Metro Health & Medical Preparedness Coalition

COVID - 19 Pandemic

September 2020 - April 2021: *Phase 2 of the Response*

Written by the Regional Hospital Resource Center

April 29, 2021

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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 disease caused by SARS-CoV-2. The virus that originated in China eventually went on to cause a global pandemic and as of this report, **16 months later**, we are still responding to the COVID-19 pandemic. As of April 30, 2021, there has been over 32 million cases of COVID-19 in the United States and over 572,000 deaths. In Minnesota, we have had over 575,000 cases and over 7,000 deaths.

Minnesota has expended a tremendous amount of resources and effort to continue to respond to and minimize the impact of COVID-19 in our state and in our community. Currently we remain under federal and state restrictions such as social distancing, masking, capacity limits for public and private venues, and employees are being encouraged to work from home if possible. See ***Appendix C*** for an illustration of our current "*Stay Safe MN*" guidance.

Along with continued efforts stated in the Phase 1 After Action Report (AAR), Phase 2 of our response has taken us through two COVID-19 surges in our hospitals and healthcare facilities, patient movement challenges when capacity nears facility limits, mass testing and vaccination efforts and events, monoclonal antibody treatment planning and administration, and supply chain challenges. Education efforts within our community and coalition continue on a variety of topics, including behavioral health and caregiver fatigue wellness efforts. In addition, our response efforts are taking place through periods of national and local civil unrest.

This report is focused on our **Phase 2** response to the COVID-19 virus from September 2020 – April 2021. 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 seven metropolitan counties of the Twin Cities.

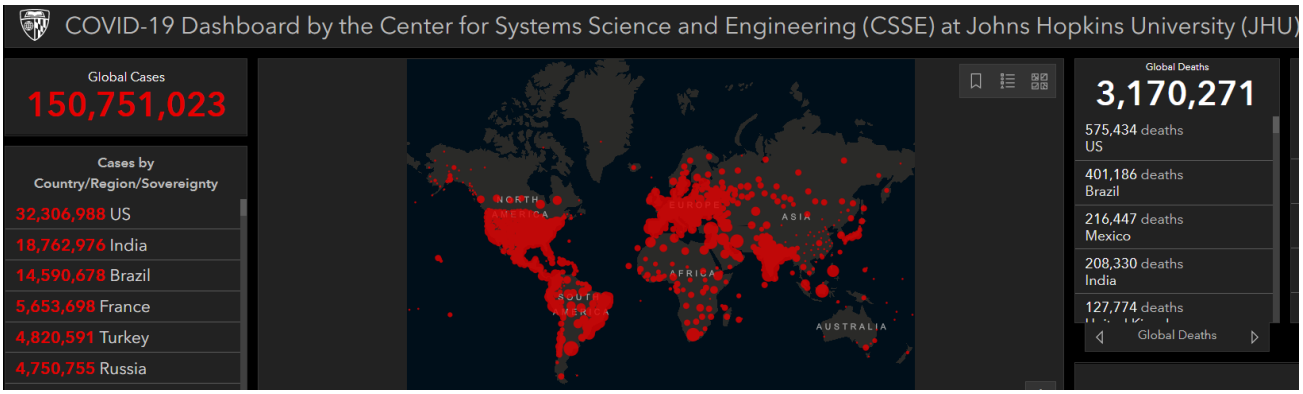
A response of this magnitude and duration requires constant communication and coordination of local, regional, and state response plans and efforts. A coordinated response is critical to slowing the spread and lessening the impact of this virus. To assist in coordination efforts, the Metro Health & Medical Preparedness Coalition's Operations center, called the Regional Hospital Resource Center (RHRC), remains activated 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 structure also includes two additional part-time contractors supporting the response effort.

In addition to the Metro Healthcare Coalition/RHRC structure, the State Emergency Operations Center (SEOC) and Statewide Healthcare Coordination Center (SHCC) remain active as of the date

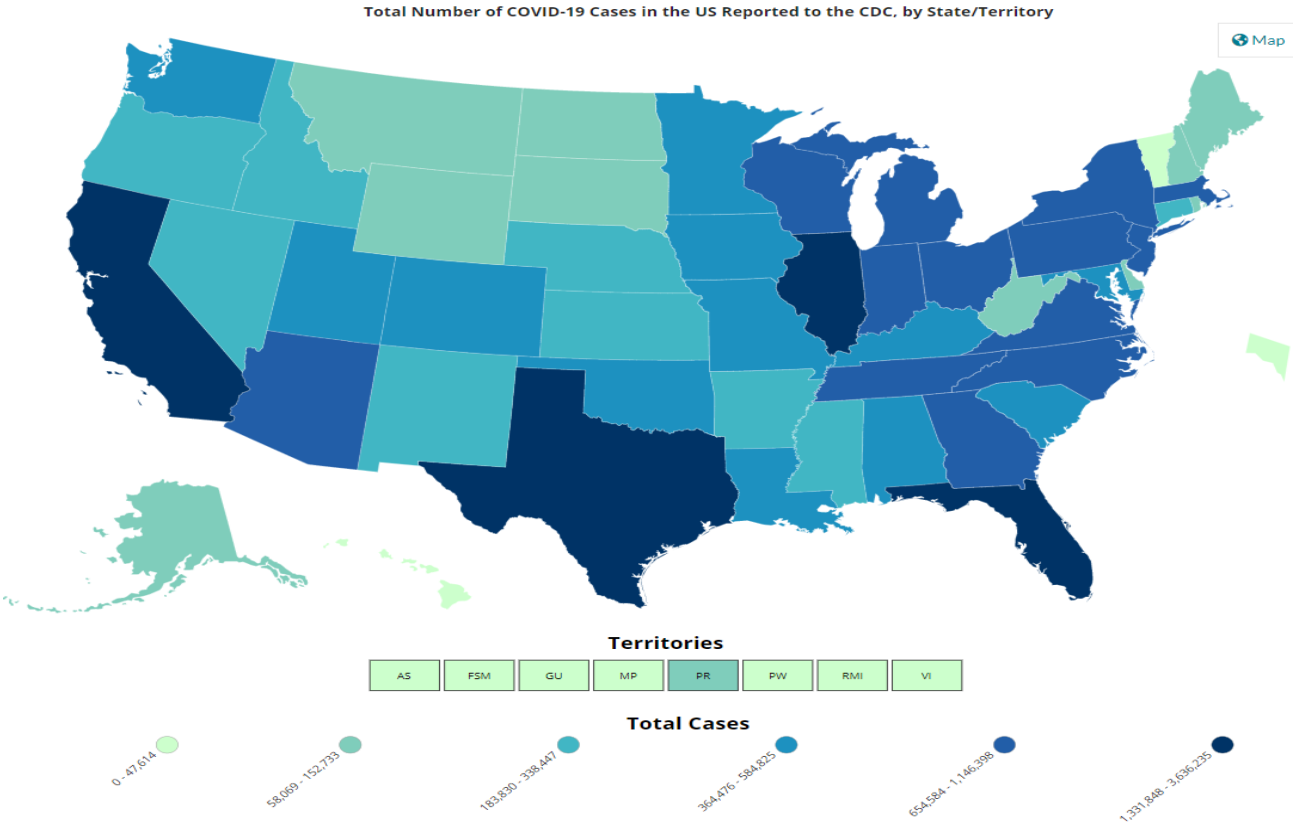
of this report. The RHRC, SEOC, and SHCC work in concert to integrate the regional and state planning and response efforts. See ***Appendix A*** for organizational charts for these entities.

The data maps below include the case and death counts from COVID – 19 as of April 30, 2021. This data, along with the charts and graphs in ***Appendix B***, illustrate just how pervasive and complex the response to this virus continues to be, and underscores the need for an on-going coordinated response within our metro region, state, nation, and around the globe.

Johns Hopkins Global Map – *as of 4.30.2021*



CDC Map of USA – *as of 4.30.2021*



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 on-going response needs. This report will also facilitate and support planning efforts for future potential epidemic and pandemic events.

Major Strengths

The major strengths identified during Phase 2 of this event are as follows:

- Coordination of regional partners.
- Communication and Information Sharing with regional partners during fluid and dynamic times.
- Providing tools, documents, and resources to assist regional partners.
- Providing case counts, hospitalization, bed capacity, and vaccine data reports.
- Providing personal protective equipment, training, and resources.
- Staff wellness topics and presentations

Primary Areas for Improvement

Throughout the Phase 2 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:

- Implementation of the Care Delivery System (CDS) caused an information void and confusion around coordination and the role of the Coalition.
- Strengthen planning/preparedness efforts for non-hospital and non-residential facilities.
- Need more MNTrac training for non-hospital entities.
- Planning efforts by Coalitions were usurped by MDH.
- Strengthen the short-term crisis staffing plans for non-hospital entities.

Overall, the event was well coordinated across our region during Phase 2 of our response. What we have learned during Phase 2 will be used to strengthen our continued response to this pandemic. The responses from our survey of the phase 2 response indicated an overall ***improvement*** from Phase 1 in planning and strategy for several key elements that were assessed. 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 (***Appendix G***). It remains 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 our continued response to COVID-19, 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 (SARS CoV-2) Pandemic

Event Start Date

January 2020. This report reviews **Phase 2** of our response which assesses the response from September 2020 – April 2021.

Event End Date

Phase 2: Ends April 30, 2021

COVID-19 Response is still on-going.

Duration

16 months

COVID-19 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 (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington).
- 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, testing, vaccination, and patient movement 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 resources.

