COVID-19 Healthcare Planning Checklist

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Planning for a potential emerging infectious disease pandemic, like COVID-19, is critical to protecting the health and welfare of our nation. To assist state, local, tribal, and territorial partners in their planning efforts, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response has developed the following checklist. It identifies specific activities your jurisdiction can do now to prepare for, respond to, and be resilient in the face of COVID-19. Many of the activities in this checklist are specific for COVID-19, however many, pertain to any public health emergency.

This checklist is adapted from a variety of HHS Pandemic Influenza Pandemic Planning resources. It is not intended to set forth mandatory requirements by the Federal government. Each jurisdiction should determine for itself whether it is adequately prepared for disease outbreaks in accordance with its own laws and authorities. We strongly encourage continued review of HHS' Centers for Disease Control (CDC) COVID-19 guidance which is available on their website for the most current information.

1. **Safety / Infection Control Activities**

Completed	In Progress	Not Started	Activities
○	○	○	1.1 Develop a pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.2 Develop an agency/facility pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.3 Provide staff education about COVID-19 infection control and update polices as required.
○	○	○	1.4 Support N95 respirator fit-testing for all agency/facility employees and just-in-time education on recommended infection control precautions including fit checking, applying simple mask to patients with cough, and hand hygiene.
○	○	○	1.5 Monitor availability of N95 respirators/powered air purifying respirators (PAPRs) and other supplies including alcohol-based hand disinfectants, gloves, etc., and watch and alert coalition members to supply shortages. Make recommendations on possible alternatives.
○	○	○	1.6 Prepare guidelines for conservative and re-use of N95 respirators/PAPRs if severe shortages are imminent (ideally regionally and in conjunction with local public health, occupational safety, and infection prevention providers and agencies - for example, consider use by only the highest-risk staff, re-use in selected situations, continued use while working on cohorted units, etc.).
○	○	○	1.7 Plan contingencies if appropriate levels of respiratory protection are unavailable.
○	○	○	1.8 Develop guidance for staff monitoring for signs of illness (including self-reporting, self-quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
○	○	○	1.9 Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
○	○	○	1.10 Encourage HCFs to plan for staff access to medical care for themselves and their families; determine whether illness will be handled as workers' compensation or personal insurance depending on situation/criteria and share best practices.
○	○	○	1.11 Determine contingency plan for at-risk staff (e.g., pregnant, other defined risk groups) including job expectations and potential alternate roles and locations.
○	○	○	1.12 Evaluate the need for family support to enable staff to work (e.g., childcare, pet care). Provide information for family care plans.

2. EMS Activities

Completed	In Progress	Not Started	Activities
○	○	○	2.1 Determine coordination mechanisms, scope, and likely authorities between coalition EMS agencies including information sharing, resource monitoring/assistance, and policy coordination. Work with local intelligence fusion centers to assist with information sharing and coordination.
○	○	○	2.2 Determine actions that the state EMS agency is likely to take including: • Suspension or modification of operational requirements for EMS agencies • Specific emergency orders or actions that may limit liability and/or expand scope of operations
○	○	○	2.3 Determine local ordinances or laws that may affect EMS disaster operations and the authorities or ability to suspend or modify if needed to support non-traditional operations.
○	○	○	2.4 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., EEI such as number of transports, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	2.5 Evaluate indicators that have effects on EMS and coordinate access through the health care coalition (e.g., status of emergency departments, alternate care sites, epidemiologic information/ forecasting, weather (e.g., snowstorms), availability of staff, availability of supplies).
○	○	○	2.6 Determine vulnerable supplies and coordinate with vendors and the health care coalition to develop contingency plans/allocation plans.
○	○	○	2.7 Develop public messages that emphasize using 911 only for life-threatening emergencies and coordinate with the joint information system.
○	○	○	2.8 Develop information sharing process both for internal staff and between EMS agencies.
○	○	○	2.9 Develop just-in-time education for EMS personnel relative to infection prevention and control, self-care, transmission and family protection, and normal stress responses.
○	○	○	2.10 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	2.11 Determine virtual coordination mechanisms that will enable remote engagement of senior staff to prevent exposures and maximize ability to engage in both daily and incident operations.
○	○	○	2.12 Determine how agency/regional EMS incident action plans will be managed.
○	○	○	2.13 Prepare to initiate auto-answer/recorded answering of 911 calls including diversion of information or non-emergency calls to another call center (e.g., public health hotline). Consider activating a community hotline if such a call center does not exist.
○	○	○	2.14 Evaluate protocols for conducting call screening to recognize COVID-19 -like symptoms (e.g., cough and fever) and advise the responding EMS personnel of a potentially infectious patient.

