STATE OF NORTH DAKOTA
HOSPITAL SURGE PLAN AND
VULNERABLE POPULATION PROTECTION PLAN (VP3)
2020 COVID-19 PANDEMIC RESPONSE

The State of North Dakota (ND) will protect its citizens during the 2020 COVID-19 pandemic by minimizing loss of life and economic hardship. The State will ensure hospitals and communities have resources to handle a potential surge of COVID-19 patients. While the State does not believe the COVID-19 pandemic will create a need for additional health care facilities beyond the hospitals' expansion capacity, in the event of an extreme increase in hospitalizations, the State is well prepared. The State will also ensure there are enhanced processes and protocols to protect the population that are most vulnerable, specifically including those that live in congregate housing settings such as nursing homes, intermediate care facilities as well as jails and prisons.

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Definitions	
Minimum Care Facility (MCF)	Facility may be established to care for COVID-19 patients when regional hospital capacity and cross-regional hospital capacity is exhausted.
Congregate Living Facility	Throughout document, congregate living refers to any skilled nursing facility, assisted living facility, basic care, intermediate care facility, adult foster care home, homeless and domestic violence shelters and facilities operated by Department of corrections
Rapid Response Team	A team consisting of subject matter experts to provide consultation, resources, and assistance for COVID-19.

Abbreviations	
DOC - Department of Health Operations Center	**PHEVR - Public Health Emergency Volunteer Reserve MRC – Medical Reserve Corps**
DOH - Department of Health	**LTC - Long Term Care**
EMS - Emergency Medical Services	**NDNG - North Dakota National Guard**
HAN - Health Alert Network	**SEOC - State Emergency Operations Center**
DOCR – Department of Corrections and Rehabilitation	**WCC - Workforce Coordination Center**
AMT - Administrative Management Team	**NDIT - ND Department of Information Technology**
DHS- Department of Human Services	**DES- Department of Emergency Services**

References

- Minimum Care Facility (MCF) Concept of Operations Plan dated February 13, 2008, Department of Health
- State Emergency Operations Plan Infectious Diseases Annex dated January 6, 2010, North Dakota Department of Emergency Services

INTRODUCTION

The COVID-19 Hospital Coordination and Vulnerable Population Protection Plan provides the framework for the State of North Dakota in collaboration with hospitals, congregate living facilities, the North Dakota National Guard (NDNG), and other state and local agencies to serve the healthcare needs of citizens with COVID-19 that require hospitalization. A six-point plan identifies key actions that will guide the State, hospitals, and care facilities through a tiered system.

Six Point Plan Overview

1. Defines a tiered framework of **Tiers 1, 2A, 2B, and 3** for all hospitals to expand capacity.
2. Sorts hospitals into four **regions** with named hospitals as regional leaders. Regional hospital leaders will communicate with the State Regional Coordinator daily. The daily report will

describe how hospitals within their region are collaborating to meet staffing, supply, and equipment demands as well as alerting the State when it believes that the region should be moved to a higher tier. Unified Command will name one State Regional Coordinator from a local public health unit, the NDNG, Department of Health (DOH), Department of Human Services (DHS), etc.

3. Provides guidance for **transferring** COVID-19 suspected, negative, and positive patients between congregate living facilities and hospitals in **Tiers 1, 2A, and 2B**.
4. Utilizes the North Dakota COVID-19 **Rapid Response Team** to quickly assess, advise, and assist congregate living facilities when they have a positive patient or staff. The rapid response team would also advise the State Regional Coordinator on transfer decisions.
5. Describes how State Regional Coordinators will work **across-regions** if all hospitals within their region have met maximum capacity. Guidance for transferring patients across-regions are described in **Tier 2B.**
6. Establishes a process to provide care for COVID-19 positive patients in a regional **minimal care facility** (MCF) if all hospitals within the region reach maximum expansion capacity and cross-region transfers have been exhausted or are not recommended for the patient. MCFs are sorted into the same regions as hospitals. Guidance for transferring patients between hospitals, MCFs, and institutional facilities are described in **Tier 3**.

Core Principals

Minimize loss of life

Although the current plan focuses on factors such as bed capacity (as well as needs for staff, supplies, and equipment), all decisions will be made to ensure **minimal loss of life**.

Minimize staff movement across facilities

Unless the Hospital Regional Leader, MCF Regional Leader, and the State Regional Coordinator identify that staffing levels have depleted to the point that they need to be filled with outside staff, and there are no other options for replenishing staff from the State, **staff should stay with their original facility**.

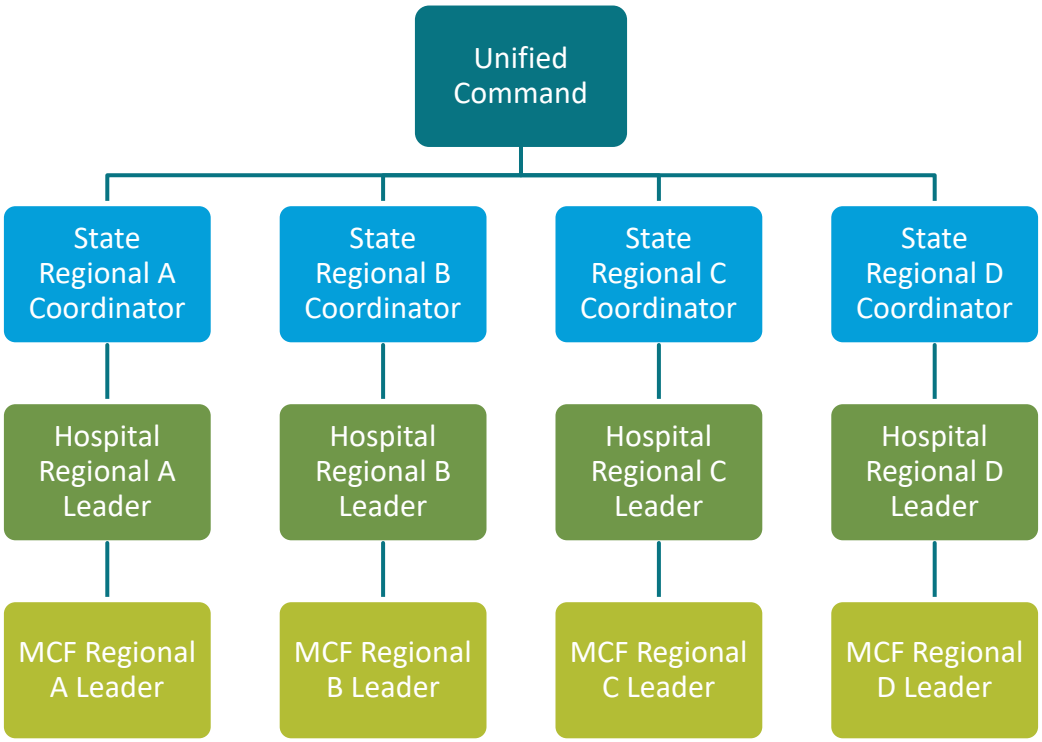
Participants

- Hospitals
- Congregate living facilities
- Emergency medical services
- City and county officials
- State agencies
- Unified Command

