Facility Type	Assisted Living Facility	Other Facility Type	Facility City	Facility County	Total Number of Tests
212	Bluestone	Not testing at this time	Assisted Living	THE PILLARS OF HIGHLAND PARK	HFID	St. Paul	Ramsey	0
720	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	AUGUSTANA EMERALD CREST	HFID 2	Victoria	Carver	62
721	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	AUGUSTANA EMERALD CREST	HFID 2	Minnetonka	Hennepin	53
734	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	THOMAS T FEENEY MANOR	HFID 284	Minneapolis	Hennepin	98
736	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	THE WATERS OF WHITE BEAR LAKE	HF	White Bear Lake	Ramsey	197
797	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	AUTUMN GLEN SENIOR LIVING	HFID	Coon Rapids	Anoka	154
802	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	THE COMMONS ON MARICE	HFID 307	Eagan	Dakota	226
815	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living	PROJECT CARING RESIDENTIAL	HFID 3	Stillwater	Washingto	20
845	Bluestone	Swab Team Needed (e.g. Mayo Health System	Other		SEEK Home-Cr	Maple Grove	Hennepin	9
847	Bluestone	Reporting Results (PPS done on our own, repo	Other		SEEK Home - L	Maple Grove	Hennepin	9
866	Bluestone	Swab Team Needed (e.g. Mayo Health System	Assisted Living			Minnetonka	Hennepin	28
868	Bluestone	Swab Team Needed (e.g. Mayo Health System	Other		Our Lady of Pe	St. Paul	Ramsey	155
								10
								0
								35
								126
								46

Minnesota Department of Health

- Health Care
- Schools and Child Care
- Businesses and Employers
- First Responders
- What MDH is Doing
- Materials and Resources
- Guidance Library

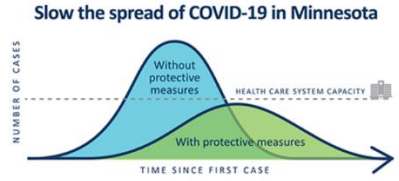
Related Topics

- Supporting Mental Well-being During COVID-19
- COVID-19 Research Studies in Minnesota
- COVID-19 Contracts for Diverse Media Messaging and Community Outreach

Staying ahead of the virus

Minnesota has a strong disease surveillance system in place that includes partnerships with our hospital and clinic systems as well as local health departments. Finding cases quickly and responding to them effectively is key. That rapid response helps ensure that the ill person receives the care they need and it lessens the chance of other people getting sick.

Slow the spread of COVID-19 in Minnesota



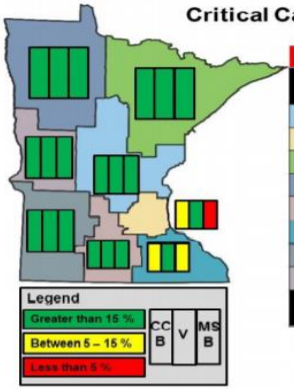
Minnesota Hospital Association

DEPARTMENT OF HEALTH

HSEM Homeland Security and Emergency Management

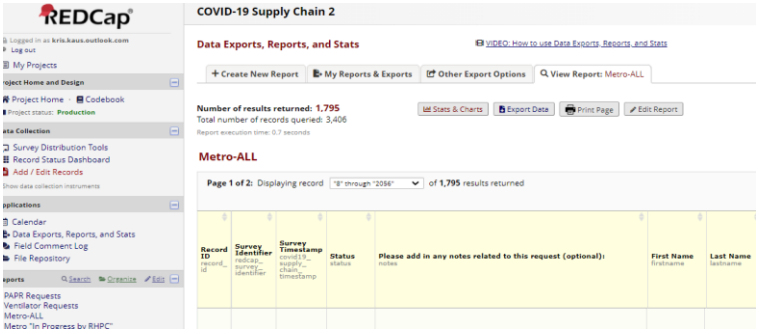
COVID – 19
Critical Care Operating Picture

Last Update: 1245 10 SEP 20



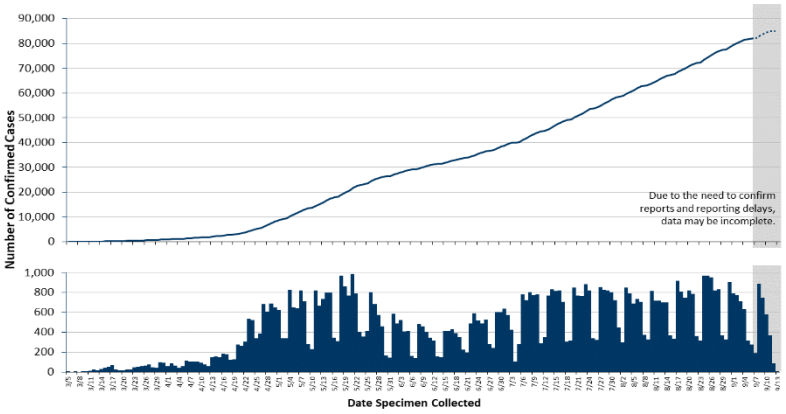
	Critical Care					Medical / Surgical Bed	
	In Use Bed		Avail Bed	In Use Vent	Avail Vent	In Use	Avail
Central	75	69%	33	25	82	655	125
Metro	634	91%	59	304	656	3776	130
NE	86	84%	16	0	72	553	141
NW	20	62%	12	3	31	141	101
SC	12	48%	13	13	32	257	146
SE	185	88%	26	60	83	1035	93
SW	9	43%	12	1	31	192	195
WC	9	45%	11	0	14	105	85
State Total	1,040	85%	182	406	1001	6714	1016