2. EMS Activities (cont'd)

Completed	In Progress	Not Started	Dispatch Activities
○	○	○	2.15 Adjust response configurations to allow flexibility including: • Prioritization of calls for service (for services that do not currently use priority dispatch systems) including basic algorithms for non-medically trained dispatchers or referring calls to recorded information, nurse triage hotlines, public health information lines, or other technology-based systems • Recommending self-transport or referral to primary care if appropriate (may need to triage calls to medical provider to evaluate if this capability is available) • Assignment of less than usual resources (e.g., assign law enforcement only on injury accidents unless and until clear information that non-ambulatory/critical injuries a represent) • Assignment of non-traditional resources (e.g., using `jump' cars, community paramedicine, and other responses) • Diversion to an alternate care site • Increasing interpretive service assistance
Completed	**In Progress**	**Not Started**	**Response Activities**
○	○	○	2.16 Develop triggers for implementing closest hospital transport - ideally done regionally.
○	○	○	2.17 Develop triggers for implementing `batch' transports (e.g., answering another call immediately if your current patient is stable) - ideally regionally.
○	○	○	2.18 Determine indicators and triggers for changing staff shifts and crew configuration - ideally this should be implemented consistently in the region.
○	○	○	2.19 Provide criteria for patient assessment and emphasis on cough/respiratory and hand hygiene as well as strict adherence to appropriate infection control precautions per Centers for Disease Control and Prevention (CDC) guidance.
○	○	○	2.20 Develop criteria for on-scene denial of transport by EMS personnel for COVID-19 -like illness and other patients - with or without on-line medical control - ideally regional rather than agency-based criteria and process.
○	○	○	2.21 Develop/provide patient information sheets on homecare for COVID-19 -like illness including usual clinical symptoms and course, infection prevention, treatment, and when to seek additional medical care.
○	○	○	2.22 Develop/provide patient information sheets for other conditions that may be left without transport if the service volume suggests a relevant need (e.g., minor injuries).
○	○	○	2.23 Determine alternate transport resources and triggers to utilize them, e.g., private ambulance, wheelchair, contract/courier, for hire vehicles, military assets, buses.
○	○	○	2.24 Evaluate available staff vs. available transport units to determine ability to meet other non-transport missions (e.g., community paramedicine, EMS personnel staffing alternate care locations or providing hospital support).
○	○	○	2.25 Determine necessary changes to record-keeping including use of templates.

3. Hospitals and Health Care Activities

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.1 Determine coordination mechanisms, scope, and likely authorities between coalition hospitals and health care systems including information sharing, resource monitoring/assistance, and policy coordination. This should include the role of the coalition to engage with vendors of PPE, pharmaceuticals, and other medical supplies that may be in shortage. Conduct a coordination conference call with healthcare facilities to ensure awareness and consistency.
○	○	○	3.2 Determine mechanism to engage outpatient settings (homecare, ambulatory care) in information sharing and policy/response coordination.
○	○	○	3.3 Determine mechanisms to engage skilled nursing facilities in information sharing and policy/response coordination.
○	○	○	3.4 Determine actions that the state of emergency management or public health agency is likely to take that affect health care including: • Suspension or modification of requirements for hospitals or clinics • Specific emergency orders or actions that may limit liability or expand scope of operations (for facilities and providers, including volunteers) • Requests for 1135 waivers from the Centers for Medicare & Medicaid Services (CMS) • Crisis standards of care activation • Issuance of clinical guidelines for care and resource allocation • 'Taking powers' of the state relative to medical materials and staff (i.e., does the state have ability to commandeer resources under their emergency powers and does this include medical materials?) • Promulgation or enforcement of legal obligations of medical staff to provide care
○	○	○	3.5 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., number ED visits available beds, available ventilators, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	3.6 Evaluate indicators that have effects on hospitals and coordinate access through the health care coalitions (e.g., status of EMS agencies, alternate care sites, epidemiologic information/forecasting, availability of supplies).
○	○	○	3.7 Determine a process for expedited credentialing of supplemental staff and for the orientation/mentoring of supplemental or shared staff.
○	○	○	3.8 Determine threshold for use and priority list for supplemental staff (e.g., first shared health care system staff, then similarity credentialed and licensed staff, then Medical Reserve Corps, etc.)
○	○	○	3.9 Determine indicators and potential triggers for implementation of alternate care systems in conjunction with public health.
○	○	○	3.10 Develop public messages that emphasize using emergency departments only for life-threatening emergencies and coordinate with the joint information system. Be prepared to manage the expectations of the public relative to scarce resources (what is the shortage, what is being done, who are the priority groups, etc.).
○	○	○	3.11 Determine common visitor policies for coalition hospitals.
○	○	○	3.12 Develop just-in-time education for health care personnel relative to COVID-19 transmission, clinical course, at-risk populations, complications, treatment prevention and control, self-care, transmission and family protection, and normal stress responses.