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
- *Carol Christians*, Emergency Management & Business Continuity Consultant
- *Jonathan Bundt*, Emergency Management & Behavioral Healthcare Consultant
- *Kris Kaus*, Emergency Management & Business Continuity Consultant

Participating Organizations

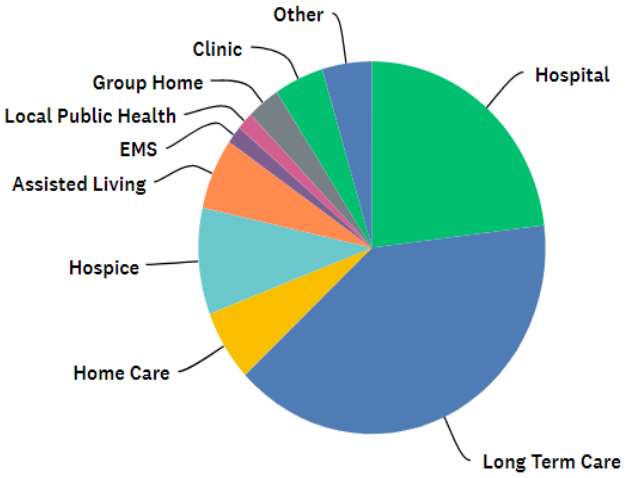
- Abbott Northwestern Hospital
- Children's Minnesota
- Gillette Children's Specialty Care
- HealthPartners - Park Nicollet Health Services, Regions and Methodist
- Hennepin Healthcare System
- Mercy Hospital
- Mercy Hospital – Unity Campus
- MHealth Ridges Hospital
- MHealth Southdale Hospital
- MHealth 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
- Minneapolis-St. Paul International Airport
- 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
- Metro Area MDH Providers
- National Guard

SECTION 2: EVENT SUMMARY

Event Summary

This after-action report is reflective of **Phase 2** of the Metro HealthCare Coalition Response, September 2020 – April 2021. 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 65 respondents to that survey across ten different disciplines.

Respondent discipline breakdown:



74% of the respondents indicated they are now more knowledgeable of the role the Metro RHRC/Coalition and how it can support regional response coordination. **25%** stated they already had a good understanding of the role the Metro RHRC/Coalition can play in a response.

The Metro Health & Medical Preparedness Coalition and Regional Healthcare Resource Center (RHRC) maintained the objectives set during the initial response (see page 8) through Phase 2. These response objectives gave the RHRC/Coalition clear direction and drove the daily response efforts. As the event continued to progress, we remained flexible and adjusted our strategies and tactics 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 focus of this report is based on the RHRC's efforts to meet our mission and ensure coordinated efforts around eight key elements: Communication, Coordination, Staffing, Testing, Vaccination, Supply Chain, Resources and Tools, and Staff Wellness.

This report does not include assessment for the many workgroups participating in patient movement, critical care, alternative care site, infection prevention, or other workgroups lead by individuals outside the Coalition or at the State level.

Listed below are the ***eight*** 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 Phase 2 of the response. These methods include phone, email, Teams Meetings/WebEx, Webinars, WhatsApp, Coalition Website (COVID page), situation reports and Incident Action Plans (IAP).

Over **98%** of the respondents to the survey "strongly agreed" or "agreed" that the RHRC was responsive and gave timely information, while over **89%** indicated the information was clear, helpful, and appropriate information during the response. **This is an 8% and 4% improvement, respectively, from the initial response phase.**

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Regularly scheduled Zoom meeting very helpful to provide coordinated updates, hear ideas of others, clarified information, and ask questions real time. (14)
- Did well coordinating communications and direction during very fluid, dynamic times. (7)
- Email communication was effective during this time, with links and updates. (4)
- Took the time to answer our questions and concerns specific to our facility. (3)
- LTC lead was consistent and prompt with relaying ever changing guidelines and information, and the weekly meetings and follow up emails after the LTC meeting were helpful. (3)
- Metro Coalition members were easily accessible, very knowledgeable, and has helped in so many ways. (2)
- Helpful to have the LTC lead talk about how and what relates to homecare/hospice. (2)
- Having the ability to see what was available for bed availability regionally and the ease of the system to input the information.
- Metro Coalition was instrumental in preventing deaths in LTC facilities by providing accurate timely information to providers and staff.
- For EMSRB, being involved in the Coalition meetings early really helped make sure that EMS planning was incorporated into the larger response.

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

Respondent Comments for Areas of Improvement:

- Very little of the information related to care or practices/trends in private homes. (4)
- When CDS stood up, that created a bit of an information void and confusion about ongoing role of Compact. It has firmed up since, but a more formal liaison role between CDS and Compact/Coalitions would be helpful. (2)
- Still areas in which an outpatient hospice provider does not exactly fit into the typical responses.
- The value of communication went way down when MDH took point in COVID data and vaccine planning. This created gaps and confusion where little existed prior to MDH taking over.
- Some facilities did not gain much from reporting requirements and reporting is a lot of work.

2) COORDINATION: The mission 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. This large-scale event required the RHRC to coordinate and integrate the COVID – 19 response efforts among Coalition groups in the metro and across the state as well as other external partners such as MDH, APIC, and ACIP. In addition, other groups were formed such as the "C4" structure who were able to assist in patient movement when bed capacity was reaching its limit in the Metro facilities.

Over **88%** of the respondents to the survey "strongly agreed" or "agreed" that the coordination meetings and their frequency were helpful, they were informed of local and state processes, and appropriate key stakeholders were invited to these meetings. **91%** stated that hearing partner updates was very helpful in developing their response. **These responses indicated a 5% and 4% improvement, respectively.**

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Weekly calls and RHRC's willingness to follow up and email responses to questions. (7)
- Feedback at the meetings from all the disciplines was highly informative and beneficial. (7)
- Frequency of meetings and meeting notes were beneficial for information sharing and coordination. Adjusted cadence when needed. (7)
- All those relationships that have been built over the years really paid off which coincidentally is what has been emphasized over the years at the pre-covid Coalition mtgs.
- Being involved at the regional level helped the EMSRB maintain a good operational picture of EMS and its involvement in the larger health care response.
- Coordination was exceptionally helpful in guiding our vaccination process with staff.
- RHRC was good at relaying MDH information in a more user-friendly format.
- The Metro Coalition brought us hope in dreary times.
- Being an outpatient hospice provider that is stand alone and not attached to a system or a national corporation there was a learning curve, but again the coalition was there when I needed the support.
- Information was always current and follow up was always done.
- Provided links to documents and needed resources.

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

Respondent Comments for Areas of Improvement:

- Vaccine coordination needed the Coalition RHRC and Leadership to convince MDH to use the coalitions to coordinate vaccine distribution.
- Sometimes less MDH focus is okay.
- At times lack of clear direction and shifting of the plan from the state level.
- More is needed from the Metro Coalition in support of smaller residential care homes, soon to be small, private Assisted Living's.

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, , vaccine data, hospital bed counts, situation reports, webinars, 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, and several other topics and tools were shared with members via email, coalition website, and/or at the Coalition and LTC meetings.

According to the survey, **85%** of the respondents "strongly agreed" or "agreed" that the COVID case count breakdowns were helpful as well as **75%** of respondents stated the Metro Coalition Situation Reports were useful. **63%** stated the Coalition Website was useful, and **57%** stated they used MNTrac during Phase 2 of this response. **These responses indicate an overall improvement of the tools and resources offered by the RHRC/Coalition (13%, 8%, 6%, and 1% respectively).**

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Case counts, hospitalizations, bed capacity reports were beneficial and easy to read. (4)
- MNTrac is a useful tool. (4)
- SitReps were helpful. (4)
- RHRC did well in providing tools, resources, and reference materials to its members.
- I was able to respond to other organization's needs (provided a thermometer to an AL) using the MN Trac system and the coalition.
- Used tools on website for staff communication on Behavioral Health.

It was noted that the data reports sent out were very helpful for many facilities. Some facilities only used MNTrac to report beds, where others found the tools and information sharing more beneficial. Reporting requests from the Coalition were adjusted as scenario and bed capacities changed.

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

Respondent Comments for Areas of Improvement:

- Need more MNTrac training.
- Some facilities did not use MNTrac or Coalition website much for information.
- Used MDH/CDC websites, Coalition website and MNTrac seemed like resource overload.
- Updating MNTrac bed counts so often seemed like overkill.

4) SUPPLY CHAIN: The RHRC worked in coordination with the SHCC to distribute PPE to requesting facilities across the region. At times, the SHCC was able to push out batches of PPE directly to Metro Coalition/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 tracked all items received. As of the time of this report, **2,064** RedCap PPE requests were made to the Metro RHRC for our regional cache supplies. The RHRC continues to distribute PPE, infrared thermometers, and fit-testing kits from the metro cache to those facilities requesting assistance. The RHRC also worked with the facilities to provide them with education such as fit-test train-the-trainer sessions and vendor lists to help them develop their own supply chain process.

According to the survey, of those requesting PPE **76%** of the respondents "strongly agreed" or "agreed" that the RedCap PPE request link was useful to request needed PPE. When PPE was requested, **80%** of the respondents "strongly agreed" or "agreed" that they received the PPE they needed, while **79%** stated the Coalition Supply chain guidance for PPE was useful (vendor lists, reuse guides, burn rate calculators, etc.). **These responses demonstrate a 12%, 21%, and 24% improvement, respectively.**

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Provided PPE supplies when needed. (9)
- Timely response to PPE requests. (3)
- Helpful education and resources provided for PPE. (2)
- RHRC was supportive for questions and coordination of PPE assistance.
- Assistance with Fit-Testing was very helpful.
- Coalition was a great place to identify future shortage possibilities and solutions.
- Appreciated the visibility to the PPE tracking. It was so well organized, and the transparency made it easy to trust.
- EMSRB process dovetailed well with the process developed by the coalition.
- Vetted vendor lists.

During phase 2 of the response, it was noted that less requests were coming in as the months passed. As the response continued, non-hospital facilities began to develop supply/vendor relationships and processes which aided in developing a dependable supply chain (which was lacking during Phase 1). It was also noted that the majority of requests for the metro cache also shifted from Long Term Care facilities to Assisted Living and group homes. Potentially due to vendor's supply being adequate and non-hospital facilities developing their own strategies.

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

Respondent Comments for Areas of Improvement:

- PPE RedCap survey was long and sometimes difficult to complete. The form kept changing.