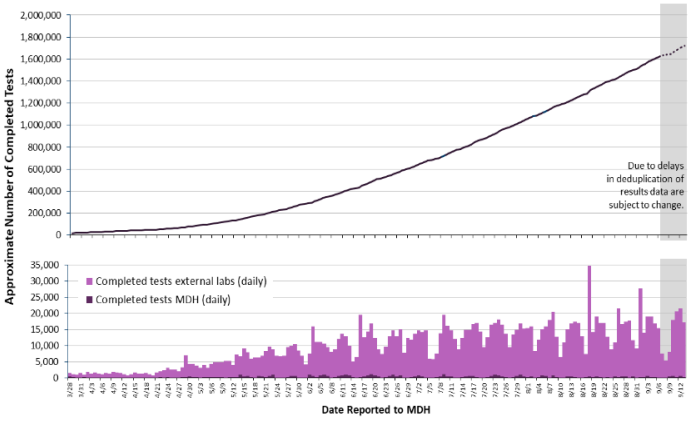
* Color status percentage determined by: availability totality



APPENDIX D: Minnesota COVID by the Numbers

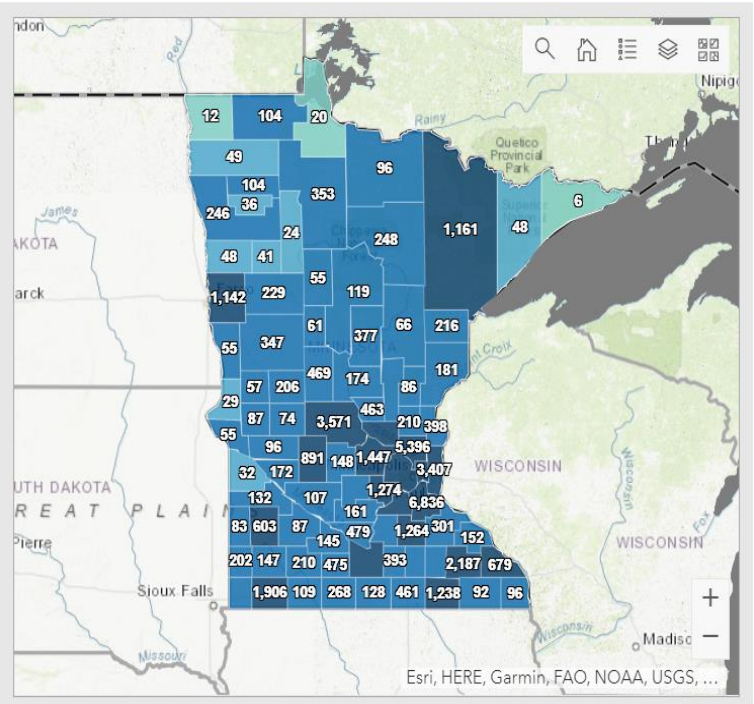
(as of 9/14/2020, MDH)