Leadership Organization

The leadership structure will be described and referred to throughout the current document (Figure 1).

Figure 1. Leadership Organization



Expectations

Each participating facility and hospital will be expected to:

- Have a disaster plan that considers localized staffing and patient needs, emergency services, and communication with local officials.
- Follow protocols as described in this document to the best of their ability.
- Follow Centers for Disease Control (CDC) and DOH guidance for infection control.
- Cooperate with the State in any requests for reporting the number of COVID-19 positive patients, bed capacity, etc. through an interagency-created data collection tool.
- Look to Medicare, Medicaid, commercial payers, as well as the State for guidance on reimbursement. The State is solely responsible for the financing of MCFs.

Department of Health Expectations

- Monitor daily hospital census.
- Respond in a timely manner to requests for supplies and equipment.
- Maintain a database of the State's volunteer medical personnel.
- Develop a long-term care rapid response plan.
- Along with the State Regional Coordinators, advise Unified Command on when regions should move to the next Tier level.
- Along with the State Regional Coordinators, advise Unified Command on when an Executive Order is needed to waiver Standard of Care.

- Collaborate with other agencies and local officials.

Limitations of Document

This document does not identify all day-to-day standard operating procedures used in the healthcare industry. Each hospital and congregate living facility are expected to use standard operating procedures to support this plan, or as needed, their disaster plans.

This document does not describe step down/return-to-normal operations. Those concepts and actions will be established in a separate planning process and document.

SIX POINT PLAN

POINT 1: Define a tiered framework for all hospitals to expand capacity

Table 1. Summary of Tiers

Unified Command, along with DOH, will decide when a region moves up in tiers. The decision to change tiers will be informed by the State Regional Coordinator after a review of data that is collected daily and reported to the State.	
Tier	**Summary**
Tier 1	Hospitals operate within their current capabilities in staffing beds using their resources (i.e., supplies and equipment). Standard of Care is maintained.
Tier 2A	Hospitals expand capacity with additional beds as illustrated in **Table 2. Hospital Expansion Capacity** below. If staffing is depleted to the point that standard of care cannot be met, or a hospital is approaching its expanded bed capacity; the Hospital Regional Leader will work with the State Regional Coordinator to balance demand across the region. Hospitals may strategically transfer patients to other hospitals within their region. Transfers must be coordinated through the Hospital Regional Leader and the State Regional Coordinator. Patients should <u>not</u> be transferred due to supply and equipment shortages as these should be replenished through a coordinated replacement effort with DOH. In regard to staffing, the State will act as a backup, meaning that if strategically transferring patients within the region does not alleviate staffing shortages, the State Regional Coordinator will request State supplied staff from DOH to support beds referred to as **"State Supported Beds"** in Table 2.

	Tier 2A will likely require an Executive Order for a waiver of "Standard of Care." The waiver may be applied on a regional basis. Uniform Command will make a request to the Governor's Office for an Executive Order.
Tier 2B	State Regional Coordinators work together to determine how patients can be transferred across regions if regional hospital capacity has been exceeded. Unified Command will be informed of decisions to transfer patients across-regions.
Tier 3	Regional and cross-regional hospital capacity has been exceeded. The State, in collaboration with hospitals, other state and local agencies, and other community partners, establishes a Minimum Care Facility (MCF). Standard of Care is still waived by Executive Order. Because statewide hospital care is not available, COVID-19 positive patients will be admitted at an MCF and will be cared for by State supplied medical personnel and volunteers. A named MCF Regional Leader will manage operations and report daily to the State the number of patients, bed capacity, etc. The State Regional Coordinator from Tiers 2A and 2B will work with the MCF Regional Leader. Whenever possible patients should only be transferred to the MCF in their region. Cross-regional MCF transfers should only occur if all MCF cots have been exhausted within the same region. Unified Command will be informed of any cross-regional MCF transfers.

Process for Requesting Supplies and Equipment

Supplies and equipment may be requested through DOH online application, Health Alert Network (HAN) Assets, and granted if available and approved by DOH. Orders are delivered by DOH or shipped through third party delivery services depending on urgency of the order and availability of medical cache staff. All supply priorities will be determined by the Unified Command.

Process for Addressing Staffing Demands

Prior to requesting staff for "State Supported Beds," facilities are encouraged to use their call back rosters or contact past employees to help augment staff. Facility Human Resource Departments are responsible for receiving and processing paid, or volunteer staff once recruited.

Process for Requesting State Supported Staffed Beds

The State Regional Coordinator will facilitate requests to supplement staff provided through State resources. State-provided supplemental staff may come from two sources including:

1. A database of Public Health Emergency Volunteer Reserve (PHEVR) and Medical Reserve Corps (MRC) volunteers maintained by DOH. State supplemented staff can be requested by the State Regional Coordinator contacting DOH Preparedness and Response section.

   The database includes registered volunteers in the following medical professions:

   - Physicians/Medical Doctors
   - Nurses, including RN, LPN, Advanced Practice RN, Nurse Practitioners
   - Nurse Assistants
   - Pharmacists
   - Phlebotomists
   - Emergency Medical Technicians, Paramedics, Emergency Medical Responders
   - Social Workers
   - Veterinarians

2. The Workforce Coordination Center (WCC) or the State Emergency Operations Center (SEOC) may be contacted by the State Regional Coordinator for additional qualified medical staff or skilled specific workers.

Process for Reporting Daily Data

This plan will only be useful if all participating congregate living facilities and hospitals report daily data so that patients and their needs can be tracked and managed. Congregate living facilities and hospitals will continue to report data to the Department of Emergency Services or DOH. All daily reports will be shared with the State Regional Coordinator as well as the Hospital Regional and MCF Regional Leaders.

POINT 2: Sort hospitals into regions

Hospitals have been sorted into Regions A, B, C and D. The Hospital Regional Leaders are shaded in green and other hospitals are shaded in orange (Table 2). Table 2 also shows the number of beds that would be expected to be produced across the tiers.

Table 2. Hospital Expansion Capacity

Facility Name	City	Tier 1 Beds	Tier 2A Beds	Tier 2B State Supported Beds
Region A				
Altru **Hospital Regional Leaders**	Grand Forks	158	177	199
CHI St. Alexius Health Devils Lake **Hospital Regional Leaders**	Devils Lake	25	41	41
Towner County Medical Center **	Cando	8	12	20
Pembina County Memorial Hospital*	Cavalier	23	23	38
Unity Medical Center	Grafton	14	14	28
Cavalier County Memorial Hospital Association	Langdon	10	10	60
Nelson County Health System**	McVille	6	8	18
Northwood Deaconess Health Center*	Northwood	12	12	22
First Care Health Center	Park River	14	14	50
Presentation Medical Center	Rolla	18	18	53
Region B				
Sanford (All locations Fargo) **Hospital Regional Leaders**	Fargo	452	518	589
Essentia Health Fargo **Hospital Regional Leaders**	Fargo	109	135	184
Jamestown Regional Medical Center **Hospital Regional Leaders**	Jamestown	67	67	67
CHI St. Alexius Health Carrington	Carrington	8	8	29
Cooperstown Medical Center*	Cooperstown	10	10	23
Sanford Medical Center Hillsboro*	Hillsboro	14	14	24
CHI Lisbon Health	Lisbon	25	40	60
Sanford Medical Center Mayville	Mayville	12	12	20
CHI Oakes Hospital	Oakes	25	40	62
CHI Mercy Health	Valley City	19	19	39
Region C				
Sanford Medical Center Bismarck **Hospital Regional Leaders**	Bismarck	170	200	247
CHI St. Alexius Health **Hospital Regional Leaders**	Bismarck	224	266	422
CHI St. Alexius Health Dickinson **Hospital Regional Leaders**	Dickinson	30	43	56
Ashley Medical Center *	Ashley	9	13	21
Southwest Healthcare Services*	Bowman	16	16	25
Jacobson Memorial Hospital Care Center	Elgin	30	30	33
CHI St. Alexius Health Garrison*	Garrison	26	28	28

St. Aloisius Medical Center*	Harvey	11	11	29
Sakakawea Medical Center	Hazen	15	15	25
West River Regional Medical Center**	Hettinger	20	28	36
Linton Hospital	Linton	14	14	24
CHI St. Alexius Health Turtle Lake	Turtle Lake	25	27	31
Wishek Community Hospital	Wishek	10	15	19
Region D				
Trinity Hospitals** **Hospital Regional Leaders**	Minot	179	179	330
CHI St. Alexius Health Williston **Hospital Regional Leaders**	Williston	29	33	53
St. Andrew's Health Center	Bottineau	20	20	33
St. Luke's Hospital**	Crosby	10	10	19
Kenmare Community Hospital	Kenmare	20	20	25
Heart of America Medical Center*	Rugby	8	8	37
Mountrail County Medical Center Inc*	Stanley	11	11	15
Tioga Medical Center*	Tioga	13	13	26
McKenzie County Healthcare Systems Inc*	Watford City	10	14	24
Government Owned or Specialty Hospitals				
VA Hospital	Fargo	44	59	69
Cobalt Rehabilitation Hospital Fargo LLC	Fargo	12	12	42
Vibra Hospital of Central Dakotas LLC	Mandan	23	23	24
Vibra Hospital of Fargo	Fargo	31	31	35
Indian Health Service Fort Yates	Fort Yates	12	12	23
Indian Health Service Belcourt	Belcourt	27	27	27
State Hospital				
North Dakota State Hospital	Jamestown	20	24	84
***Hospital with nursing home attached** ****Hospital with nursing home detached**	**Totals**	**2,098**	**2,394**	**3,488**

Note: For planning purposes, 50 hospitals are included. The data is from hospital survey dated March 21, 2020.

	Staffed Adult and Pediatric Beds	Staffed Adult, Pediatric and ICU Beds	Total Beds Available in 72 Hours
Tier 1	1860	238	2098
Tier 2A	2112	282	2394
Tier 2B **State Supported Beds**	3084	404	3488

POINT 3: Provides statewide guidelines for transferring COVID-19 suspected, negative, and positive patients between congregate living facilities and hospitals.

The five categories for all patients include:

Category 1: Patients who have no symptoms and were never suspected to have COVID-19.

Category 2: Patients for whom COVID-19 is suspected, but testing shows that the patient is negative. Testing should be in accordance with DOH and CDC procedures.

Category 3: Patients for whom COVID-19 is suspected, but testing is pending. Testing should have been done in accordance with DOH and CDC procedures.

Category 4: Patients who tested positive for COVID-19 but are eligible for transfer because they have not had a fever in 3 days (72 hours) without the use of fever-reducing medications, they have improved respiratory symptoms such as coughing or shortness of breath, and it has been at least 7 days since COVID-19 symptoms first appeared.[1]

Category 5: Patients who tested positive for COVID-19 and are still in active and higher-level treatment.

Hospital Transfer Plans

Please note that the plan is conditional on rapid access to tests and turnaround time for test results. Plan also acknowledges that as the State moves through the tiers that the decision making will reflect capacity in the region.

Hospitals should transfer patients according to category.