5) STAFFING: The RHRC continues to participate in staffing planning groups with state and regional partners. In the latter half of phase 2 the requests for staffing assistance decreased. Staffing strategies developed in Phase 1 and continued throughout Phase 2, included volunteer sign up, MDH contracts, use of the National Guard, and sharing staff between healthcare systems when able. A link was put on the Coalition website to request staffing assistance. Staffing requests ranged from patient care staff to COVID testing staff to vaccinators for the COVID 19 vaccine. The SHCC and MDH handled those requests and coordinated efforts to assist facilities in need. The RHRC served as a resource for requesting guidance and bringing concerns back to the SHCC as needed.

Over **54%** of the respondents to the survey "strongly agreed" or "agreed" that the RHRC shared relevant staffing updates, and **55%** noted the RHRC shared appropriate staffing resources. Though we had a 2% drop for those responding about relevant staffing updates, 26% did indicate it was not applicable to their facility and may have affected those results. We did see a 2% improvement from the initial phase for sharing appropriate resources. Only **31%,** though a 7% improvement from Phase 1, stated the RHRC assisted with staffing as needs arose. Continued low utilization is likely due to many facilities not using this resource, as **35%** indicated the need for staffing resources were "not applicable" to their facility.

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Provided awareness, education, and updates on staffing concerns across the Metro Region.
- Connected LTC and Group Homes to staffing resources.
- Coalition communicated well and always offered assistance.
- Helpful tools, resources, and support were provided (i.e., emergency staffing plan).
- Critical staffing workshops were helpful.

It should be noted that staffing struggles were a result of increased patient volume and staff being exposed to or contracting COVID – 19. Those exposed and/or positive with COVID-19 had to isolate or quarantine for 14 days. Many facilities noted they used retired employees and longer shifts to cover their staffing needs, while other indicated they used other creative strategies to fill the gaps. As the response continued through Phase 2 the need for crisis staffing began to decrease.

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

Respondent Comments for Areas of Improvement:

- Could a staffing website be developed the employees could access and manage on their own?
- Difficulties building a short-term need/crisis staffing plan.
- Seemed to get staffing help only in extreme cases.

6) TESTING: The RHRC participated in COVID testing planning and coordination 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 during the peak of the testing phase. The SEOC and MDH led the efforts for scheduling and coordinating resources for testing sites. The RHRC led weekly Coalition Testing meetings, in the first part of Phase 2, to share updates, resources, lessons learned, and brought back any concerns to the SHCC and MDH as needed. By the end of Phase 2 the weekly testing meetings were demobilized as facilities found their stride with the process and cadence for COVID-19 testing.

Of the respondents who completed the survey, **62%** "strongly agreed" or "agreed" that the RHRC was helpful and answered questions regarding testing concerns. **60%** indicated the weekly testing data they received was useful, and **52%** stated the regularly scheduled testing meetings were useful. **This was a 4%, 17%, and 12% improvement respectively over the initial phase response.** It should be noted that not all facilities conducted testing, as **25%** indicated the testing component was not applicable to their facility.

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Timely information sharing regarding testing processes, resources, and updates were beneficial.
- Responsive to emails and questions about testing.
- The LTC lead was a valuable resource and extremely helpful.
- RHRC lead served well as a liaison to the state.
- MDH allowed our RHPC to take point in this area, information and needed answers flowed better.
- Receiving testing data was helpful for organizational planning efforts.

At times, outpatient providers who were unable to provide inhouse testing had to use other sites and resources, which were obtained through the state, and were able to receive further direction from the Coalition. The availability of tests and test options rapidly improved during the beginning of Phase 2.

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

Respondent Comments for Areas for Improvement:

- Testing program was frustrating at times with the stop, start, change plans, etc.

7) **VACCINE:** The vaccine planning efforts began in November 2020 and played a significant role in the RHRC's planning efforts for the remainder of Phase 2 of the response. The RHRC participated in and led vaccine planning and coordination groups with Coalition members and worked with the State and Regional planning partners. Strategies were developed, and priority facilities were identified for equitable vaccine allocation. Vaccine updates, statistics, resources, and guidelines were shared with Coalition members weekly. The RHRC also worked with MDH and regional hospital partners to send lists to or "match" individuals in need of vaccine with local healthcare vaccine providers. The Metro Coalition developed a Vaccine Planning Group and activated a vaccine Incident Management Team (IMT). These two groups coordinated our metro response, developed an Incident Action Plan with set objectives and key strategies and tasks, as well as the development of a weekly vaccine situation report.

   The RHRC identified two critical areas of coordination: large- and small-scale allocation. Small-scale pertained to matching individuals who had unique access to vaccine for first and second doses (1a priority three HCW for first dose, second dose matching, priority workers that are minors). Large scale, the RHPC held weekly vaccine allocation meetings to provide equitable distribution of Pfizer, Moderna, and later, Janssen vaccine. Care was given to ensure access to vaccine across the Metro area was fair and equitable and took into account factors such as state guidelines, storage capability, and the social vulnerability index (SVI). As the vaccine process evolved, MDH providers were brought on board and attended the weekly allocation meetings. A "hub and spoke" model was created to assist smaller facilities in receiving and storing vaccine. See ***Appendix D*** for vaccine statistics and illustrations.

   Of the respondents who completed the survey, **62%** "strongly agreed" or "agreed" that the RHRC met their need for vaccine coordination and **68%** indicated the RHRC was helpful and answered their questions. **42%** found the Vaccine SitRep helpful, while **38%** found the IAP helpful. **57%** "Strongly agreed" or "Agreed" that the weekly vaccine meetings were beneficial. It should be noted that vaccine efforts began in the second half of the second phase (Dec 2020) and **22%** of the respondents indicated that coalition vaccine coordination efforts were not applicable to their facility.

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- Vaccine coordination was to me the RHRC's strongest achievement.
- Provided bold leadership to multiple meetings where State leadership needed to hear that the coalitions were ready and willing to assist.
- Great coordination efforts and clear communication regarding what to do in planning for vaccinations.
- RHRC was timely, supportive, and helpful throughout the vaccine process.
- Appreciated the reach outs and confirmations of vaccine allocations.
- Provided information when questions arose and worked well with facilities and public health.
- The implementation of the IMT vaccine group was very helpful.

A MNTrac Coordination Room was developed in November 2020 to assist in housing key information, guidelines, and resources. In addition, this coordination room allowed coalition members to post questions and read weekly sitreps and meeting notes.

It should be noted that some facilities coordinated their vaccine efforts through MDH and the Pharmacy Partnership Program (PPP), and did not receive weekly vaccine allocations from the Coalition. Also of note, part way through the vaccine response, MDH developed a group of large metro hospitals/systems called the Care Delivery System (CDS)/Consortium who worked with MDH to receive their weekly allocations.

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

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

Respondent Comments for Areas for Improvement:

- The lines of authority grew fuzzy and in spite of careful planning, efforts felt usurped by decisions that were made at another level.
- Great initially, then development of CDS caused some disruption and communication & coordination gaps.
- The biggest disappointment was the separation of large hospitals vs smaller, in the Metro area (i.e., the CDS). Those hospitals still left in the coalition are not comparable in patient contacts as the other health agencies vying for limited vaccine and trying to distribute felt awkward.
- Due to the MDH allocation process, unable to plan ahead (didn't know from week to week the amount of vaccine coming, if at all).

8) STAFF WELLNESS: Efforts of the RHRC staff to provide education and resources for Behavioral Health/Staff Wellness increased significantly throughout the second phase of the response. Addressing this critical issue was a high priority for this complex and prolonged pandemic response. The RHRC invited organizations and facilities to participate in regularly scheduled brown bag seminars, included it as a standing agenda item on weekly Coalition calls, created one-page information sheets on various staff wellness topics, posted behavioral health and staff wellness resources on the metro coalition website, and developed a new website (wellnessmn.org) to post relevant topics and provide additional resources.

Of the respondents who completed the survey, **68%** "strongly agreed" or "agreed" that the staff wellness information/presentations shared at the Coalition meetings have been useful, and **57%** went on to share that information with others in their organization. The responses indicate a 7% and 11% decrease from the initial phase. **51%** indicated the wellnessmn.com website was helpful (this website was a new resource added) and **38%** of the respondents indicated the brown bag series was helpful. It should be noted that between up to 25% indicated that staff wellness was not applicable to their organization. Although staff wellness and behavior health are a critical component of this response for all staff, that particular subset did not use any of the resources the metro Coalition provided.

Respondent Comments for Strengths: Strategies identified that should be maintained through the end of this response:

- RHRC having established relationships was able to bring on great wellness information, trainings, and access to self-care.
- Information was on point, timely, and appreciated.

Though not all respondents used the resources developed by the RHRC, it was noted by some facilities that the information was very useful and was shared with staff with their organization. The RHRC worked to develop a multi-pronged approach to share information such as webinars, one-pagers, and website resources with facility leaders, who then could share information with staff in an easy, timely fashion.

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

Respondent Comments for Areas for Improvement:

- Some facilities access to resources was different and resulted in staff being reluctant to leave the patient and/or the job for a break.
- Develop the resources sooner in the event.

SECTION 3: CONCLUSION

The years of working on the development of the Metro Health & Medical Coalition and building community relationships have made a positive impact in response capability to one of the most complicated incidents 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. Our **16-month** response to this event certainly has proved that to be true.

One of the immense challenges to our response during Phase 2 was the dynamic and fluid nature of the fast-changing information and state and federal guidelines. Navigating those challenges proved to be difficult at times yet rewarding to see the coalitions and communities pull together for the greater good. The metro region RHRC and the Coalition set up a coordination and communication process that supported our regional needs as indicated by the responses to our after-action survey. While communication and coordination needs are being met, there is still much work to be done. Offering continued collaboration and coordination for our community partners as we continue to navigate through this response and eventually implement demobilization processes will be an on-going focus of the RHRC staff.

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 planning groups of regional needs. Ensuring that all healthcare institutions, including the non-residential facilities, are part of communication pathways will be important for future response needs.