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.13 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	3.14 Determine how facility/regional hospital incident action plans will be managed.
○	○	○	3.15 Determine how awareness of retail pharmacy stocks will be maintained and shared with ambulatory/emergency care workers.
○	○	○	3.16 Determine behavioral health support plan that includes use of individual HCF staff as well as local, regional, state and federal assistance for meeting patients and staff needs (including those in a leadership role.)
○	○	○	3.17 Determine direction for tracking response cost and lost revenue implications associated with response.

Completed	In Progress	Not Started	Health Care Facility Activities
○	○	○	3.18 Determine incident management activation/configuration based on impact (phased approach) as well as incident action plan cycle and development process.
○	○	○	3.19 Identify SMEs to inform operational decisions and potential resource allocation decisions.
○	○	○	3.20 Determine methods for patient/family information provision including alternate languages/ interpretive services.
○	○	○	3.21 Determine staff communication mechanisms and redundant information management process.
○	○	○	3.22 Determine indicators and potential triggers for changing services provided (e.g., limit elective services).
○	○	○	3.23 Determine strategies to maintain services for at-risk patients during outbreak period (e.g., pregnant, dialysis) but unrelated to COVID-19.
○	○	○	3.24 Determine likely resource shortages and identify relevant vendor, cache, and coalition options for managing shortages.
○	○	○	3.25 Develop service restriction plans in case of staff shortages or increased demand (e.g., respiratory care, nutritional support, pharmacy, laboratory, radiology, elective surgeries/ procedures).
○	○	○	3.26 Develop/update crisis standard of care language in emergency operations plan including the potential for triage decision-making (who, process, communication, considerations) and staff management (how will staff expertise be maximally utilized vs. add additional training for some staff.
○	○	○	3.27 Evaluate the plan for providing just-in-time staff education via electronic and other non-classroom means including information about the COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, risk factors, and complications.
○	○	○	3.28 Establish connection with homecare and long-term care partners to facilitate rapid discharge process from the hospital.

Completed	In Progress	Not Started	
○	○	○	3.29 Develop indicators and possible triggers for implementing alternate systems of care (including phone and web-based assessments as well as in-person care) including establishing health care system-based alternate care sites (e.g., on-site or managed completely by health care entity at owned and re-purposed site).
○	○	○	3.30 Develop indicators and possible triggers for establishing community alternate care sites in conjunction with public health and emergency management including what support may be required from the health care system.
○	○	○	3.31 Develop demand staffing plans for all categories of staff. Modify staff responsibilities and shifts as required (supervisory staff work clinically, suspend most education and other administrative burdens, determine where less-trained staff can safely provide support and the extent of family member support).
○	○	○	3.32 Engage union/labor leaders in relevant discussions of staff responsibilities and hours during pandemics.
○	○	○	3.33 Anticipate supply shortages and coordinate with vendors, the health care coalition, and emergency management to coordinate resource supply, distribution, and scarce resource strategies.
○	○	○	3.34 Develop a plan for implementing a supplemental facility security/controlled access plan (which may be phased) particularly during the peak pandemic weeks to assure controlled campus ingress and egress and monitoring.
○	○	○	3.35 Provide patients and staff with information about stress responses, resilience, and available professional mental health resources. Develop staff monitoring for those exposed to high levels of cumulative stress or specific severe stressors (death of co-worker, etc.).
○	○	○	3.36 Consider ways to maintain staff resilience and morale when congregate gatherings and close physical contact are discouraged. This may need to include memorial services for staff members.
○	○	○	3.37 Determine if the fatality management plan is sufficient for an increased volume of decedents at the facility.
○	○	○	3.38 Develop procedure for notifying the state agency for healthcare administration if licensed bed availability/capacity changes as a result of COVID-19.
Completed	**In Progress**	**Not Started**	**Emergency Department Activities**
○	○	○	3.39 Determine screening process and location (e.g., curb side screening prior to entry, supplemental screening at intake, etc.).
○	○	○	3.40 Determine how suspect cases will be isolated from other waiting patients and during ED care.
○	○	○	3.41 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.42 Develop referral plans for patients that do not need emergency care.