Category	Ability to Transfer?	Transfer Location	Rapid Response Team Notified?	Any difference in Tiers?
1- No COVID-19 Concerns	Not until testing is completed. Test is required. If positive, move to Category 4. If negative, move to Category 2.		No	No
2- Concern, but test was negative	Yes, using normal process	Home or Community; if they meet level of care can be	No	No

[1] Based on the Centers for Disease Control's test-based strategy for discontinuation of transmission-based precautions. www.cdc.gov/coronavirus

		transferred to long term care or ICF; if homeless contact Governor's Task Force Lead		
3- Test pending	No, cannot transfer	If possible, cohort patients in separate units, floors, or wings.	No	No
4- Positive test, but not in need of advanced treatment	Options: 1) hospital has the bed capacity but cannot keep patient because no longer medically necessary. 2) hospital does not have bed capacity and needs to discharge patient.	If option 1 or 2, patient can be discharged to: another hospital in region; Home or Community; if homeless contact Governor's Task Force. Option 1 or 2: Patient meets level of care for an LTC or congregate living facility but cannot be transferred to a facility with no other positive patients. State Regional Coordinator to find a facility with positives or send to alternative site based on regional resources and	Yes, if Option 1 or 2 is chosen AND hospital wants to discharge to long term care or ICF. This must be coordinated with the State Regional Coordinator.	As region moves up in tiers, it is more likely to run out of long-term care beds first before running out of acute care beds. This may push patients back into acute care or toward the MCF in Tier 3.

		clinical expertise. State Regional Coordinator will consult with Rapid Response Team about receiving facility capability. State Regional Coordinator works with hospital and receiving facility, to direct transfer decision.		
5- Positive and in active, higher level treatment	No, cannot transfer	NA	No	No

Staff capacity at the receiving facility will also be considered by the State Regional Coordinator.

Long Term Care Facilities and ICFs Transfer Plans

Considerable work has already been done by all long-term care facilities and ICFs to have a disaster plan in place that follows DOH protocols for infection control. The plan includes contingencies for the upcoming tiers including how they will address displacement of staff and how they will track staffing needs by discipline and hours. Facilities are expected to have a plan to quarantine patients as soon as symptoms present or they suspect COVID-19. Facilities will be expected to report daily on staff, patient, and bed capacity to the State and this data will be used by the State Regional Coordinator.

Congregate Living Facilities should transfer patients according to category.

Category	Ability to Transfer?	Transfer Location	Rapid Response Team Notified?	Any difference in Tiers?
1- No COVID-19 Concerns	No, unless medically necessary.	NA		No

2-	Concern, but test was negative	No, unless medically necessary	NA		No
3-	Test pending	No, wait until test is completed	Cohort residents in separate units, floors, or wings.	Yes	No
4-	Positive test, but not in need of advanced treatment	Options: 1) resident can stay at facility and should isolate according to CDC protocols 2) resident should be transferred because State Regional Coordinator/facility concerns about facility capacity, facility capability, resident being high risk (i.e. on ventilator/ memory cares), or resident worsens.	Rapid Response team to advise State Regional Coordinator about facility capability. State Regional Coordinator works with facility(ies) to direct transfer decision. Must heed Advanced Planning Directives as appropriate.	Yes. Any transfer must be coordinated with State Regional Coordinator.	As region moves up in tiers, it is more likely to run out of long-term care beds first before running out of acute care beds. This may push resident back into acute care or toward the MCF in Tier 3.
5-	Positive and in active, higher level treatment	Yes	Hospital as directed by State Regional Coordinator	Yes	No

Staff capacity at the receiving facility will be considered by the State Regional Coordinator. Long term care and ICFs that will transfer patients should contact the State Regional Coordinator to assist in where they should be transferred, as well as the Department of Emergency Services (DES) if they need help coordinating the transportation.

Geriatric-Psychiatric Long-Term Care Units and Residents with Head Injuries

For nursing homes that have a geriatric-psychiatric unit or residents with head injuries, the facility's plan will need to specifically address the unique nature of care requirements for this population. In order to provide proper care and the isolation necessary, these facilities will transfer any Category 4 or 5 COVID-19 patients to the State Hospital which will have a designated unit available and staffed to provide specialized care for these residents.

Justice-Involved Persons

Internally generated models of virus propagation within the ND Department of Corrections and Rehabilitation (DOCR) facilities predict that once COVID-19 cases appear in the prison system, spread throughout the facilities is inevitable, despite isolation and quarantine activities.

- At peak infection, 15-20% of the resident and staff population will be infected.
- Time to peak infection is 60-85 days from the first reported infection.
- At some point in the first 45-60 days, the number of cases will exceed the number of single rooms available for isolation, and the prison system will need to switch over to COVID-19 wards to care for sick residents.

Key Strategies

All jail and prison cells across the state should be viewed as pooled corrections assets, with usage to be coordinated to decrease risk and rate of infection of all justice-involved persons who are currently detained or incarcerated. Understanding that moving residents between facilities cannot improve this situation but will only hasten spread of the disease, facility staff will avoid intersystem (jail and prison) transfer of justice-involved persons during this critical time in order to decrease spread of infection within jails and prisons, and within the state. This is the most effective way to protect the health of justice involved individuals in both the jails and the prisons and will safeguard the health of individuals in the community as well.

Key Strategies to slow and control the rate of infection include:

- Decrease the number of residents housed in each facility in order to decrease the number of daily contacts with staff and with each other, leading to a lower exposure rate to the illness.
- Decrease the occupancy rate across all facilities to free up single rooms that can be used for housing, quarantine, and isolation.
- Keep movement between units in each facility and between facilities to a minimum to prevent the spread of the illness within and between facilities.
- Take positive action to equalize the occupancy rate across all facilities (jails and prisons) in order to decrease risk to residents at each facility.
- As occupancy rate decreases in each facility, spread out residents to minimize the proportion of individuals in shared accommodations.
- Avoid moving residents to facilities that have higher rates of individuals in accommodations other than single cells.
- Avoid moving individuals from facilities with lower occupancy rates and less crowding to facilities with higher occupancy rates and increased crowding.

POINT 4: Utilize the North Dakota COVID-19 Rapid Response Team to control outbreaks and advise on transferring some patients.

The purpose of a rapid response team is to quickly assess, advise, and assist. After long term care or ICF reports a positive test to DOH, the team is notified. Using information learned about the patient and the facility, the team should work with the facility to mitigate risk. As part of this plan, it is envisioned that the State Regional Coordinator will know and be in contact with the rapid response team if there is a positive patient(s) at a long-term care or ICF. While the rapid response team will come in and immediately address infection control, the State Regional Coordinator will be involved in decisions to transfer patients. Finally, the State

Regional Coordinator will work with the rapid response team to understand the risk associated with transferring patients even when there is not an outbreak of positive patients.