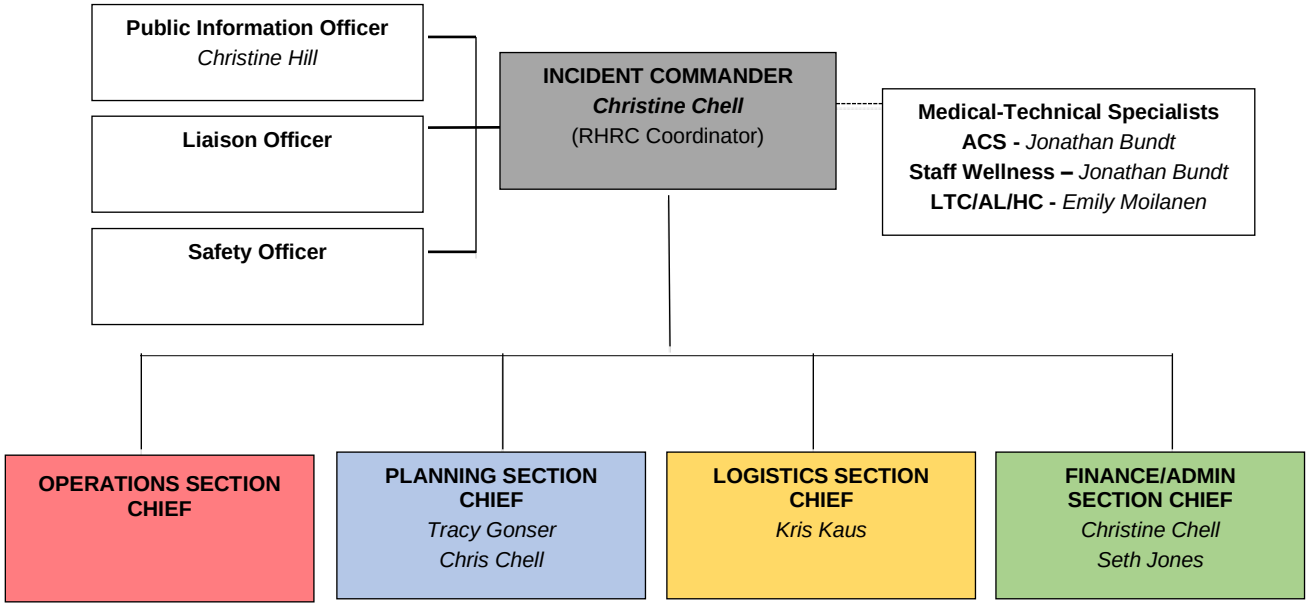
The emergency management cycle of mitigation, preparedness, response, recovery, and repeat takes on a different progression when you are continuously responding. This report, along with the improvement plan, will give use a brief time to pause to address the identified areas of improvement along with our response assumptions and objectives. 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

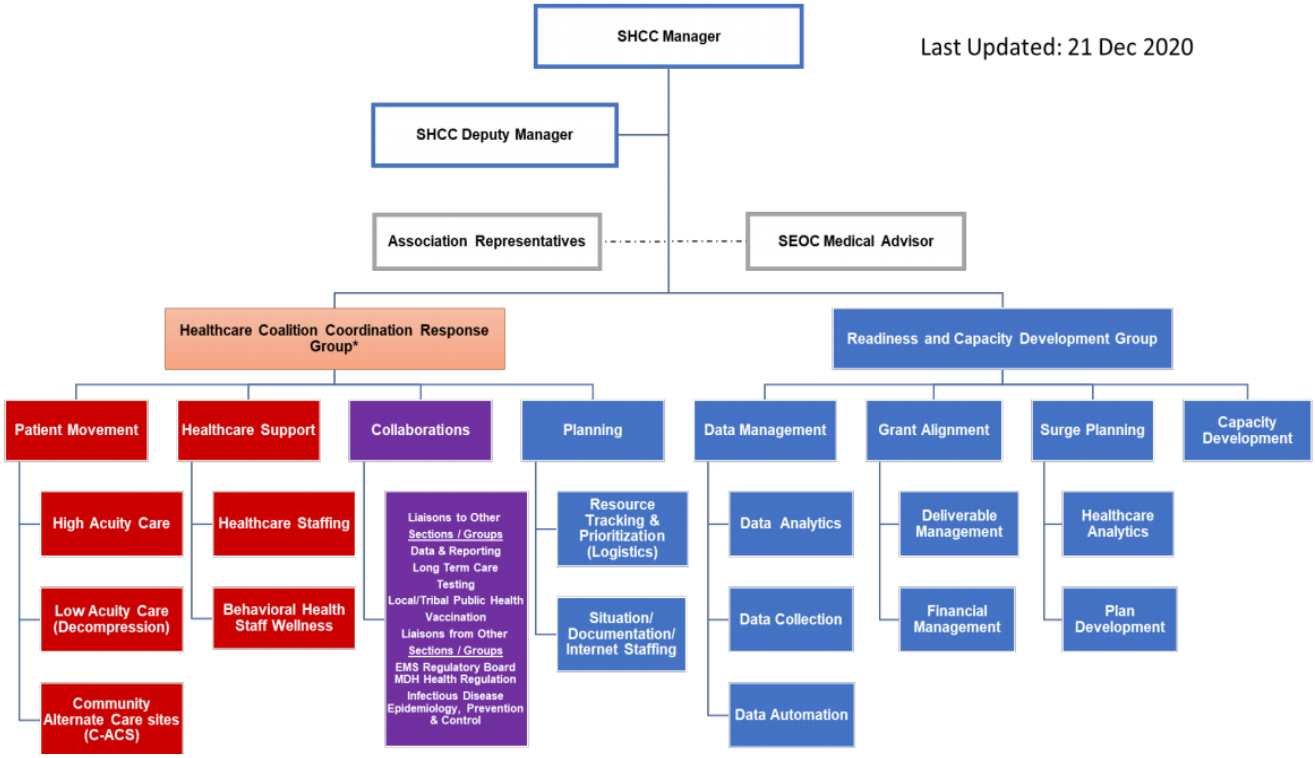
While this report is limited to addressing Phase 2 of the response to COVID-19 in the metro region, it would be remiss to not acknowledge and express appreciation for all the facilities, services, agencies, organizations, first responders, and others that ensured the safety and well-being of the citizens of the seven-county metro area in Minnesota. Every organization 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

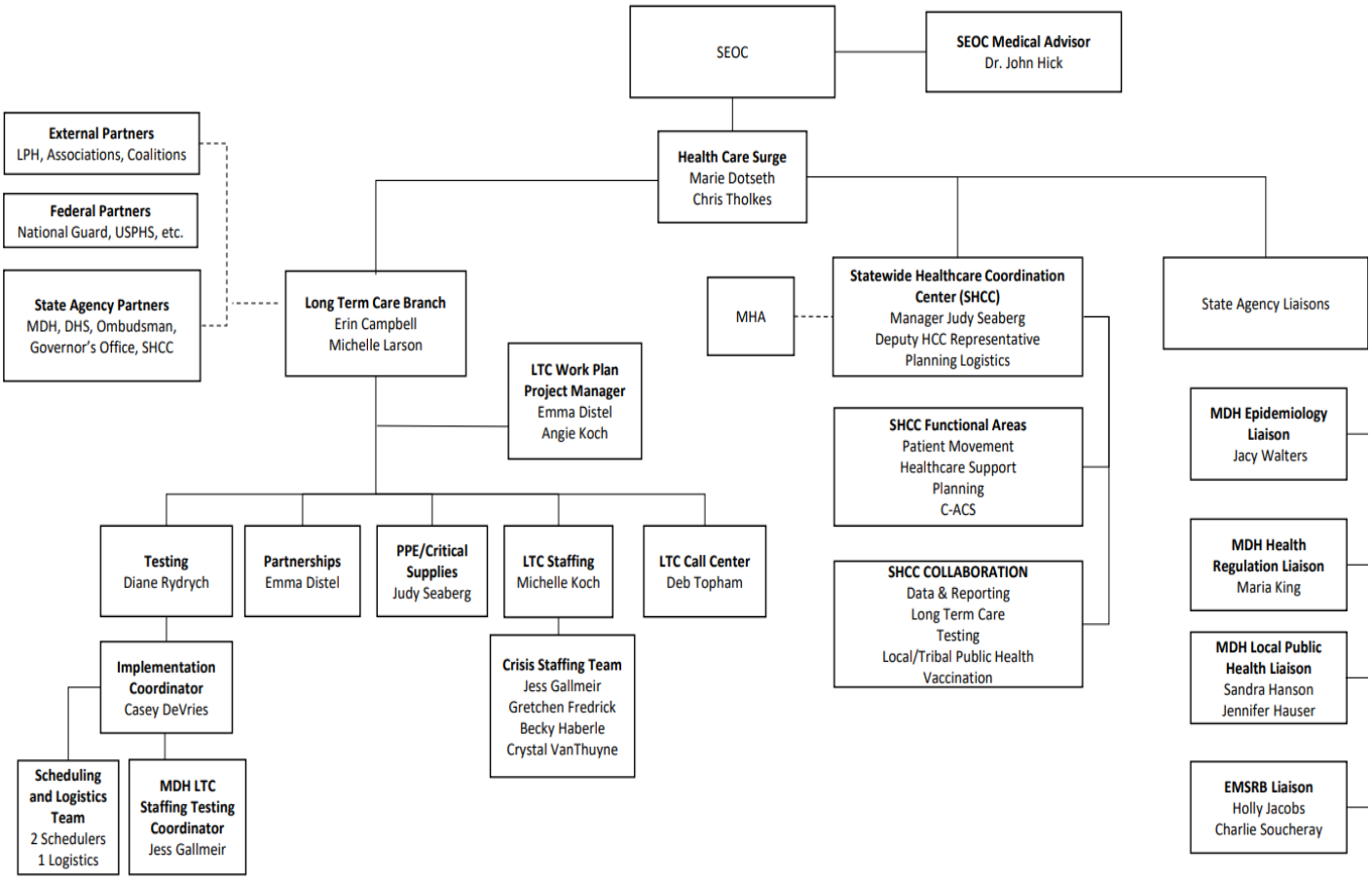


SHCC Organizational Chart



APPENDIX A: ORGANIZATIONAL CHARTS CON'T…

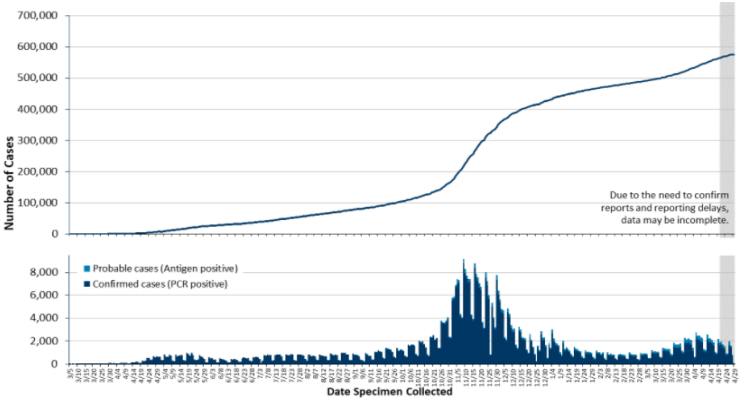
SEOC Organization Chart for COVID Response



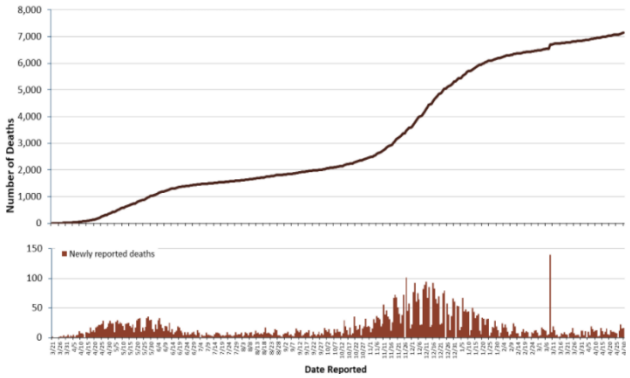
APPENDIX B: Minnesota COVID by the Numbers

(as of 4/30/2021, MDH)

Minnesota Case Overview

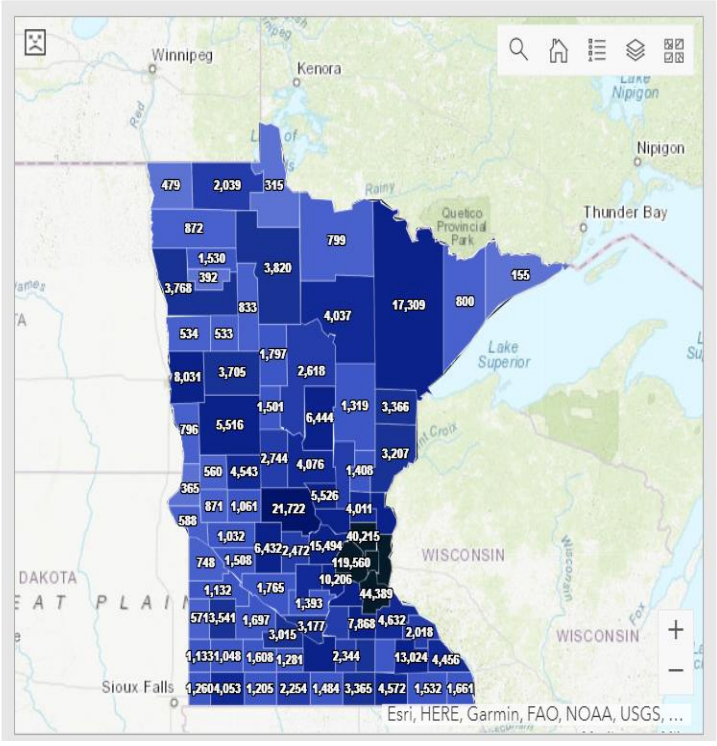


Deaths

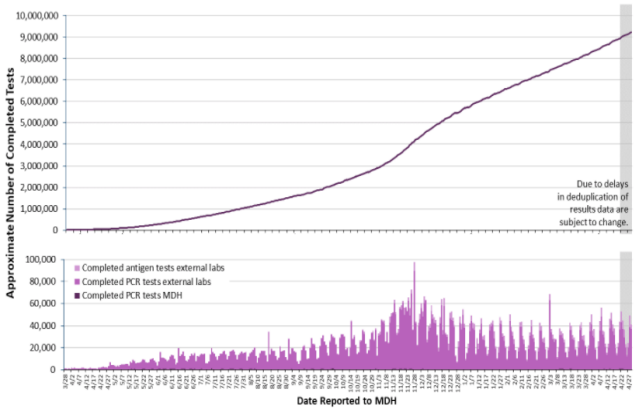


Cases by County of Residence

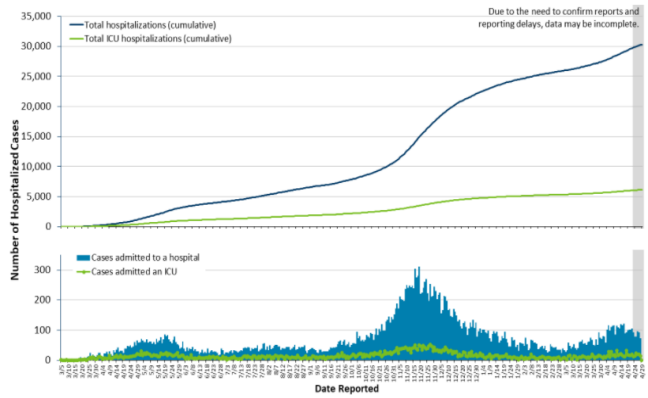
County of residence is confirmed during the case interview. At the time of this posting not all interviews have been completed.



Testing

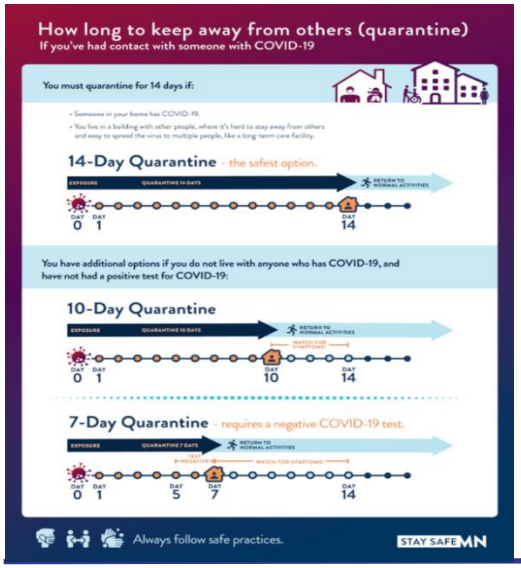


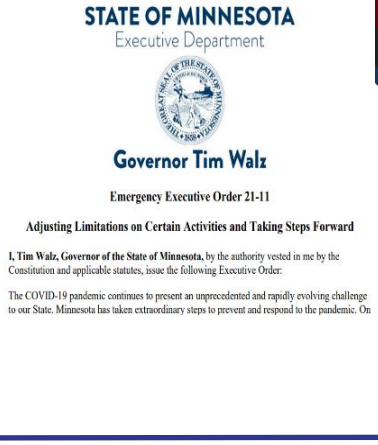
Hospitalizations



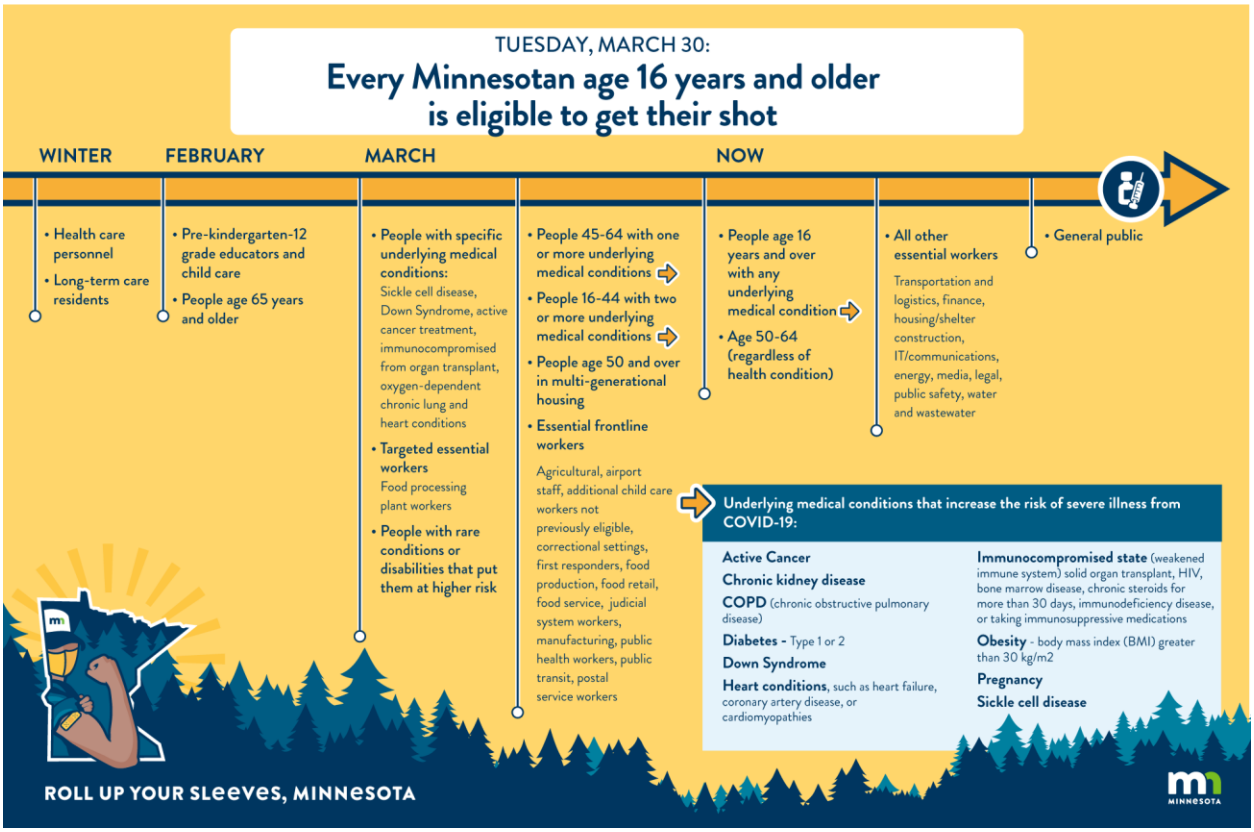
APPENDIX C: Stay Safe MN

This guidance posted on March 15th, 2021 is an illustration of current guidelines as of this report. Previous iterations of this poster showed a sequential loosening or "turning forward the dials" throughout Phase 2 culminating in what is shown here. Future loosening of restrictions is expected in the coming months as more and more Minnesotans get vaccinated and COVID – 19 cases decline.