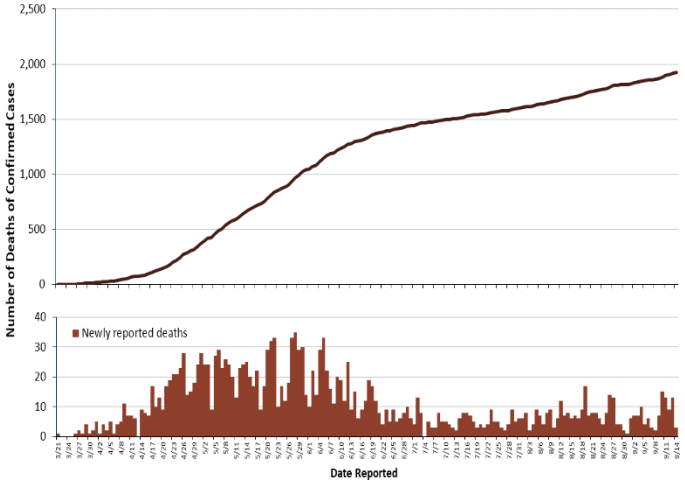


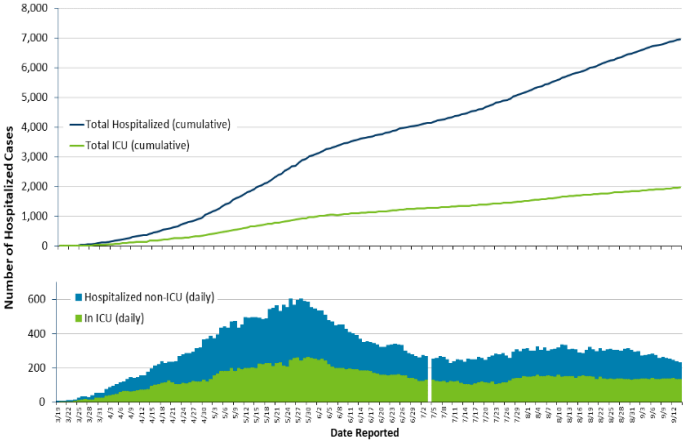


Cases by County of Residence

County of residence is confirmed during the case interview. At the time of this posting not all interviews have been completed.







Appendix E: Acronyms

Table 1: *Acronyms*

Acronym	Meaning
AAR/IP	After Action Report / Improvement Plan
AL	Assisted Living
CDC	Center for Disease Control and Prevention
EM	Emergency Management
HCC	Hospital Command Center
HSEEP	Homeland Security Exercise and Evaluation Program
ICU	Intensive Care Unit
LPH	Local Public Health
LTC	Long Term Care
MDH	Minnesota Department of Health
MHC	Metro Health & Medical Preparedness Coalition
MRC	Medical Reserve Corps
PHPC	Public Health Preparedness Coordinator
PPE	Personal Protective Equipment
RHPC	Regional Healthcare Preparedness Coordinator
RHRC	Regional Healthcare Resource Center
SEOC	State Emergency Operations Center
SHCC	Statewide Healthcare Coordination Center
SitRep	Situation Report
SME	Subject Matter Expert

APPENDIX F: IMPROVEMENT PLAN

This Corrective Action/IP has been developed specifically for the Metro Health & Medical Coalition/Regional Hospital Resource Center for the initial response phase (January – July 2020) of the ongoing COVID – 19 pandemic. These recommendations draw on group discussions, on-going internal process evaluation, and an initial response survey sent out to our regional partners.

Area of Improvement	Corrective Action Description	Primary Responsible Department	Point of Contact	Date Completed
1. Communication & Information Sharing	**1a)** Clarify roles of the SEOC, SHCC, and the Coalition and who owns what processes.	RHRC	Chris Chell	
	1b) Send out Coalition meeting agenda earlier to allow facility SMEs to attend to speak to issue and answer questions.	RHRC	Chris Chell	
	1c) Add report outs from Home Care, Assisted Living, and Infection Prevention to the weekly Coalition meeting agenda.	RHRC	Chris Chell	
2. Coordination	**2a)** Clarify expectations from State vs. Coalition vs. Public Health for the response.	RHRC	RHRC Staff	
	2b) Strengthen support for non-residential entities (i.e. clinics, homecare, hospice, etc.).	RHRC	RHRC Staff	
	2c) Initiate a concerted and focused effort to have more metro facilities set up as closed pod sites in anticipation of a vaccine. Share data regarding which facilities in the area are already designated as a closed pod.	LPH	LPH Leads	
3. Supply Chain	**3a)** RedCap survey is time-intensive and inflexible. Assess if we can auto-populate or make other improvements to address concern.	SHCC	SHCC/MDH	
4. Staffing	**4a)** Develop contingency staffing plans tiered to small, independent facilities.	RHRC/SHCC	Emily Moilanen	
	4b) Staffing assistance mainly focused on LTC, are we able to broaden focus to include crisis staffing for hospitals?	RHCC/SHCC	Chris Chell	

Area of Improvement	Corrective Action Description	Primary Responsible Department	Department POC	Date Completed
5. Staff Wellness	**5a)** Consider strategies to bring staff wellness to a mobile workforce.	RHRC	Jonathan Bundt	
	5b) Ensure other existing and anticipated priority items are covered first (i.e. vaccines, influenza) during the Coalition meetings.	RHRC	Jonathan Bundt	
	5c) Consider having other psyche-based institutions chip in on this effort.	RHRC	Jonathan Bundt	
6. Tools & Resources	**6a)** Assess use of MNTrac during event. Is that the best platform or would other platforms work better (i.e. EMResponse). Use of MNTrac was strong in beginning and lessened over time.	RHRC	Chris Chell	
	6b) Add METRO COVID case counts and positivity rates to the Coalition SitRep.	RHRC	Tracy Gonser	
	6c) Assess if hospitalization/ICU/MS utilization rates can be added to the Coalition SitRep.	RHRC	Tracy Gonser	
	6d) Assess if the Coalition can develop a dashboard and have it accessible to Coalition members.	RHRC	Chris Chell	
	6e) Provide more tools and resources specific to Home Care and Clinics.	RHRC	Emily Moilanen	