Utilizing Contingency Surge Methods and Alternate Care Sites to Address Hospital Space Needs in Context of COVID-19

**Audience:** Emergency Preparedness Coordinators, Discharge Planners, Social Workers, Chief Medical Officers, Hospital Administrators, and Operations.

**Purpose:** To provide resources and recommendations as health care facilities attempt to surge for increased numbers of critically ill and moderately ill patients with COVID-19 Syndrome.

**Background:** In the context of the coronavirus disease 2019 (COVID-19) epidemic in New York City, it is vital for hospitals to prepare to receive higher volumes of critical care patients making it more essential to rapidly discharge patients that can otherwise be managed in a lower acuity setting or even as outpatients.

Hospitals are strongly encouraged to adjust their daily operations to create COVID-specific care areas and designated care staff to maximize use of limited resources, including personal protective equipment (PPE), and minimize potential exposure to untrained staff and other patients. For more information on cohorting patients and surge spacing recommendations, see the [NYC Health Department’s Hospital Surge Guidance](#).

**Definitions**

**Conventional capacity:** The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.

**Contingency capacity:** The spaces, staff, and supplies used are not consistent with daily practices but provide care that is *functionally equivalent* to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster when the demands of the incident exceed community resources.

**Crisis capacity:** Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a *significant* adjustment to standards of care.

**Alternate care facility:** A temporary site, not located on hospital property, which is established to provide patient care. It may provide either ambulatory or non-ambulatory care. It may serve
to “decompress” hospitals that are maximally filled, or to bolster community-based triage capabilities. This has also been referred to as an “alternate care site.” (IOM 2012)\(^1\)

**Medical surgical — high acuity:** Medical/surgical patients with medical illness treated by pharmaceutical and other supportive intervention, but do not require critical care. For example, a COVID patient requiring some level of high flow oxygen and continuous IV fluids. Standard supplies include medical gases and delivery system, IV, and telemetry monitoring, if available. Standard staff include internal medicine, doctors/hospitalists, subspecialty consult physicians, medical/surgical nurses (RN and LPN), respiratory therapists, and dieticians. Standard infection control includes airborne isolation for those requiring aerosol-generating procedures while infectious (will be infrequently needed in this setting) and cohorting of COVID patients. Standard transport includes advance life support (ALS). Standard (conventional) placement includes general hospital floors and non-traditional surge space.

**Medical surgical — low acuity:** Medical/surgical patients with medical illness treated by pharmaceutical and other supportive intervention, but do not require critical care, and can be managed in a hospital setting with less frequent monitoring. For example, a COVID patient requiring low flow oxygen, IV medications by push (no continuous IV). Standard supplies include electrical oxygen concentrators, pharmacy, and crash cart. Standard staff include doctors, mid-level providers (NP, PA), nurses (LPN). Standard infection control includes cohorting of COVID patients, airborne isolation is not required. Standard transport includes basic life support (BLS). Standard (conventional) space includes general hospital floors and non-traditional surge space.

**Convalescent care/skilled nursing:** Medical patients recovering from illness but no longer requiring hospital-level care. Patients only need skilled nursing care during recovery period, or to manage preexisting conditions that require skilled nursing (e.g., a long-term care resident returning to facility after hospitalization). Standard supplies include electrical oxygen concentrators and pharmacy. Standard staff include medical oversight and nurses (RN and LPN). Standard infection control includes cohorting based on need for continued transmission-based precautions, airborne isolation is not required. Standard transport includes BLS (probably). Standard (conventional) placement includes in-hospital, alternate level of care (ALOC), or long-term care facility.

Discharging Patients to Alternate Care Sites
During this time, contingency capacity measures may need to be implemented in order to optimize space for high acuity patients in the hospital. It may be necessary to discharge or transfer patients who would remain hospitalized under conventional capacity practices. These patients may be discharged or transferred to alternate care sites after considering the following:

- Acuity level of patient
- COVID status of patient (confirmed vs. probable vs. asymptomatic/low suspicion)
- If COVID-19 is confirmed or probable, risk status for decompensation (age ≥ 50 or with comorbidities including diabetes, chronic respiratory conditions, heart disease, or immunocompromising conditions; respiratory rate > 24; heart rate > 125; SpO2 < 90% on room air)
- Capability (e.g., supplies, staffing, infection precautions, and transport) of alternate care site to accommodate patient needs with care that is functionally equivalent to usual patient care practices

Visit gnyha.org and search for Hospital Guidance for the Transfer and Tracking of Patients to Alternate Care Sites to see guidance that can be used in conjunction with recommendations in this document.

Alternate care site recommendations in this document are made based on ability of alternate care facilities to provide care that is functionally equivalent to usual patient care practices based on patient acuity. For transporting patients during COVID infectious window, follow U.S. Centers for Disease Control and Prevention (CDC) guidance at cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html. Patients should wear a face mask for source control during transport (CDC).

Considerations for Patient Discharge to Alternate Care Sites Based on Acuity Level

Patients recovering from COVID-19 who have met the definition for release from isolation: COVID-19 recovering patients that have met the definition for release from isolation [i.e., at least three days (72 hours) after recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms, such as cough or shortness of breath, and at least seven days have passed since symptoms first appeared] can be safely discharged to home (even if a congregate setting) or, if needed, a skilled nursing facility or acute inpatient rehabilitation. Skilled nursing facilities cannot refuse to take a recovering
COVID-19 patient that meet this recovery criteria. If the patient is unable to return home or the hospital is unable to find placement in a skilled nursing or rehabilitation facility please call one of the following placement options:

- If patient is already connected with the Department of Homeless Services (DHS), call 212-361-5590. Inform them of need for placement of a recovered COVID-19 patient.
- If a patient needs placement in a skilled nursing facility, facilities can follow routine procedures for placement of a recovered COVID-19 patient that has been cleared from isolation.
- If unable to place patient in a conventional facility, follow the process outlined below for placement in an alternate care site.

Patients recovering from COVID-19 who are still infectious but otherwise able to be discharged and able to isolate at home:

<table>
<thead>
<tr>
<th>Criteria for determining ability to isolate:</th>
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<tr>
<td>❑ Separate bedroom, with ability to maintain at least 6 feet distance from others</td>
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<tr>
<td>❑ Separate bathroom — if shared, ability to clean and disinfect after each use</td>
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<tr>
<td>❑ Ability to access food and laundry by oneself — if shared kitchen, ability to clean and disinfect after each use</td>
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<tr>
<td>❑ Ability to monitor symptoms by oneself or by another who can practice physical distancing</td>
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COVID-19 infected patients that can reasonably self-isolate during their illness should be allowed to return home or to a hotel with instructions regarding home isolation and accessing care if symptoms worsen. See CDC’s home care guidance at cdc.gov/coronavirus/2019-ncov/if-you-are-sick/caring-for-yourself-at-home.html. Upon discharge, patients should be provided with a face mask to wear during transport and while in public spaces while infectious. Instructions should include guidance to continue self-isolation for at least three days (72 hours) after recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms, such as cough or shortness of breath, and at least seven days have passed since symptoms first appeared. Ensure they have clear instructions on when to seek care if they develop severe symptoms (including difficulty breathing, constant pain or pressure in the chest, new confusion or inability to stay awake, or bluish lips or face) that would usually require an urgent evaluation. Direct them to call 911 and to alert the operator that they have or may have COVID-19. If their symptoms do not require urgent care, but do need to be evaluated, advise them to call their provider to

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determine if they can be evaluated remotely. If patient needs to be seen in person, advise them to call ahead to let the staff know that they have or may have COVID-19, and to notify staff again upon their arrival.

Patients recovering from COVID-19 who are still infectious but otherwise able to be discharged and unable to isolate at home:

Patients recovering from COVID-19 who are still in their infectious window and live in confined areas (such as group settings and small one bathroom/bedroom apartments) who cannot reasonably return home without potentially exposing others in the household (i.e., they are unable to self-isolate) can be referred to one of the following placement services:

- If patient is already connected with DHS, call 212-361-5590; inform them of need for patient isolation for possible mild COVID-19.
- If patient has a home but cannot safely self-isolate at home, an authorized Point of Contact should call the Call Center at 718-422-HOTEL (718-422-4683). **The call center will only allow authorized points of contact to refer clients to hotels.** If facility staff do not know the point of contact at their facility, they can ask a Call Center operator. Inform them of the need for patient isolation for possible mild COVID-19. Note: these individuals cannot require skilled social services or medical monitoring — these are not available in hotels.
- If a patient needs placement in a skilled nursing facility or other high-risk congregate setting, they may be eligible for transfer to an alternate care site until they are able to be taken off isolation. See the New York State Department of Health’s Health Commerce System (HCS) at commerce.health.state.ny.us to review available sites and their exclusion criteria. To request transfer, call the Healthcare Evacuation Coordination Center (HECC) at 212-542-1700 and inform them of need for patient isolation for confirmed or possible mild COVID-19.

Those that are discharged to a hotel or alternate care site should be given a face mask to wear during transport and while in public spaces, and should stay until at least three days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms, such as cough or shortness of breath, and at least seven days have passed since symptoms first appeared.

Patients recovering from COVID-19 who are still moderately symptomatic but otherwise able to be discharged with close follow-up:

Patients who are recovering from illness but may need some continued low-level care or who are at risk for relapse may benefit from placement at an alternate care site for closer observation (low acuity care site). The most up-to-date admission criteria will be posted on the NYS Health Commerce System (HCS) at commerce.health.state.ny.us/hpn/controldocs/alrtview/postings/criteriapatienttransfer.pdf. Please review inclusion and exclusion criteria for the different alternate care sites to determine if your patient meets transfer criteria. To request placement at an appropriate alternate care site, call the HECC at 212-542-1700 to make the request for a COVID-19 patient that does not
meet hospital admission criteria but would benefit from closer observation than is available at home.

Patients who would be conventionally placed in convalescent care, skilled nursing facility, or acute rehabilitation unit:
Health care facilities should attempt to utilize normal processes to discharge to convalescent care, skilled nursing facilities, and acute rehabilitation units. If these are not available, facilities should consider use of alternative surge spaces including convalescent or low-acuity medical/surgical surge spaces that have similar capability as hospital sites (e.g., medical air, suction, back-up power, dialysis accessible). Alternate care sites may be able to provide convalescent care for some higher functioning skilled nursing and acute rehabilitation patients. Assistance provided may include basic medical needs such as oxygen, wound care, assistance with medication, and monitoring of vital signs. Clinical staff should include a physician and nurse lead complemented by experienced caregivers. Please see the NYS Health Commerce System for current inclusion and exclusion criteria for these spaces to determine if your patient is a good fit for placement:
commerce.health.state.ny.us/hpn/ctrldocs/alrtview/postings/criteriapatienttransfer.pdf.

To request placement at an appropriate alternate care site, call the HECC at 212-542-1700, and inform them you have a non-COVID-19 patient that would normally be placed in a skilled nursing facility or acute rehabilitation unit but you are unable to locate a bed and would like them placed in an alternate care space to make room for COVID patients in your facility.

Patients who would usually be placed in medical surgical low or high acuity units: Health care facilities should attempt to utilize normal processes to discharge to medical surgical low and high acuity units. If these are not available, facilities should consider use of lower acuity alternative surge spaces including high and low-acuity medical/surgical surge spaces that have similar capability as hospital sites (e.g., medical air, suction, back-up power, dialysis accessible). Please visit commerce.health.state.ny.us for the most up-to-date inclusion and exclusion criteria for these spaces to determine if your patient may be fit for such placement.

To request placement at an appropriate alternate care site, call the HECC at 212-542-1700 and inform them that you have a non-COVID-19 patient who would normally be placed in a medical surgical unit but you are unable to locate a bed and would like them placed in an alternate care space to make room for COVID patients in your facility.

The NYC Health Department may change recommendations as the situation evolves. 4.20.20