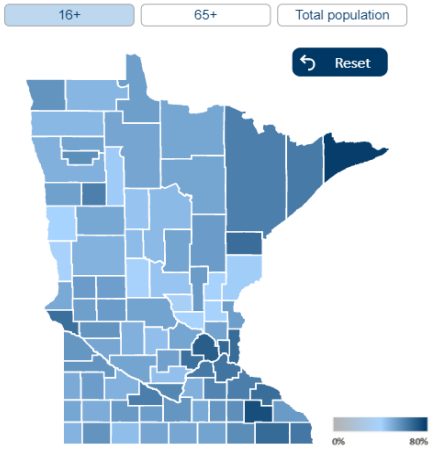
APPENDIX D: Vaccine Data and Illustrations

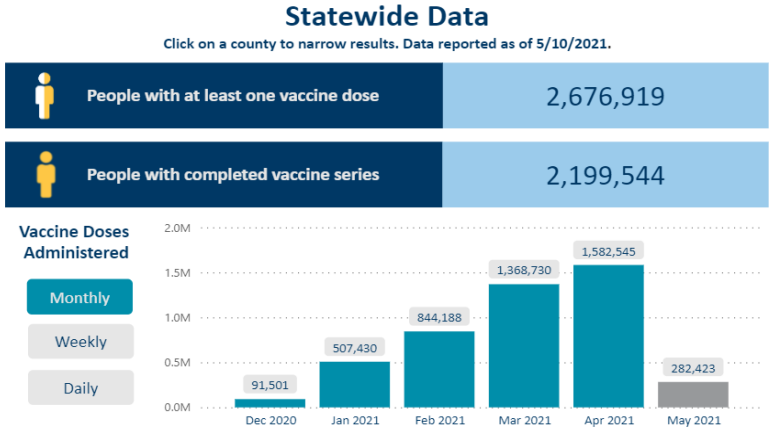


Phase 1 Subdivisions: Healthcare Workers and LTC Residents

Phase 1A - *First Priority*	Phase 1A - *Second Priority*	Phase 1A - *Third Priority*
Hospitals: All personnel working in dedicated COVID-19 units, ICU, emergency departments, designated COVID-19 urgent care clinics. (Includes, but not limited to: nurses and nursing assistants, doctors, advanced practice providers, respiratory therapists, lab/tech staff, and environmental services/maintenance staff.) **LTCF** (SNFs and nursing homes): All personnel working and residents living in these facilities. **EMS Personnel**: People providing direct patient care as part of the EMS system. This includes: Air Ambulance Pilots, Ground Ambulance Drivers, Physicians, Physician Assistants, Nurses, and those personnel certified or registered by the EMSRB: Paramedics, Advanced Emergency Medical Technicians, Emergency Medical Technicians, and Emergency Medical Responders. **COVID testers:** Personnel providing testing at large community testing centers. **COVID community vaccinators:** Public health vaccinators and those administering COVID-19 vaccine in Phase 1a.	**Hospitals:** All personnel providing direct patient services or handling infectious materials and not included in the first priority group. **LTCF** (assisted living facilities/housing with services with an arranged Home Care Provider): All personnel working in these facilities. **Urgent care settings:** All personnel providing direct patient services or handling infectious materials and not included in first priority group. **Dialysis centers:** All personnel providing direct patient services or handling infectious materials. **LTC Residents:** Residents living in Housing with services with an arranged Home Care Provider, otherwise known as Assisted Living (including veterans' homes).	**HCP:** All remaining HCP not included in the first and second priority groups that are unable to telework. This includes, but is not limited to: HCP that work in hospitals, ambulatory and outpatient settings, home health settings, emergency shelters, LTCF, dental offices, pharmacies, public health clinics, mental/behavioral health settings, correctional settings, and group homes. **LTC Residents:** Adult residents living in Intermediate Care Facilities for People with Intellectual Disabilities and other adult residents living in residential care facilities licensed in MN, primarily serving at-risk people including older adults, people with intellectual and physical disabilities, in settings such as community residential settings and adult foster care.

APPENDIX D: Vaccine Data and Illustrations con't…



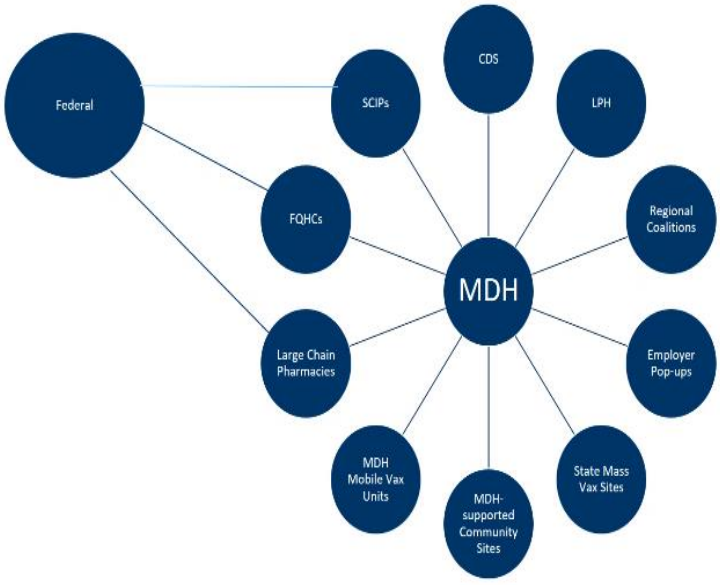


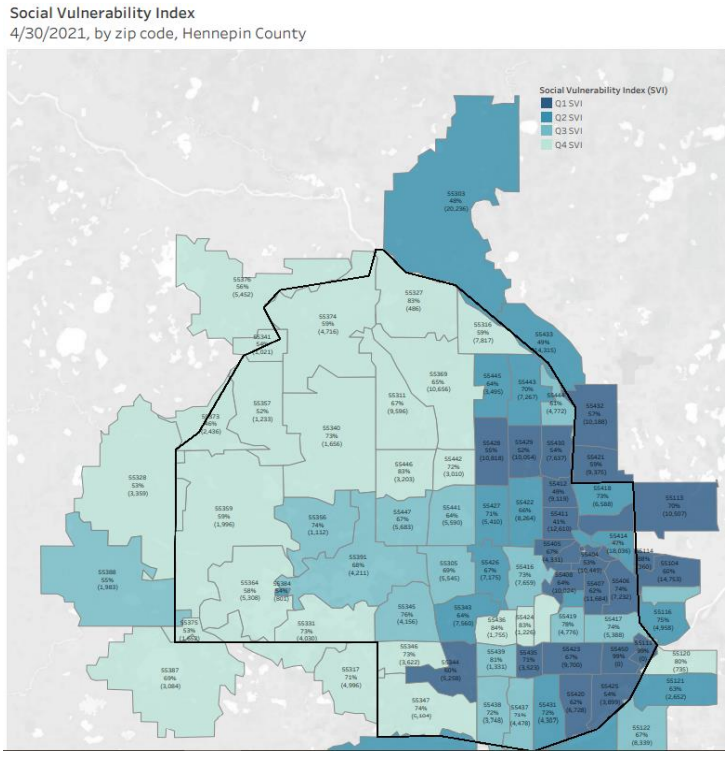
Regional percent vaccinated with at least one dose of COVID19 Vaccine for 16+ years old).
Data from 5.12.2021

Metro		
ANOKA	52.30%	16+
DAKOTA	64.40%	16+
SCOTT	63.20%	16+
WASHINGTON	66.70%	16+
RAMSEY	67.70%	16+
HENNEPIN	70.30%	16+
CARVER	65.50%	16+

Regional Averages - based upon age range selected:		
Regional Average vaccinated		Rank w/i Regions
Central	45.23%	-9.48%
Metro	64.30%	9.60%
Northeast	61.06%	6.35%
Northwest	51.38%	-3.32%
South Central	52.56%	-2.14%
Southeast	61.09%	6.39%
Southwest	52.87%	-1.84%
West Central	49.14%	-5.57%
Statewide %	54.70%	