Completed	In Progress	Not Started	
○	○	○	3.59 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.60 Adjust daily nursing expectations/duties as required to meet demand.
○	○	○	3.61 Develop environmental services room decontamination and waste stream plans.
○	○	○	3.62 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.63 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.64 Develop palliative care plans for implementation when needed.
Completed	**In Progress**	**Not Started**	**Outpatient Services/Community Health Centers/Free Standing Health Facilities Activities**
○	○	○	3.65 Develop staffing plan to allow for expanded service hours when needed. Determine if outpatient locations and services should remain open if the threat is too great to staff and patients.
○	○	○	3.66 Determine screening process and location (e.g., curbside screening prior to entry, supplemental screening at intake, separate well/ill clinics, etc.).
○	○	○	3.67 Develop telemedicine service plan for use for patients with special needs or general population.
○	○	○	3.68 Develop a plan to expedite medication refills, obstetrician visits, and other office visits prior to the arrival of COVID-19 cases in the community. The practice should have days to weeks to pre-emptively manage its workload in anticipation of limited elective services during the outbreak period.
○	○	○	3.69 Develop a process for screening and triage of phone and email requests for care to limit office visits to those that require an in-person provider evaluation.
○	○	○	3.70 Develop a process to limit/cancel non-essential visits which can `flex' with the demands of the COVID-19 outbreak.
○	○	○	3.71 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies. Develop patient movement and transportation route plans.
○	○	○	3.72 Evaluate maximal use of space. Convert specialty clinics to acute care, extend hours, etc.
○	○	○	3.73 Consider which clinics may be converted into in-patient units (e.g., surgicenters).
○	○	○	3.74 Develop referral/deferral plans for patients that do not need acute care (e.g., perform virtual/ telephone medication management, automate prescription refills).
○	○	○	3.75 Assure administrative engagement in decision-making/use of incident management to assure continuity and consistency between providers and agencies/facilities.

Completed	In Progress	Not Started	
○	○	○	3.76 Develop infection prevention plan for the clinic specific to COVID-19 and conduct education and develop signage and other necessary materials.
○	○	○	3.77 Create templated charts for COVID-19 patients including discharge instructions and prescriptions.
○	○	○	3.78 Create `fast-track' or other methods for rapid evaluation and prescribing for minor illness.
○	○	○	3.79 Determine how suspect cases will be isolated from other patients in the clinic space.
○	○	○	3.80 Consider specific clinics designated for suspect cases, or specific hours for acute illness clinics.
○	○	○	3.81 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.82 Determine at-risk and functional needs populations that may be impacted and assure access to care.
○	○	○	3.83 Plan to provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19 transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.84 Determine potential indicators/triggers for alternate care systems (including telephone prescribing/encounters and early evaluation and treatment locations as needed).
○	○	○	3.85 Provide or develop patient resources on COVID-19 including transmission, prevention, usual clinical course, risks for more severe disease, and when to seek medical care. These materials should also encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.86 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.87 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.

Completed	In Progress	Not Started	**Homecare Activities**
○	○	○	3.88 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.89 Establish prioritization process for homecare intake or ongoing services including denial and referral to other services. Adjust home visit schedules and responsibilities as required.
○	○	○	3.90 Establish liaison process with hospitals to share information on current and projected capacity and needs.
○	○	○	3.91 Establish liaison process with health care coalition to provide updates on capacity and assist with resource and staffing issues including the process for requesting additional resources from coalition partners or emergency management.