Hospitals that wish to transfer Category 4 patients to a long-term care or ICFs should be approved to do so with the consultation of the rapid response team. When positive patients are identified in a long-term care of ICF, the rapid response team should also be consulted on if they should be transferred, and if so, where.

POINT 5: State Regional Coordinators will work across regions to transfer patients if all hospitals within their region have met maximum expansion capacity.

In Tier 2B**,** State Regional Coordinators should work with each other to determine how patients can be transferred across regions if regional hospital capacity has been exceeded. At this point it is expected that any transfers will move patients from their original region to a hospital in a receiving region. Across-region transfers should not be made to move patients from a hospital to an MCF at this point, or to another facility such as long-term care or ICF. The State Regional Coordinator from the originating region will be responsible for making the request to the receiving region. If the request is granted, the original region is responsible for coordinating transportation but can reach out to DES for assistance. Unified Command will be informed of decisions to transfer patients across-regions.

POINT 6: Establish MCF processes and expectations, sort into regions, and describe the role of the MCF Regional Leader.

Tier 3 will be activated if regions have: 1) reached their own maximum level of capacity expansion and 2) across-region hospital expansion has also been exhausted. In Tier 3, DOH will increase statewide capacity to an additional 4,000 beds in MCFs. Unified Command will declare that the region is now in Tier 3 and that MCFs should be used. However, it is not expected that all regions will move to Tier 3 at the same time. MCFs should be expected to receive patients within 48 hours. MCFs will be led by a medical oversight team assigned by the Regional Lead Hospital. The North Dakota National Guard (NDNG) will establish the Administrative Management Team (AMT) at each MCF and name an MCF Regional Leader. Equipment and supplies will be provided by DOH. Staffing will be supplied by volunteers and State supplied medical personnel. A staffing ratio of 1:25 is desirable.

A MCF is not an alternate hospital, it is a facility that is set up and organized to handle: 1) COVID-19 positive patients who need hospital admission (Category 5), but based on hospital capacity and triage priorities, that level of care is not yet available or 2) COIVD positive patients for whom transmission-based precautions have been discontinued but cannot yet be transferred to another facility (Category 4).

Regional Hospital Leaders will provide medical guidance to the MCF. As patients present at a hospital for COVID-19 suspicion or having a positive test, the hospital will be responsible for triage. Triage is a medical decision that will occur at the hospital or an alternate triage location

determined by the hospital. The hospital triage process will assess severity of illness and COVID-19 status. If beds are available at the hospital, within the region, or across-regions patients should not be sent to an MCF. Likewise, a long-term care or ICF may wish to send Category 4 or 5 patients to an MCF if no acute care hospital beds are available. Transferring a patient to an MCF must be approved and coordinated by the State Regional Coordinator and MCF Regional Leader.

The MCF Regional Leader is responsible for the management of operations, daily reporting requirements to the State, as well as coordinating transfers. As hospital beds become available in the region, and even across-regions, MCF patients should be transferred. This transfer should be coordinated by the State Regional Coordinator working with both the MCF and Hospital Regional Leaders. It is expected that patients will be transferred back and forth between the hospitals and MCF based on agreement with the State Regional Coordinator, the Hospital Regional Leaders and the MCF leader. Medical professionals at the regional lead hospitals may be consulted as needed.

MCFs may also house patients from Category 4 if there are no other options for them to be transferred. They should not be sent to long term care or intermediate care facilities until they are: 1) 14 days from symptoms first appearing, 2) have not had a fever for the last 7 days without the use of fever-reducing medications, and 3) have significant improvement in respiratory symptoms. Once these three requirements are met, and they meet the level of care requirements for a long-term care facility or ICF, the MCF should coordinate the transfer. The MCF Regional Leader should have up to date contact information from long term care and intermediate care facilities in their region.

MCFs may include patients ranging from non-acute or acute. MCF patients may need oxygen, or ventilation but because of non-availability may have to rely on alternative methods of oxygenation such as continuous positive air pressure (CPAP) or less complex travel ventilators. These treatment options will only be used in an MCF if they are available and appropriate staff, such as respiratory therapists, paramedics or nurses, are available to manage them. MCFs will not provide resuscitation if a patient stops breathing or their heart stops.

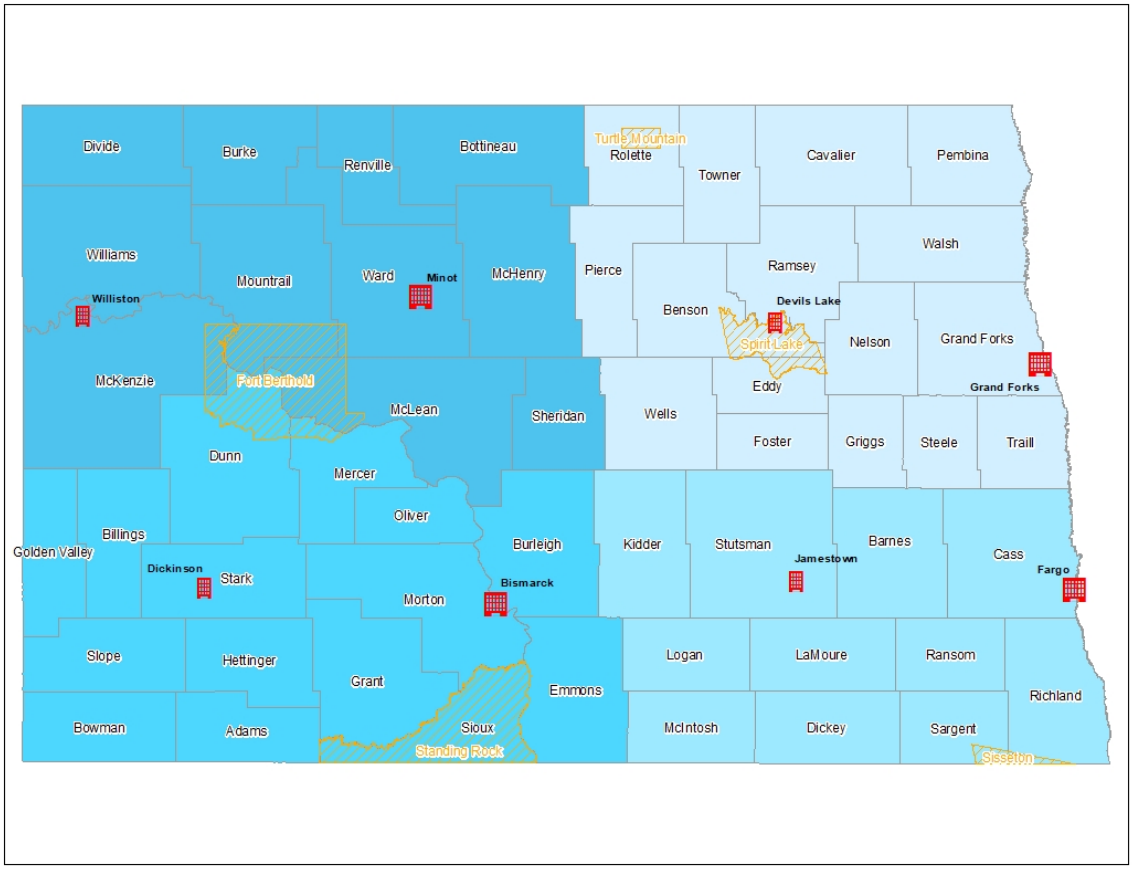
It is not expected that patients will be transferred to an MCF outside of their region; however, the State Regional Coordinator will determine if transfers are needed and will report those to Unified Command.

Table 3. MCFs by Region and Lead Hospitals

Region	Community	Facility Name	Facility Location	Regional Hospital Leader
A	Grand Forks	University of North Dakota, Wellness Center	801 Princeton St	Altru Health System
A	Devils Lake	Lake Region State College, Gym	1801 College Dr. N	Altru Health System
B	Fargo	FargoDome	1800 N University Dr	Sanford Health Fargo
B	Jamestown	University of Jamestown Newman Center/Larson Ctr	1004 7th St. NE	Sanford Health Fargo

C	Bismarck	University of Mary	7500 University Dr	Sanford Health Bismarck
C	Dickinson	Dickinson State University, Weinbergen Gym	1104 2nd St. West	Sanford Health Bismarck
D	Minot	Minot State University, Dome	500 University Ave	Trinity Health
D	Williston	Williston State College, Thomas Witt Leach Complex (The Well)	1410 University Ave	Trinity Health

Figure 2. MCFs Locations by Region



MCF Setup

Any MCF across the four regions in North Dakota is the responsibility of DOH who may mobilize the PHEVR/MRC, contract for services, or request resources from the SEOC. DOH will monitor hospital expansion capacity and make the determination when the regional MCF will be opened. If needed, initial operating capability will be established in Bismarck and Fargo each site with 200 beds.

All supplies and equipment including Personal Protection Equipment (PPE) such as masks, gowns, and gloves will be provided by DOH to workers and volunteers. Equipment needed on

site, but not available from the State's medical cache will be coordinated by the Administrative Management Team (AMT) working with local partners and the SEOC.

Security of equipment and supplies will be coordinated by NDNG AMT.

Medical Oversight

Each Tier 3 MCF will have a medical oversight team provided by hospital staff from the Lead Hospital in the city where the MCF is located. The team may include a physician, advanced practice nurse, registered nurse, or other medical professional.

Health care volunteers with various qualifications can be recruited and assigned to the MCF by the WCC.

Administrative Management

Each Tier 3 MCF will have an AMT provided by skilled volunteers or NDNG soldiers missioned to support the center. The teams will consist of twelve (12) to twenty-five (25) staff with an NDNG officer in charge to handle twenty-four (24) hour operations. This team will keep the MCF open and running until no longer needed or its function is consolidated with other facilities.

The AMT will consist of the following positions at a minimum:

- Officer in Charge
- Liaison Officer
- Administrative Support/Clerical staff (2)
- Operations Chief
    - Triage and Patient Care Unit Leader
- Logistics Chief
    - Food and Feeding Unit Leader
    - Transportation Unit Leader
- IT Officer
- Safety and Security Officer
- General support staff (1-10)

MCFs that need to expand to handle additional personnel on site can expand the AMT as required. Offsite expansion will require assigning a new AMT. Each team will be able to contact the Department of Health Operations Center (DOC) and SEOC for support, supplies and equipment as needed.

Patient documentation will be on paper, will be minimal and consist of patient identification; general physical condition; description of patient care activities and interventions taken. A copy of the patient record will be sent with the patient if they are transferred to a hospital, long term care facility, or home. The original documents generated at the MCF will be the property of DOH and will be their responsibility to determine disposition of the records in accordance with their records policies.

Minimum care facilities are closed facilities. No visitors will be allowed, due to the contagious nature of the illness. Family members will have the option of volunteering as facility staff and may be assigned to help care for additional patients.

Volunteers

The largest workgroup at each MCF will be the volunteer care providers. Personal care staff may consist of professionals if available; however, are more likely to be community volunteers, or family members, with little to no health or medical experience. The expected care provider-to-patient ratio will vary based on illness severity and on volunteer response.

Volunteers and family members providing care will be provided PPE.

Just-in-time training will be provided by local or state public health officials on infection control measures, use of personal protective equipment, safety in delivery of personal cares, administration of fluids and nutrition, and maintenance of oxygen or simple mechanical ventilation, if available.

Volunteers will be rostered as volunteers and supported like employees including food service. They will be assumed to be at increased risk for direct contact or community spread and will be housed in dormitories or hotels for the duration of their service.

Upon completion of service in the MCF, volunteers may be required to remain in home quarantine for a period of 14 days or test negative for COVID-19, depending upon the status of the pandemic and availability of testing at that time.

The AMT is responsible for all aspects of volunteer management except for providing medical advice which is the function of medical oversight personnel.

Supplies and Services

All supplies are the responsibility of DOH.

Services provided include:

- **Food service** will be provided by the University in the Region and will draw upon on-campus food service operations to provide meals to the MCF. Nutritional guidance will be provided by DOH. A continental breakfast, lunch, and dinner will be provided daily. The AMT will provide a meal count daily based on patients, workers, and volunteers at the MCF. A meal pickup and delivery system will be established to avoid cross-contamination of workers.
- **Janitorial service** will be organized among the volunteers and AMT in support of each MCF. Supplies for services will be coordinated by the AMT. Surfaces will be cleaned twice daily with a hospital approved quaternary cleaner allowing adequate dry times according to manufacturer recommendations. Shared patient care items (such as basins, commodes, etc.) will be cleaned by patient care staff with a disinfectant solution between patients. Small items such as stethoscopes or thermometers can be cleaned with alcohol wipes between patients.

- **Medical waste service** will be provided through the Lead Hospital. Medical waste, contaminated with body fluids, will be collected in red garbage bags. Red garbage bags and sharp object containers will be segregated for pickup by the Lead Hospital and integrated into their current process for incineration, whether managed internally or through contract. Non-medical waste, such as paper waste and patient care items not containing body fluids, is bagged and disposed of through normal garbage collection services at the MCF.
- **Other services** including maintenance will be contracted by the SEOC. Need for service is communicated by the MCF Liaison Officer to the Medical Branch Director who moves the request through the proper chain of communication. Maintenance on facility-installed equipment will be coordinated with the university's site facility manager. No replacements or alterations of existing equipment is authorized without selected site facility manager and SEOC approval.

Security and Emergency Response at MCF

The AMT can establish security at MCF using NDNG personnel if determined to be necessary.

In the absence of full-time security, the 911 System will be used to dispatch law enforcement response as needed.

Emergency response for emergent medical events experienced by staff or volunteers will be provided by the local EMS. Call 911 to initiate EMS response.

Communications

The AMT will communicate needs and status reports to the State Unified Command Medical Branch Director or Operations Section Chief (currently includes Department of Emergency Services and DOH staff as co-section chiefs).

The AMT will provide daily status updates to the SEOC including the number of patients, number of admissions, number of transfers to the hospital, number of discharges, number of deaths, and status of supplies on hand at the MCF.

Technology includes:

- ND Department of Information Technology (NDIT) will assign support staff to establish internet access at the facility and remain available on site to assure on-going connectivity to hospitals, local agencies, and state agencies.
- Software applications for documentation of patient care are not feasible for use in MCF. Critical data will be shared with the unified command system through paper forms or excel spread sheets that can be scanned, emailed, or posted to WebEOC.
- Limited land lines and internet access will be available at each MCF. NDIT will expand services as identified by AMT and Medical Team.
- Radios, computers, and other hardware required by facilities will be support by SEOC or DOC.

- Staff and volunteers will respect patient privacy and Health Insurance Portability and Accountability Act (HIPAA) laws. Cell phone use will be restricted to staff and volunteer break areas. No photography will be allowed in the patient care areas.
- AMT and volunteers are not authorized to provide information, comment, or interview to the media. All media requests should be referred to the Joint Information Center (JIC).

Patient Death

- If an employee or volunteer believes a patient has died, the medical director for the MCF must notify the medical director of the lead hospital. Death must be pronounced by a physician, or county coroner.
- The MCF will have a designated area away from patient care to hold bodies of the deceased until funeral home staff or a mortuary can pick up the body. The deceased's personal belongings remain with the body.
- The Medical Director or AMT Officer in Charge will notify the next of kin or point of contact for the deceased to inform them of death.

Rapid Response Team for COVID-19 Pandemic: Long-term Care and Congregate Living Facilities

Background

Congregate living facilities, including nursing homes and intermediate care facilities, are currently preparing to manage COVID-19 positive patients and some have already encountered this situation. Given their congregate nature and vulnerable population served (e.g., older adults often with underlying chronic medical conditions), these populations are at the highest risk of being infected by COVID-19. If infected with COVID-19, residents are at increased risk of serious illness. Intermediate care facilities and other facilities are also at greater risk due to their congregate nature.

The State of North Dakota will protect its citizens during the COVID-19 pandemic by minimizing loss of life and economic hardship. The State will ensure that long-term care and congregate care facilities have resources to handle an onset, or potential increase, of COVID-19 patients. The State is organizing regional based rapid response teams to assist facilities in their preparation and response to COVID-19.

Approach

Use rapid response teams to work with long-term care and congregate living facilities to provide consultation, resources, and assistance for COVID-19. The rapid response teams will follow the same regional leadership organization structure outlined above. The rapid response team reports to the State Regional Coordinator.

Rapid Response Team Composition

The State Rapid Response team members consists of the following representatives:

- State Lead: State Regional Coordinator
- Site Lead: Representative from DOH Division of Health Facilities
- Support: As needed and determined by Site Lead in consultation with State Lead
    - Representative from DOH Division of Emergency Preparedness and Response
    - Representative from DOH Division of Emergency Medical Systems
    - Representative from DOH Division of Disease Control epidemiologist
    - Representative from DOH Division of Disease Control infection control
    - Representative from Medical Reserve Corp

The tribal members may be invited to participate or be informed. These members may consist of the following:

- Representative(s) from tribal leadership
- Representative(s) from COVID-19 Task Force/Incident Command (if applicable)
- Representative from tribal health facility public health nursing
- Representative from tribal health facility medical team
- Representative from tribal infection control

Rapid Response Teams Overview

- Defines a tiered framework of Tiers 1, 2A, 2B, and 3 so that the State can intensify its response as long-term care and congregate facilities need more assistance.
- Sorts the State into four regions: Northeast, Southeast, Northwest, and Southwest.
- Provides education, training, and infection control assessment and assistance as appropriate.

Summary of Tiers

Tier	Summary
Tier 1	All of the following criteria must be met: • No known COVID-19 infections in facility staff or residents. • Facility has not had issues with infection control in the most recent two years, as demonstrated by NDDOH survey results. • No COVID-19 complaints to the State about the facility.
Tier 2A	Both of the following criteria must be met: • No known COVID-19 infections in facility staff or residents. • The State has received a COVID-19 related complaint about the facility **OR** the facility has had previous issues with infection control as demonstrated by DOH survey results from the most recent two years.
Tier 2B	• One or more positive cases of COVID-19 in facility staff or residents.
Tier 3	• Five or more positive cases of COVID-19 in facility staff or residents.

State Rapid Response Proposed Actions by Tier

Tier	State Response Plan
Tier 1	Rapid response team to meet with facility team to ensure the facility has the knowledge and resources it needs to: 1. Prevent COVID-19 from entering the facility 2. Identify infections early 3. Prevent spread 4. Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply 5. Identify and manage serious illness If requested by the facility, the rapid response team will go onsite to the facility to meet with the facility team. Facilitate supplies, equipment, and testing materials that are needed as appropriate through DOH.
Tier 2A	Rapid response team to meet with facility team initially by videoconference to gather information and plan for an onsite visit. Onsite visit if necessary
Tier 2B	Rapid response team to meet with facility team initially by videoconference to gather information and plan for an onsite visit. Onsite visit to be conducted if resident is positive and stays in facility - must occur within two days.
Tier 3	Rapid response team to meet with facility team initially by videoconference to gather information and plan for an onsite visit. Onsite visit to be conducted within two days of videoconference.

Content of Rapid Response Team Training/Information for Facilities

1. Testing
2. Supplies including PPE
3. Transfers to and from long-term care facilities
4. Staff training
5. Special considerations for facilities with memory care units

Request for Rapid Response Team

The State or the individual facility can request rapid response assistance or investigation.

Communication Plan

Once the rapid response team's plan for the facility is finalized, all facilities will be contacted by their State Regional Coordinator within 24 hours. The plan will be shared with facility administrators, and tribal leadership where appropriate, and they will be notified of the tiered response that has been assigned. The facility will be offered consultation and technical assistance based on the tier ranking.

The State Regional Coordinator will inform Unified Command of all plans, follow up activities, and COVID-19-related outcomes.

Ancillary Support for Facilities

COVID-19 is a stressful situation for staff and residents. The North Dakota Department of Human Services has resources to help employees, residents, and community members take care of their behavioral health during this time. A toolkit of resources is located at: behavioralhealth.nd.gov.

STATE OF NORTH DAKOTA TIER 3 SUPPORT

DOH

- Lead Tier 3 MCF set up.
- Provide or coordinate for all equipment and supplies needed.
- Coordinate medical oversight team with lead hospital.
- Coordinate with each MCF support hospital to assure a medical triage process is established.
- Arrange for disposal of medical waste.
- Train AMT to complete tracking and patient forms.

NDNG

- Assign AMT to each MCF.
- Manage the services and support contracts needed to sustain facility operations including meals, maintenance, janitorial, security, and patient tracking.

NDIT

- Assess the connectivity of MCF and ensure adequate phone lines, cell reception, and internet connections are available for facility.
- Assign a person to the AMT for sustaining connectivity.

NDUS

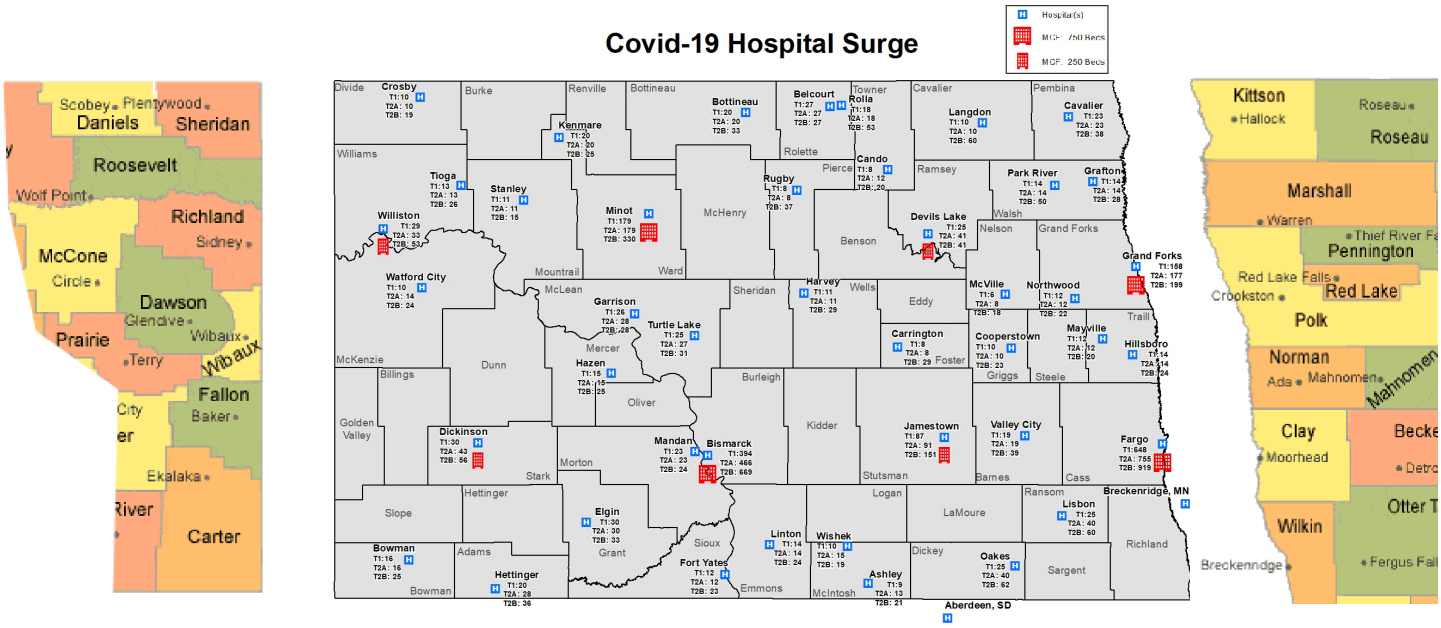
- Coordinate campus support for MCF to include housing for those assigned to work or volunteer at the MCF.
- Coordinate food service support at MCFs.
- Coordinate a cost accounting process for all services provided by campuses.

SEOC

- Set up WebEOC access for each MCF.
- Train AMT member to submit reports and logistics requests.

This 2020 COVID-19 Hospital Coordination and Vulnerable Population Protection Plan is well defined and coordinates the many entities and actions that would be required if COVID-19 patients exceed hospital expansion capacity. The State of North Dakota does not expect to see a surge in COVID-19 patients that would trigger Tier 3 and the establishment of an MCF, but we are prepared.
Any questions about this plan should be directed to the ND Department of Human Services.

SUPPLEMENTAL INFORMATION



This Plan supports nonresident inflows to the state's hospitals and resident outflows to regional medical facilities in bordering states. While the populations in these counties are known, hospitals know best what their service areas might add to their capacity needs and will adjust.