Vaccine Distribution Chain





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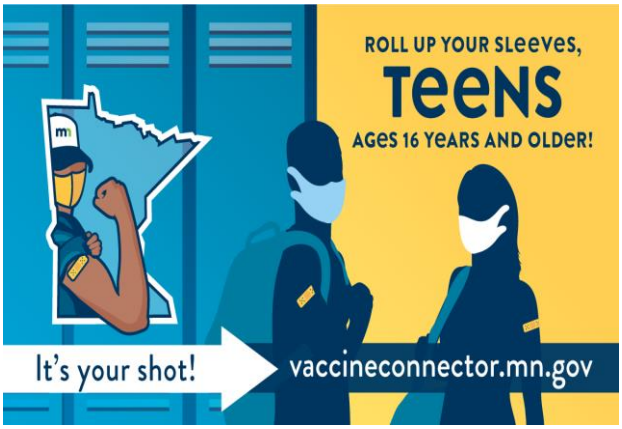
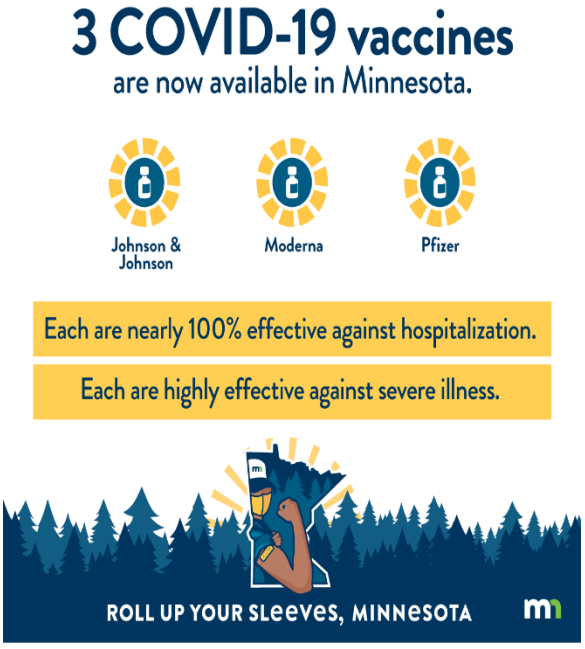
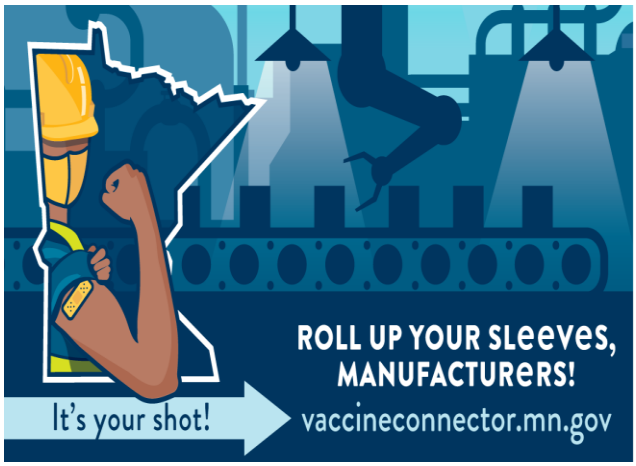
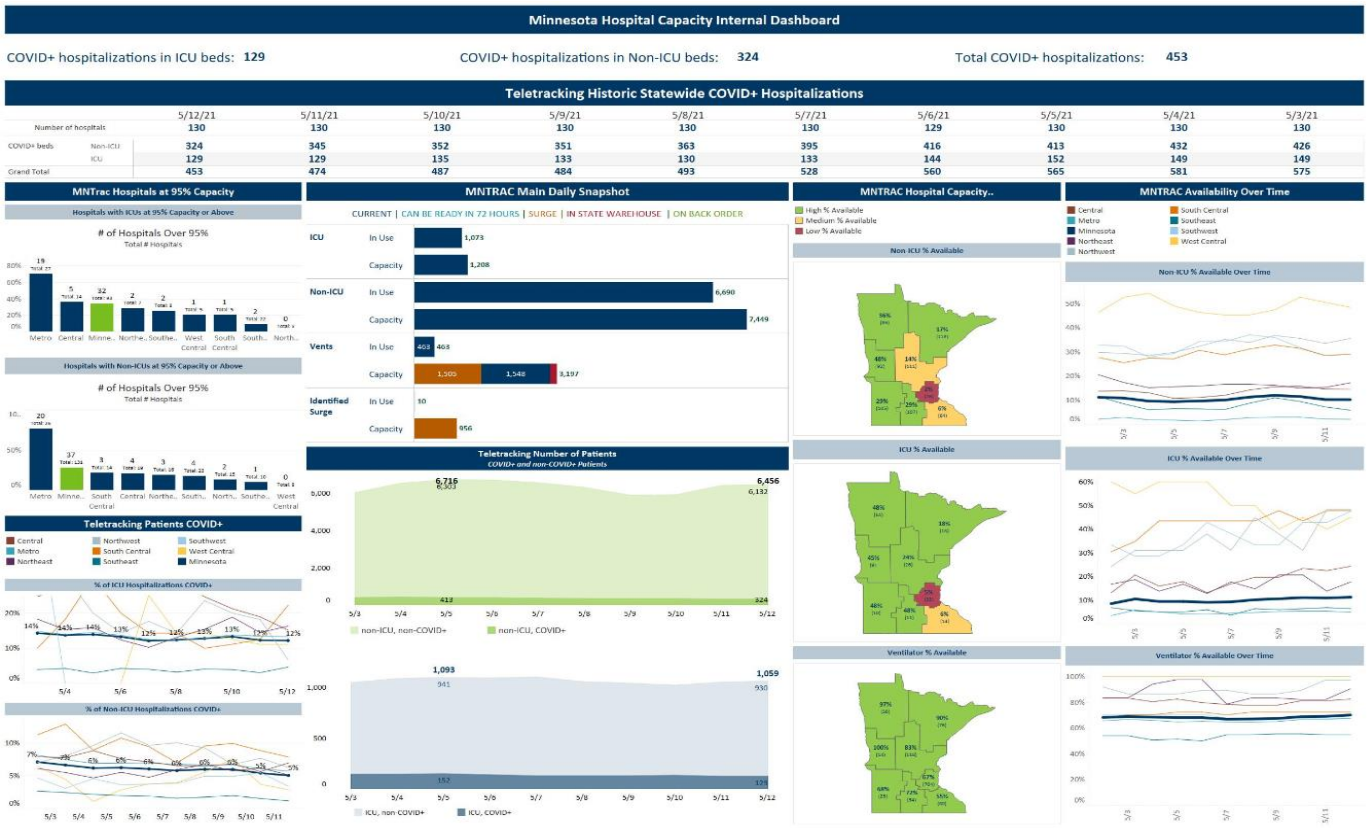
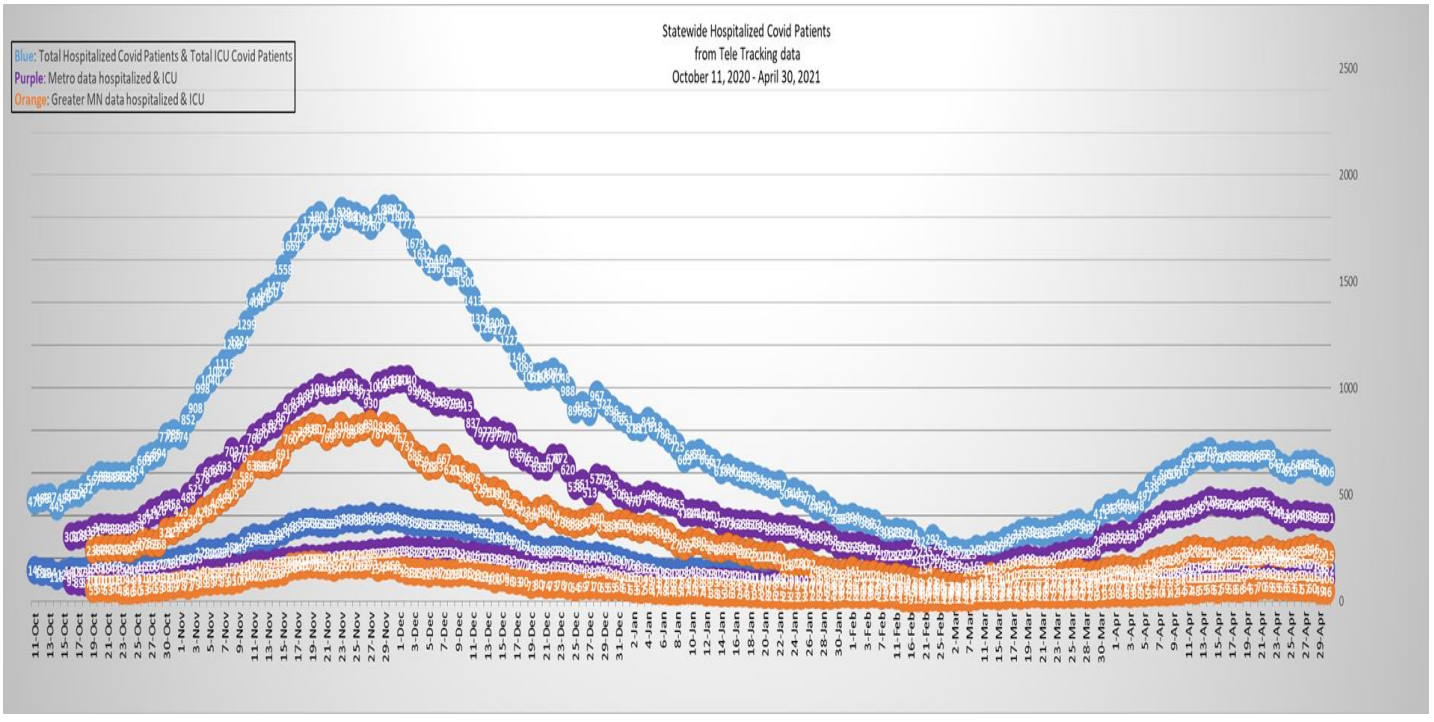






APPENDIX E: Tracking Report Examples





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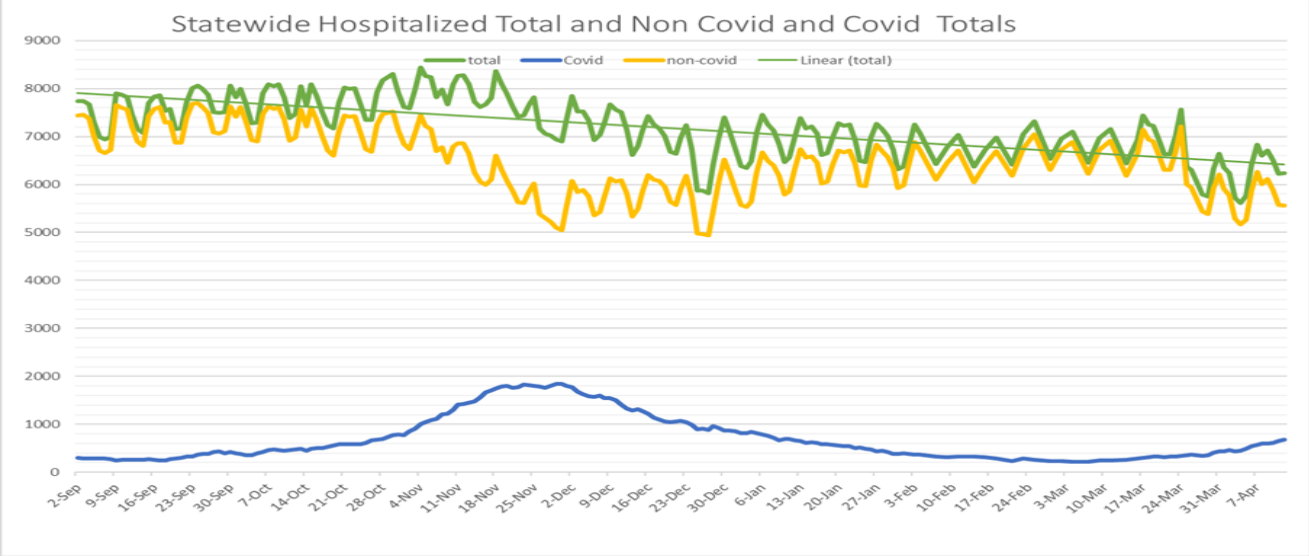
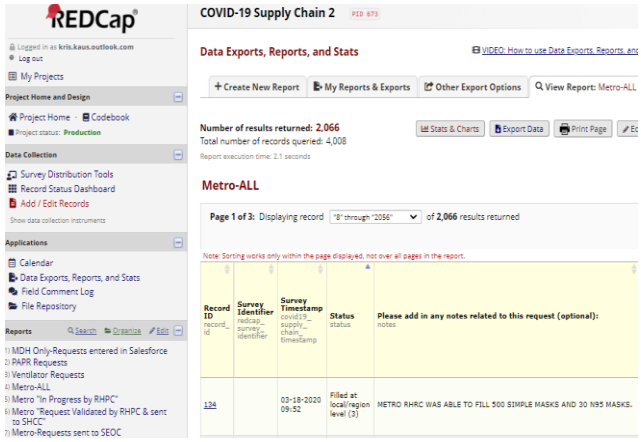
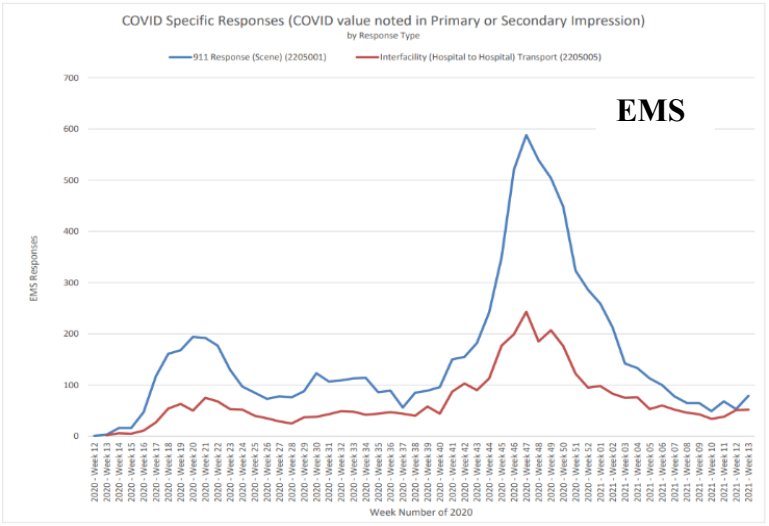
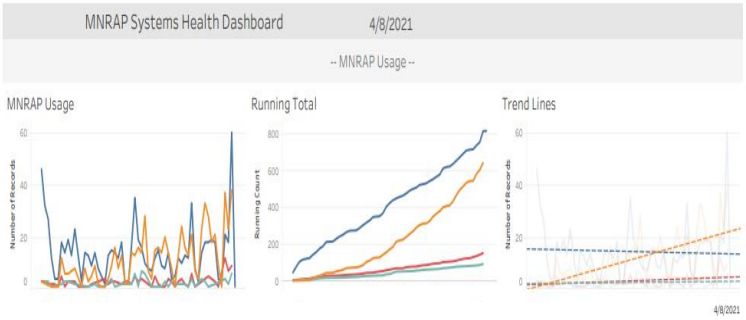


PPE requests and distribution





Total MASK Distribution	358,705				Different Metro Facilities: 225	
Facility Type	**# Face Masks**	**# N95 masks**	**Cloth**	**Gloves**	**Gowns**	**Shields**
Hospital	123,500	96,210	30,000	0	0	0
LTC/HCH/AL	96,175	4,440	0	105,500	6,675	2,100
Other	8,000	380	0	34,100	1,286	663
Totals	**227,675**	**101,030**	**30,000**	**139,600**	**7,961**	**2,763**



MNTRAC

Metro only Bed Availability by Bed TYPE

Bed Available Staffed	Bed Total	Agency Name	Agency Bed Last Modified Local Time
Bed Type: Adult Intensive Care Unit			

APPENDIX F: Acronyms

Table 1: *Acronyms*

Acronym	Meaning
AAR/IP	After Action Report / Improvement Plan
ACIP	Advisory Committee on Immunization Practices
ACS	Alternate Care Site
AL	Assisted Living
APIC	Association for Professionals in Infection Control and Epidemiology
CDC	Center for Disease Control and Prevention
CDS	Care Delivery System
COVID	Corona Virus Disease (SARS CoV – 2)
EM	Emergency Management
EMSRB	Emergency Medical Services Regulatory Board
EMS	Emergency Medical Services
FOUO	For Official Use Only
GH	Group Homes
HCC	Health Care Coalition
HCW	Health Care Worker
HPP	Healthcare Preparedness Program
HSEEP	Homeland Security Exercise and Evaluation Program
IAP	Incident Action Plan
IMT	Incident Management Team
LPH	Local Public Health
LTC	Long Term Care
MDH	Minnesota Department of Health
MHC	Metro Health & Medical Preparedness Coalition
MN	Minnesota
MRC	Medical Reserve Corps
PH	Public Health
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
SVI	Social Vulnerability Index

APPENDIX G: IMPROVEMENT PLAN

This Corrective Action/IP has been developed specifically for the Metro Health & Medical Coalition/Regional Hospital Resource Center for **PHASE 2** of the response (September 2020 – April 2021) 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. **It is noted that some gaps identified were not processes implemented at Coalition level and those items will be shared with the State level at the MDH and/or SHCC debriefs*.

Area of Improvement	Corrective Action Description	Primary Responsible Department	Point of Contact	Date Completed
1. Communication & Information Sharing	**1a)** Lacked more information related to care or practices/trends in private homes.	RHRC	Emily Moilanen	
	1b) Adding a formal liaison role between CDS and Compact/Coalitions would be beneficial.	RHRC	Chris Chell	
	1c) Strengthen planning for Hospice/Home Care.	RHRC	Emily Moilanen	
2. Coordination	**2a)** More coordination is needed from the Metro Coalition in support of smaller residential care homes, soon to be small, private Assisted Living's.	RHRC	Emily Moilanen	
	2b) Vaccine coordination needed the RHRC to convince MDH to use the coalitions to coordinate vaccine distribution. (*this was a state level decision, not coalition level*)	RHRC/MDH	Chris Chell/MDH Liaison	*Bring forward at MDH/ SHCC debrief.*
3. Supply Chain	**3a)** RedCap survey is time-intensive and kept changing what information they needed and quantities of supply to request. (*this was a state level decision, not coalition level*)	RHRC/SHCC	SHCC/MDH	*Bring forward at MDH/ SHCC debrief.*
4. Staffing	**4a)** Difficulties building a short-term need/crisis staffing plan. Need to strengthen the plan.	RHRC	Emily Moilanen	
	4b) Assess if a staffing website could be built for employees to manage during times of a staffing crisis.	RHRC/MDH	Chris Chell/MDH Liaison	

Area of Improvement	Corrective Action Description	Primary Responsible Department	Department POC	Date Completed
5. Staff Wellness	**5a)** Some facilities access to resources was different and resulted in staff being reluctant to leave the patient and/or the job for a break. Record and post brown bag series, webinars, one-pagers).	RHRC	Chris Chell	
	5b) Begin Behavioral Health/Staff Wellness discussion earlier in the event.	RHRC	Chris Chell	
6. Tools & Resources	**6a)** Conduct more MNTrac training for non-hospital facilities.	RHRC	Emily Moilanen	
	6b) Consider information type listed on Coalition Website. Having multiple sources for same information caused some resource overload (CDC, MDH, Coalition websites). Potentially narrow focus of topics on Coalition site.	RHRC	Chris Chell	
7. Vaccine	**7a)** The lines of authority grew fuzzy and in spite of careful planning, efforts felt usurped by decisions that were made at another level.	RHRC/MDH	Chris Chell/MDH Liaison	*Bring forward at MDH/ SHCC debrief.*
	7b) The development of CDS caused some disruption and communication & coordination gaps for vaccine. *(this was a state level decision, not coalition level)*	RHRC/MDH	Chris Chell/MDH Liaison	*Bring forward at MDH/ SHCC debrief.*
	7c) The separation of large hospitals vs smaller, in the Metro area (i.e., the CDS) left those in the coalition vying for limited vaccine and trying to distribute felt awkward. (*this was a state level decision, not coalition level*)	RHRC/MDH	Chris Chell/MDH Liaison	*Bring forward at MDH/ SHCC debrief.*