Lessons Learned

1. **Darcy Golliher: Timeline, AAR, What Went Well & What Needs Improvement**
    a. Print out stickers for employee badges with the size and type of mask they were fit tested for
    b. Changes occurred daily, so an internal COVID portal was developed, which also recorded a daily COVID call for all employees
    c. Tornado plan needed to be revised for social distancing
    d. ICU rooms converted to double occupancy when the original plan was for COVID patients to be on ventilators. Med surge rooms converted to "ICU" rooms when it was realized that putting patients on ventilators was not the best option
    e. Cross train more staff to work in ICU
    f. Telehealth and PPE management will continue Post-COVID

2. **Theresa Reiss: Deployment of Staff in Alternate Roles**
    a. Have a very organized person manage your staff re-deployment
    b. Maintain relationships within your region, even with those considered competitors

3. **Dave Reddick: Team of Remote Contact Tracers**
    a. Remote contact tracing takes the pressure off of local health departments
    b. Public Health Graduate students are a great option for remote contact tracing
        i. They get experience in the field, paid hourly and can earn school credit in some cases

4. **Pat Frost: COVID-19 Operational Response**
    a. Children are always disproportionally impacted in disasters. In COVID, this is being seen in vaccination rates, childcare, mental health, and more
    b. Child disaster readiness is whole community readiness
    c. For every child admitted to a PICU with COVID-19, it is estimated there are 2,381 children in the community who are

d. infected that you do not know about *this projection is based on projections associated with what is known about COVID as of 7/8/2020*

5. **Steve Ikuta: LOX (Liquid Oxygen) System – Do You Have a Backup?**
    a. Assess current LOX system capacity and capability
    b. Conduct an eyes on assessment routine
    c. Develop de-icing strategy and establish a trigger point to commence de-icing
    d. Develop a backup LOX system, if possible

6. **Paul Mikita: Adapting Mass Casualty Triage Algorithm and Process to Pandemic Response**
    a. Response plans, even if not specific to a particular incident type, can be used in combination to develop an incident-specific response "on the fly" with limited operational interruption
    b. Education and training allow for the application of learned concepts outside of original intentions
    c. Identification of units to cohort COVID positive and PUI patients aids in management of critical resources
    d. Identification of COVID units based on potential future state makes expansion of operations at the height of response easier (I.e. select "non-ICU" units that have the infrastructure to expand to ICU care if needed)
    e. At the height of the response, they were experiencing a ratio of approximately 4 non-ICU patients to 1 ICU patient

7. **Rachel Lookadoo: COVID-19 Tracking Dashboard**
    a. Use all the data available to you to prepare (Social Vulnerability Index, emPOWER data, etc.)
    b. Be aware of all the resources available in your community
    c. Use existing dashboards in your region to plan for potential surges or peak events
    d. Future applications: applying the dashboard to other emergency situations or other regions
    e. Link to the dashboard: https://arcg.is/0r4bXe

Discussion Summary

Communication

Strategies used for communication:

- Team huddles
- Briefings
- When information changed hourly, one infection prevention team worked with leadership taking in that information as a team and make decisions based on CDC, QHO, and local health departments for that day and the next day. Not pushing out multiple items of information per day. So at most doing daily changes, but not more than that. Triaged information to determine who needed what and let directors and managers give the information to those who needed it when they needed it

Mental Health

- We are awfully tough on ourselves expecting to be prepared for everything. Even the best prepared organization and countries are struggling with this. Even if they have better outbreak stats – this has not been an easy ride.
- What is working well?
- One hospital system in created a compassionate care training module for all staff, and have a wellness program with the mental health aspect for the protracted prolonged response to COVID-19. The training module basically goes over how to deal with patients on ventilators and keeps them in check as far as how do you treat the patients and patients' families compassionately.
- Some directors have demanded that employees take 3-4 days off to stop them from overworking themselves, taking away email access and everything.
- One organization gave all employees 80 hours of "Resiliency Time" from March to May. Some of the hardest impacted units are allowed to use it up until July 11. Twice per week they also held resilience lounges at 7am and 4pm where staff could talk to a mental health professional. They did a lot of meditations and breathing exercises, different people that had different practices to deal with stress. All by zoom, skype, or Microsoft teams. Pastoral Care and Social workers would run these on Tuesdays and Thursdays
- One organization enlisted the chaplain service early on to set up what they felt was appropriate for the staff. They rounded on staff, staff could request them to come for end of life decisions where family may not be present. Virtual sessions offered for groups, to talk, memorialize patients, etc. Still waiting to hear back on the pros and cons of that. Played a song every time a COVID-19 patient was discharged so staff heard more than just the cardiac arrests and deaths and such. Staff are very happy when that song goes off
- Staff in some places are dying. They let them grieve in their own way, replaced some staff that weren't dealing with it well.

- Nursing education group for clinical staff sends out surveys to staff to keep a pulse on how staff are doing and adjusting in general

Needs

- Post-vention for staff when COVID-19 is done and healthcare workers have time to think again
- There are programs staff are able to reach out to, but few programs designed to reach out to staff.
- Mitchell Model – designed specifically for healthcare workers in the hospital setting, but no one has really heard of it or done it. It's meant to process stress, not just debrief after an incident, but a safe place to process feelings, the events, missing pieces, in order to reduce the stress and burnout of staff.