Completed	In Progress	Not Started	
○	○	○	3.92 Determine contingency staffing plan.
○	○	○	3.93 Address staff transportation-related issues that may be anticipated such as reduced access to fuel.
○	○	○	3.94 Develop/provide education to homecare professionals about COVID-19 transmission, and complications (in addition to infection control/staff safety information as outlined above).
○	○	○	3.95 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.96 Develop/provide just-in-time training to staff taking on non-traditional roles as required to maintain critical services. Coordinate with health care coalition to determine potential options.
○	○	○	3.97 Obtain or develop printed materials (including at appropriate reading level and in relevant languages) for clients including information about COVID-19 (including infection prevention measures and clinical disease), service modifications due to COVID-19, and resources. These materials should encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.98 Determine how volunteer/other staff could contribute to homecare activities.
○	○	○	3.99 Establish telephone/virtual support for clients to provide information and `check in' status.
○	○	○	3.100 Monitor clients for mental health related issues and provide information on normal stress responses.
○	○	○	3.101 Provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.102 Assure that at-risk individuals serviced (e.g., on home oxygen, dialysis patients, etc.) have ongoing access to appropriate services and are listed in an agency database for easy reference.
○	○	○	3.103 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Completed	In Progress	Not Started	**Long-term Care/Skilled Nursing Activities**
○	○	○	3.104 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.105 Liaison with the health care coalition/hospitals to assure maximal available residential beds.
○	○	○	3.106 Determine potential supply shortages and work with vendors and the health care coalition if resource availability is limited.
○	○	○	3.107 Develop a process to address shortages of supplies at the facility level including administration, nursing, medical direction, and subject matter expert input - ideally this can be a regional construct rather than at each facility.

Completed	In Progress	Not Started	
○	○	○	3.108 Develop a plan for more advanced care at the facility if hospital capacity is unavailable. This should involve nursing, medical direction, administrative representatives, and include consideration of telemedicine.
○	○	○	3.109 Determine any potential regulatory relief (CMS 1135 or other waivers, state regulations relief, staffing requirements, etc.) that may be needed to effectively respond to COVID-19 as well as issues regarding staff licensure/certification.
○	○	○	3.110 Determine with medical director and nursing director changes in thresholds for emergency department referral. These may vary across the period according to demand.
○	○	○	3.111 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.112 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.113 Develop a process for rapid credentialing and training of non-facility supplemental health care staff.
○	○	○	3.114 Develop infection detection process at the facility to promptly detect and isolate residents and staff with suspected COVID-19 and monitor their close contacts.
○	○	○	3.115 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.116 Develop visitor policies designed to minimize potential exposures (ideally consistent across the coalition) and communicate via physical (signs at entrances and on units) and electronic means. Determine if visitation should be restricted or stopped if threat is too high for patients and staff.
○	○	○	3.117 Communicate any change in services or policies to staff, residents, families, and the health care coalition.
○	○	○	3.118 Designate a point of contact for the health care coalition.
○	○	○	3.119 Designate a point of contact for family/resident information or questions.
○	○	○	3.120 Develop infection control/isolation plan for ill suspect or confirmed cases.
○	○	○	3.121 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.122 Assure fatality management plans are appropriate to address potentially increased numbers of deaths during a COVID-19 outbreak.
○	○	○	3.123 Plan for providing just-in-time staff education via electronic and other non-classroom means including information about COVID-19 , transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.

Completed	In Progress	Not Started	Alternate Care Site/System Activities
◯	◯	◯	3.124 Assure integration with public health and other health systems regarding consistent scripts for web and telephone based nurse triage lines/9-1-1 public safety answering points/ poison control centers/locally generated "apps" and integration with additional telephone/virtual prescribing - particularly for at-risk populations.
◯	◯	◯	3.125 Determine support needed from the health care system for `flu clinics' for early screening and treatment as planned by public health.
◯	◯	◯	3.126 Understand/assist with plan for alternate care site(s) for hospital overflow - roles, responsibilities, authorities, staffing, material resources, criteria, level of clinical care (understanding that this may not be feasible if staff absenteeism is high at the hospitals).
◯	◯	◯	3.127 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
◯	◯	◯	3.128 Assure enough staff, supplies, prophylaxis, and logistical support are on hand before opening the site.
◯	◯	◯	3.129 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Comments: