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Reframing the Pandemic Response:

UCSD Health's Framework for Endemic COVID-19 Operating Procedures

Wednesday, April 13, 2022
1-2pm

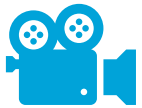
Recording Link

Housekeeping

Rename yourself to include your name and organization

Feel free to chat in responses at any time or speak up during Q&A

You're encouraged to turn on video for peer discussion



This meeting is being recorded and will be posted online

Materials will be available at SNI Link/Coronavirus Resources

Agenda

Time	Topic	Lead(s)
5 min	**Welcome & Introductions**	Zoe So, SNI
30 min	**Member Presentation: The "New Normal" for COVID-19 @ UCSD Health**	Dr. Chris Longhurst, UCSDH Matthew Jirsa, UCSDH
20 min	**Q&A**	All
5 min	**Wrap-up & Announcements**	Zoe

Reframing the Pandemic Response:
UCSD Health's Framework for Endemic COVID-19 Operating Procedures

Dr. Chris Longhurst, Chief Medical Officer & Chief Digital Officer

Matthew Jirsa, Administrative Fellow

UC San Diego Health

The "New Normal" for COVID-19 @ UCSD Health

Dr. Chris Longhurst, Chief Medical Officer & Chief Digital Officer
Matthew Jirsa, Administrative Fellow
On Behalf of the UC San Diego Health New Normal Workgroup

UCSDH Motivations and Strategy for a New Normal with COVID

VIEWPOINT

Ezekiel J. Emanuel, MD, PhD
Perelman School of Medicine and The Wharton School, University of Pennsylvania, Philadelphia.

A National Strategy for the "New Normal" of Life With COVID

As the Omicron variant of SARS-CoV-2 demonstrates, COVID-19 is here to stay. In January 2021, President Biden issued the "National Strategy for the COVID-19 Response and Pandemic Preparedness." As the US moves from crisis to control, this national strategy needs to be updated. Policy makers need to specify the goals and strategies for the "new normal" of life with COVID-19 and communicate them clearly to the public

strategy.[2] Neither COVID-19 vaccination nor infection appear to confer lifelong immunity. Current vaccines do not offer sterilizing immunity against SARS-CoV-2 infection. Infectious diseases cannot be eradicated when there is limited long-term immunity following infection or vaccination or nonhuman reservoirs of infection. The majority of SARS-CoV-2 infections are asymptomatic or mildly symptomatic, and the SARS-CoV-2 incubation period is short, preventing

Without a strategic plan for the "new normal" with endemic COVID-19, more people...will unnecessarily experience morbidity and mortality, health inequities will widen, and trillions will be lost from the US economy.

Situation & Background

- Reflecting 2 years into the pandemic, we have been in a state of "**perpetual emergency**" with a reactive strategy to new variants and regulations
- The need to transition to a "new normal" with COVID as one of many endemic viruses is necessary for us as a health system and community

Goals and Actions

- Launch workstreams to identify key strategies recommendations to translate into policies and procedures for UCSDH and San Diego to adapt to COVID
- **Lead the way in a public health informed, data-driven approach to COVID across the UCs and California**

JAMA, Jan 6, 2022

VIEWPOINT

A National Strategy for COVID-19
Testing, Surveillance, and Mitigation Strategies

David Michaels, PhD, MPH
Milken Institute School of Public Health, George Washington University, Washington, DC.

Ezekiel J. Emanuel, MD, PhD
Perelman School of Medicine and The Wharton School, University of Pennsylvania, Philadelphia.

Rick A. Bright, PhD
The Rockefeller Foundation, New York, New York.

At the beginning of the COVID-19 pandemic, the response of the US federal government was seriously flawed. For exam and Prevention (development and masking, and vent were also defecti ment of Health an sector progress, f Early guidance on testing was mistargeted, getting tested was a logistical nightmare, and too few tests were performed. Once an acceptable, yet suboptimal, testing infrastructure was established, it was marginalized, thought to be superfluous because of the vaccines. Even now, testing results are not reliably linked with sociodemographic data, vaccination status, or clinical outcomes; the availability of reliable rapid tests remains limited; and prices are too high.[1]

Every person in the US should have access to low-cost testing to determine if they are infected and infec- the population to help individuals who might be infectious avoid transmitting the virus to others in their homes, workplaces, schools, and other settings and to get prompt medical care if needed. Several states currently send their residents free, rapid COVID-19 test kits. All states and the federal government should also make tests readily available.

Importantly, when the CDC tracking system receives notification of a positive test result from a health

"A comprehensive national wastewater system is needed to reach the full potential of this surveillance approach, which should empower local jurisdictions with rapid, actionable data and **transform pandemic prevention into a more equitable and proactive practice**."

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Leading the Way: Testing and Surveillance

Surveillance thresholds can be used to develop predictable system-related changes

The San Diego Union-Tribune

UCSD fears mass COVID surge could hit San Diego around New Year's. Here's why

Smruthi Karthikeyan, left, and Rob Knight collect wastewater samples on UC San Diego campus. (Erik Jepsen / UC San Diego)

Testing of a treatment plant that processes wastewater from two-thirds of the county detected alarmingly high levels of the coronavirus

BY JONATHAN WOSEN | BIOTECH REPORTER

DEC. 18, 2021 5:06 PM PT

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OBSERVATION

March/April 2021 Volume 6 Issue 2 e00045-21

https://doi.org/10.1128/mSystems.00045-21

High-Throughput Wastewater SARS-CoV-2 Detection Enables Forecasting of Community Infection Dynamics in San Diego County

Smruthi Karthikeyan [a], Nancy Ronquillo [b], Pedro Belda-Ferre [a], Destiny Alvarado [b], Tara Javidi [b], Christopher A. Longhurst [a,c], and Rob Knight [a,d,e,f]

[a] Department of Pediatrics, University of California, San Diego, La Jolla, California, USA
[b] Department of Electrical and Computer Engineering, University of California, San Diego, La Jolla, California, USA
[c] Department of Biomedical Informatics, University of California, San Diego, La Jolla, California, USA
[d] Department of Bioengineering, University of California, San Diego, La Jolla, California, USA
[e] Department of Computer Science & Engineering, University of California, San Diego, La Jolla, California, USA
[f] Center for Microbiome Innovation, University of California, San Diego, La Jolla, California, USA

Wastewater surveillance serves as an early warning system and can be used as threshold for proactive triggers

Office of Governor
GAVIN NEWSOM

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Governor Newsom Unveils SMARTER Plan Charting California's Path Forward on Nation-Leading Pandemic Response

Published: Feb 17, 2022

Building on lessons learned over the past two years and the state's commitment to equity, the SMARTER Plan focuses on continued readiness, awareness and flexibility to guide California's pandemic response

California has implemented the most robust vaccination and testing programs in the country, maintaining one of the lowest death rates among large states

FONTANA – As California emerges from the Omicron surge, Governor Gavin Newsom today unveiled the state's SMARTER Plan, the next phase of California's pandemic response. Building on lessons learned over the past two years and the state's ongoing commitment to equity, the SMARTER Plan will guide California's strategic approach to managing COVID-19 while moving the state's recovery forward. Emphasizing continued readiness, awareness and flexibility, the Plan will ensure California can maintain its focus on communities that continue to be disproportionately impacted, and stay prepared to swiftly and effectively respond to emerging COVID-19 variants and changing conditions.

Read the California SMARTER Plan: The Next Phase of California's COVID-19 Response here.

SMARTER	METRICS OF PREPAREDNESS
Shots **Vaccine administration**	Capacity to administer at least **200,000 vaccines per day** on top of existing pharmacy and provider infrastructure.
Masks **Personal protective equipment distribution**	Maintain a stockpile of **75 million high quality masks** and the capability to distribute them as needed.
Awareness **Communications**	Maintain capability to promote vaccination, masking and other mitigation measures in all **58 counties** and support engagement with at least **150 community-based organizations.**
Readiness **Surveillance and surge staffing**	Maintain wastewater surveillance in all regions and enhance respiratory surveillance in the healthcare system while continuing to sequence at least **10% of positive** COVID-19 test specimens. Ability to add **3,000** clinical staff within **2 - 3 weeks** of need and across various health care facility types.
Testing	Maintain commercial and local public health capacity statewide to perform **at least 500,000 tests per day** - a combination of PCR and antigen.
Education **Expand vaccination rates among kids**	Expand by **25% school-based vaccination sites supported by state** to increase vaccination rates as eligibility expands and vaccination requirements are enacted.
Rx **Therapeutics**	Maximize order for the most clinically effective therapeutic available through the federal partnerships. Ensure allocations of effective therapeutics are ordered **within 48-hours**.

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Enterprise Tiers @ UC San Diego Health as of March 23rd, 2022

The wastewater thresholds are accurate in predicting future surges of COVID waves and cases. This early warning system will help us maintain proactive, data-drive strategies against respiratory outbreaks

Threshold Criteria	Tier 1 Low Prevalence	Tier 2 Medium Prevalence	Tier 3 High Prevalence
Wastewater Viral Loads and Pathogenicity	< 2 Standard Deviations (SD) above the endemic mean *and/or* changing trend	2 – 3 SDs above the endemic mean, changing trend, *and/or* potential new variant(s) with different pathogenicity	> 3 SDs above the endemic mean *and/or* confirmed new variant(s) with different pathogenicity
New Daily SD County Cases	< 2 Standard Deviations (SD) above the endemic mean *and/or* changing trend	2 – 3 SDs above the endemic mean *and/or* changing trend	> 3 SDs above the endemic mean
SD County ED ILI %	< 4 Standard Deviations (SD) above the mean of ED ILI %	4 - 6 SDs above the mean of ED ILI %	> 6 SD above the mean of ED ILI %
Incident Command Center	Monitoring	Activate Incident Command Center to Level 2 (Minor/Virtual)	Elevate Incident Command Center to Level 2/3 to manage response

Tiers are designed for health system purposes; not for general use like CDC guidelines

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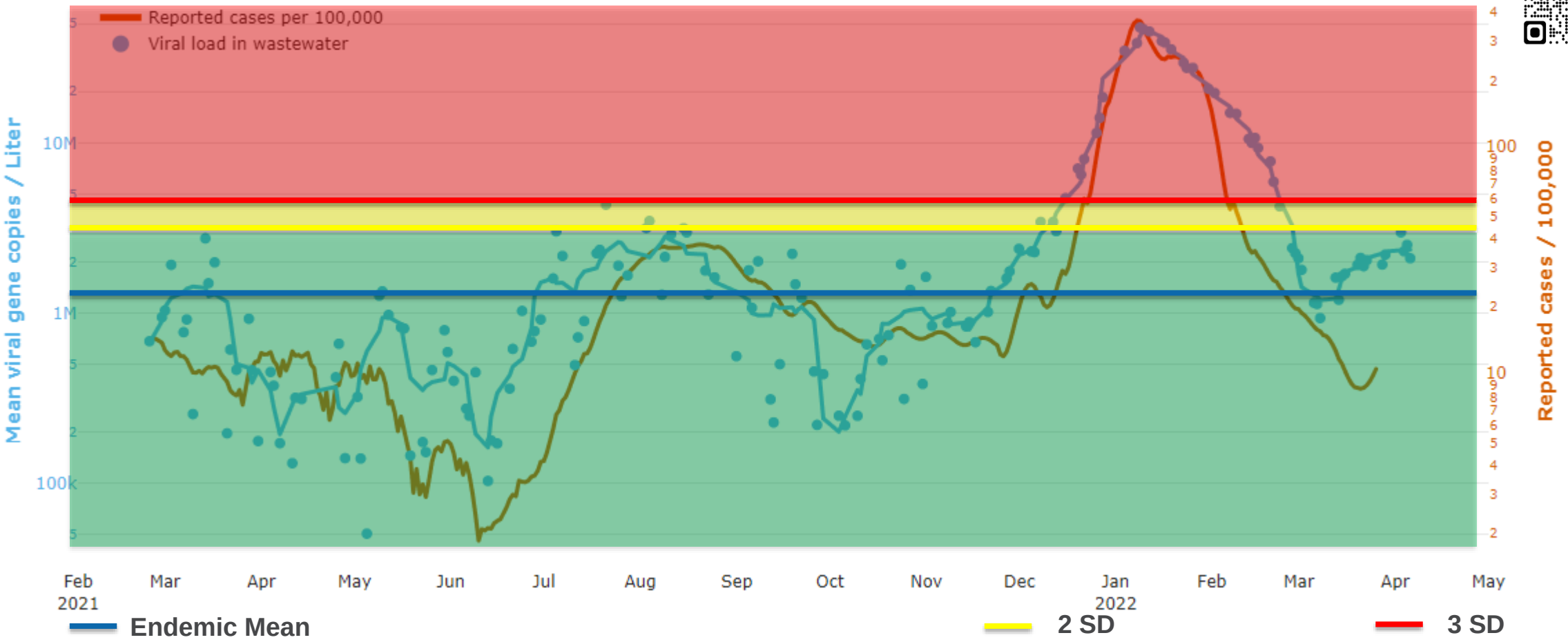
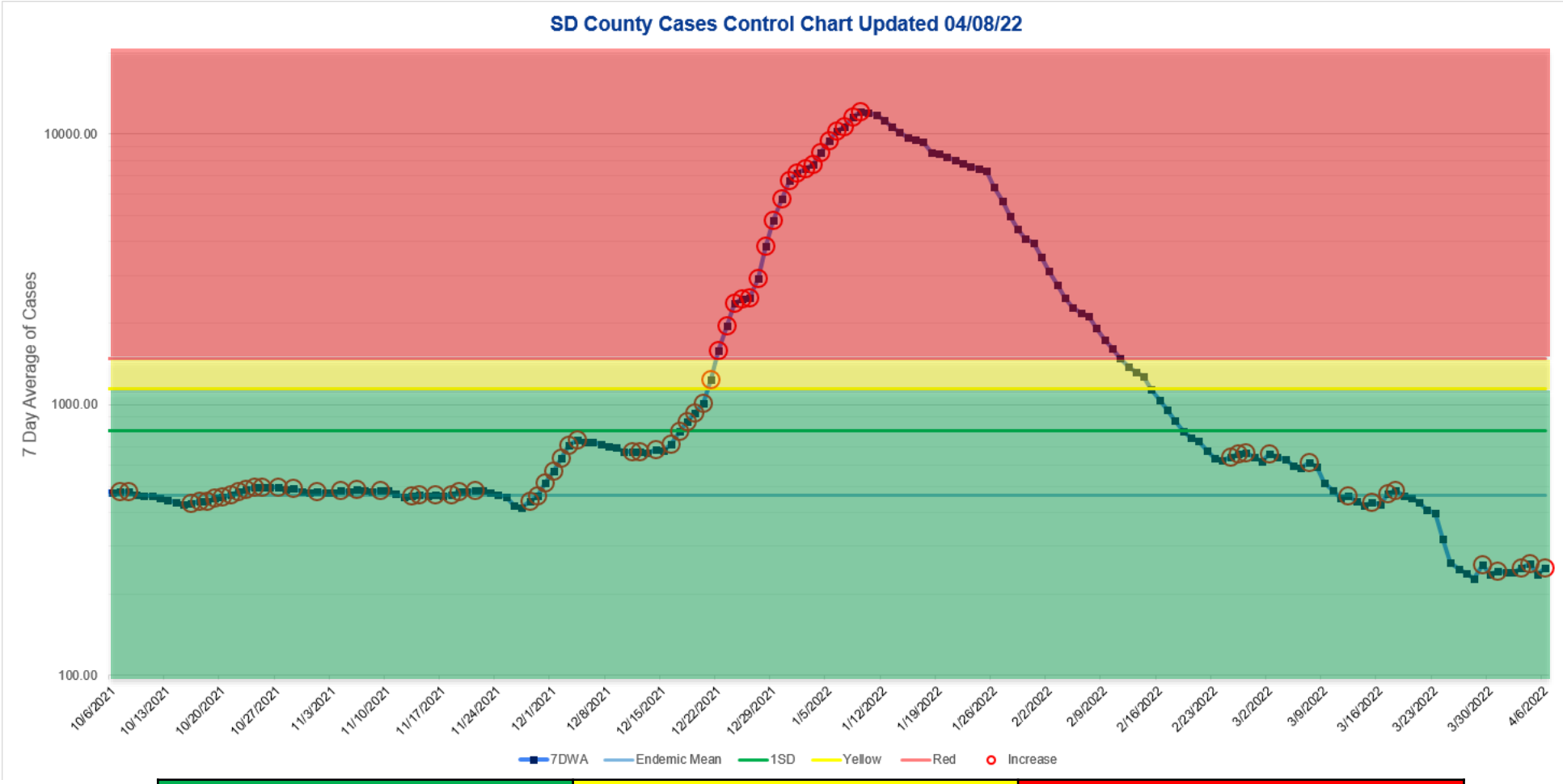
Wastewater Levels and Tiered Thresholds



As of April 8th, we are officially in the Yellow Tier at UC San Diego Health

< 2 Standard Deviations (SD) above the endemic mean *and/or* changing trend	2 – 3 SDs above the endemic mean, changing trend, *and/or* potential new variant(s) with different pathogenicity	> 3 SDs above the endemic mean *and/or* confirmed new variant(s) with different pathogenicity

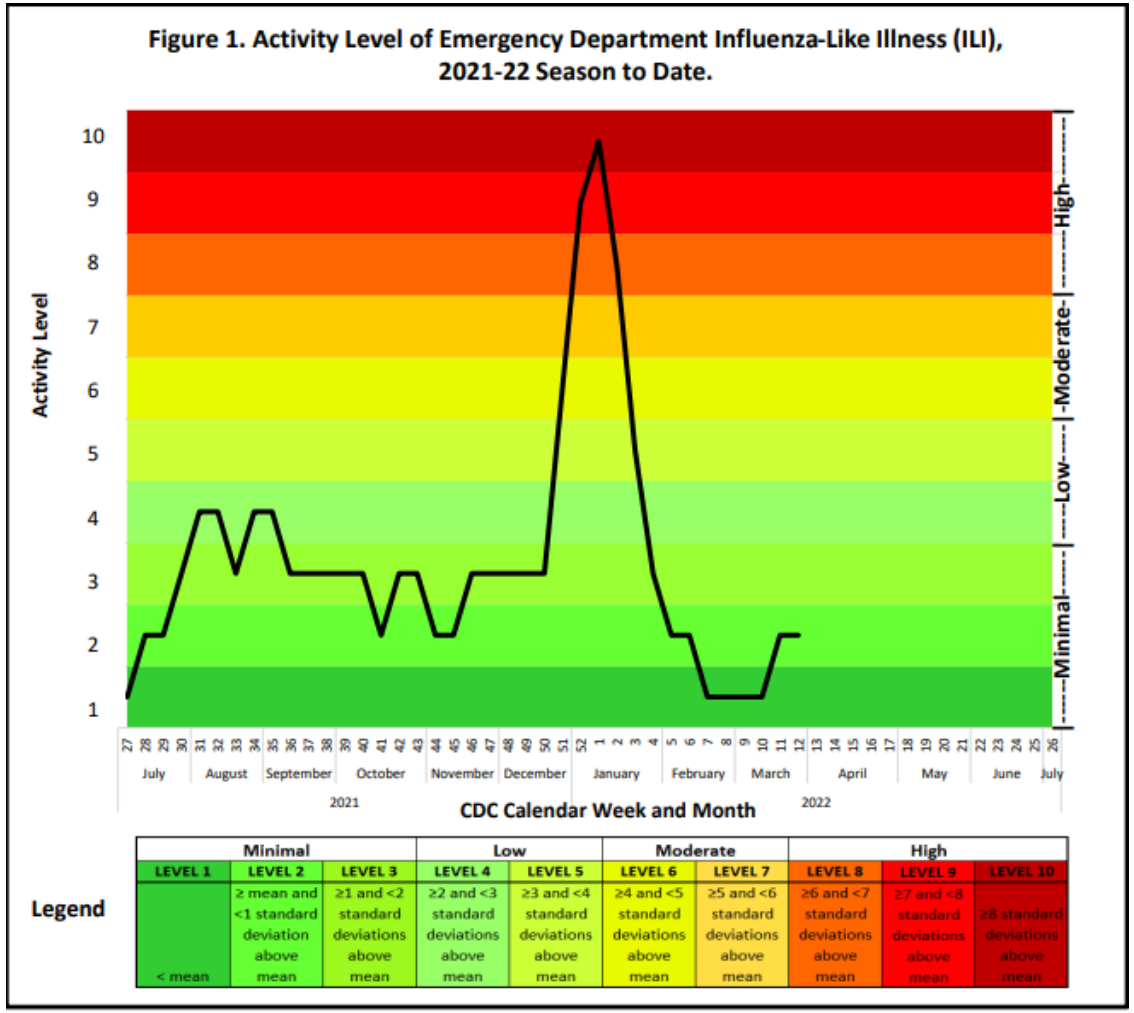
New Daily County Cases & Thresholds – Updated April 8th, 2022



< 2 Standard Deviations (SD) above the endemic mean *and/or* changing trend	2 – 3 SDs above the endemic mean *and/or* changing trend	> 3 SDs above the endemic mean

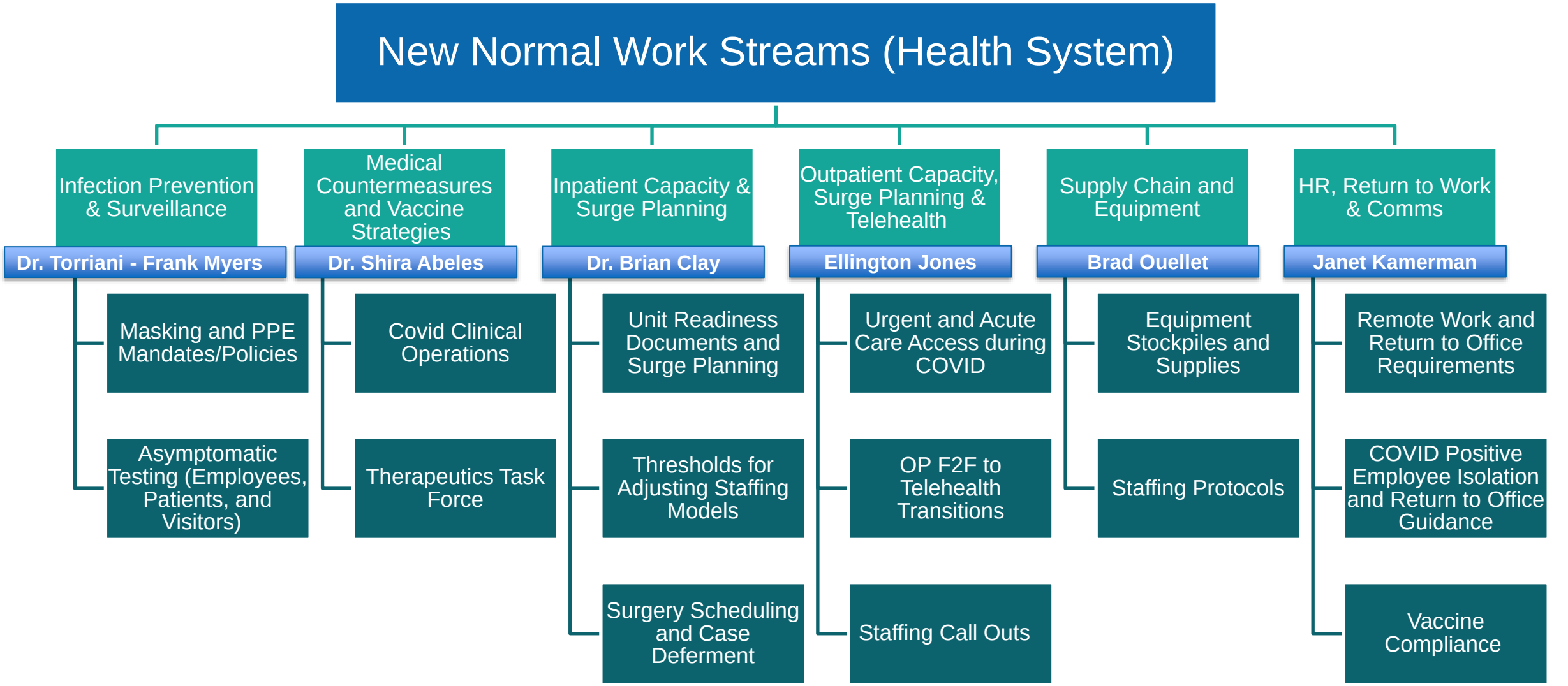
* 7 day moving average of daily covid cases for weekly smoothing

San Diego County ED % of ILI (Influenza-Like Illness)



< 4 Standard Deviations (SD) above the mean of ED ILI %	**> 4 and < 6 SD above the mean of ED ILI %**	**> 6 SD above the mean of ED ILI %**

Workstream Structure and Objectives



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The UC New Normal Workgroup

Interdisciplinary Membership

- An interdisciplinary group of 50+ individuals
  - Executives, physicians, quality, project management, IS, infection prevention, occupational medicine, ambulatory care, researchers, campus leadership, nursing, capacity management, Covid operations, telehealth, supply chain, etc.

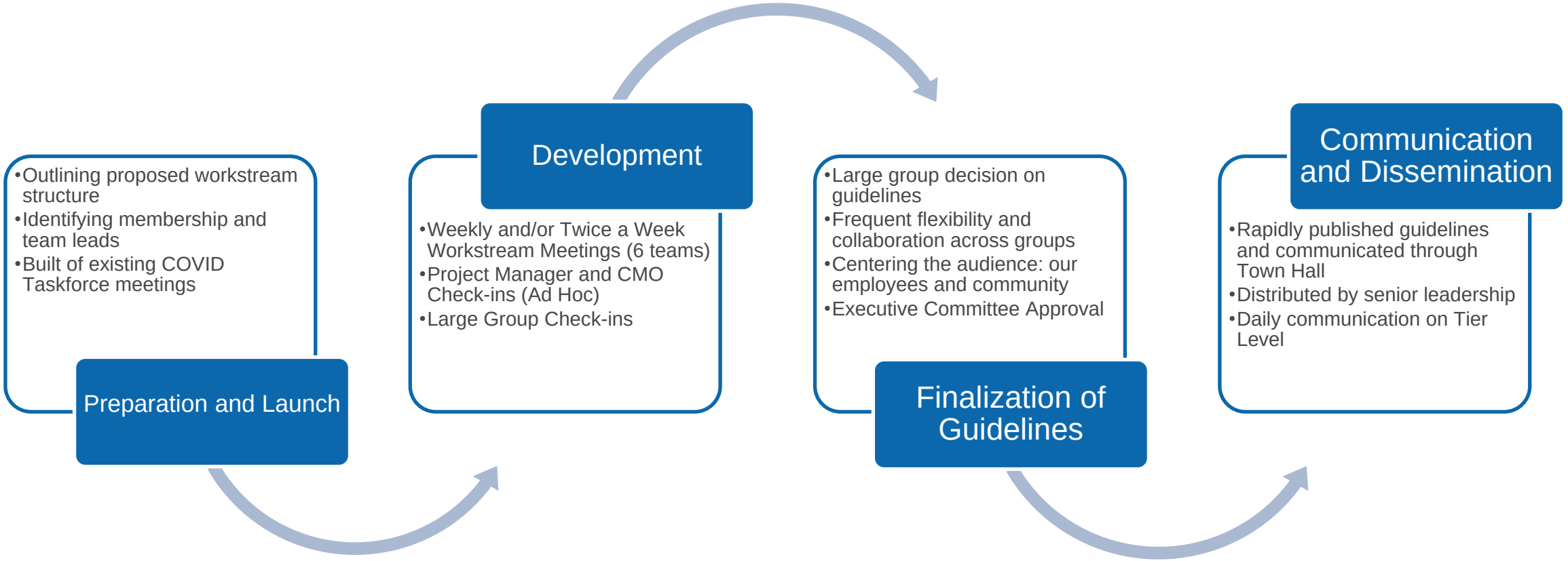
Scope and Speed

- The group emphasized a limited scope that would be broadly applied and serve as a baseline framework to be iterated on overtime (SMART Goals)
  - We are not going to eliminate COVID, but we have the tools and resources to control it
- We had outlined clear deadlines and meeting expectations from the beginning and gave groups flexibility in development of recommendations within scope

Executive Oversight

- The final recommendations were approved and reviewed extensively by senior leadership across the health system and physician group to ensure system-wide approval

Workgroup Timeline



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Infection Prevention: COVID Testing and Surveillance

	Tier 1 – Low Prevalence	Tier 2 – Medium Prevalence	Tier 3 – High Prevalence
Testing and Surveillance Guidelines	**Patients**		
	Testing on Admission: Current CDPH mandate; discontinue and stop testing if changed **Testing in Multi-Patient Rooms (>2 patients) and Routine Testing 72 Hours After Admission:** No testing **Testing pre-Procedure:** No routine testing	**Testing on Admission:** Current CDPH mandate; continue testing if changed **Testing in Multi-Patient Rooms (>2 patients) and Routine Testing 72 Hours After Admission:** Optional testing **Testing pre-procedure:** Routine testing for not fully vaccinated patients only	**Testing on Admission:** Current CDPH mandate; continue testing if changed **Testing in Multi-Patient Rooms (>2 patients) and Routine Testing 72 Hours After Admission:** Routine testing **Testing pre-procedure:** Routine testing for all patients
	Patient testing may always be performed at the individual discretion of MD/APPs		
	Employees and Staff		
	Unvaccinated: Current CDPH mandate; if changed, discontinue routine testing **Vaccinated:** Surveillance testing optional	**Unvaccinated:** Current CDPH mandate; if changed, mandate surveillance testing locally **Vaccinated:** Surveillance testing optional	**Unvaccinated and vaccinated:** Surveillance testing required for all onsite employees
	Visitors		
	Per CDPH guidance		

Infection Prevention: Masking and PPE Guidelines

	Tier 1 – Low Prevalence	Tier 2 – Medium Prevalence	Tier 3 – High Prevalence
Masking and PPE Guidelines **Healthcare Setting**: Any location where patient care is delivered or patients are present (e.g., clinics, patient care units, hallways, lobbies, cafeteria, etc.) *Masking is defined as a surgical mask or a KN95. It does not include a mask with an expiratory valve or non-filtered cloth masks*	**Masking in healthcare setting:** Required (CDPH), KN95 optional **Eye protection in healthcare setting**: optional **Masking non-healthcare settings:** optional	**Masking in healthcare setting:** Required (CDPH), KN95 recommended **Eye protection in healthcare setting**: recommended **Masking in non-healthcare settings**: required	**Masking in healthcare setting:** Required (CDPH), KN95 strongly recommended **Eye protection in healthcare setting**: required **Masking in non-healthcare settings:** required; KN95 recommended
Eating and Meeting Guidelines	**Eating:** Eating together is allowed **Meetings:** In-person meetings are allowed	**Eating:** Eating alone recommended **Meetings:** Virtual meetings recommended	**Eating:** No eating together in-person **Meetings:** Virtual meetings whenever feasible

Note: UC San Diego Health masking guidelines in non-healthcare settings may be more conservative than CalOSHA requires because we want to **mitigate risk of workplace transmission** and **role model best practices as a healthcare delivery organization**

HR and Return to Office

We will continue to offer remote, hybrid, and onsite work options. Managers will have discretion on how often their reports should "return to office" in the Tier 1 – Low Prevalence

	Tier 1 – Low Prevalence	Tier 2 – Medium Prevalence	Tier 3 – High Prevalence
Remote to Office Policies	**Work Environment:** Hybrid & onsite work strongly encouraged where operationally feasible	**Work Environment:** Remote work is encouraged where operationally feasible	**Work Environment:** Remote work is required where operationally feasible
	The decision of remote, hybrid and in-person work expectations remain to the discretion of the executive team leader and management		
Return to Office after Positive COVID Test	**Vaccinated:** If asymptomatic or mildly symptomatic with improving conditions, return to work after day 5 with a negative antigen test **Unvaccinated:** If asymptomatic or mildly symptomatic with improving symptoms, return to work after day 7 with a negative antigen test	**Unvaccinated and Vaccinated:** If asymptomatic or mildly symptomatic with improving symptoms, return to work after day 5 with a negative antigen test	**Vaccinated** Return to work <5 days with most recent diagnostic test result to prioritize staff placement **Unvaccinated:** Return to work on day 5 with most recent diagnostic test result to prioritize staff placement
	Positive Test Result Notification: Directed Communication	**Positive Testing Result Notification**: Risk Stratified Notification	**Positive Testing Result Notification:** All Electronic Notifications
Vaccine Compliance	**Vaccine Compliance:** Adherence: UCOP/CDPH Regulatory Requirements	**Vaccine Compliance:** Adherence: UCOP/CDPH Regulatory Requirements	**Vaccine Compliance:** Adherence: UCOP/CDPH Regulatory Requirements

Inpatient Capacity and Surge Planning

The key recommendations of the workstream include Census Management meeting frequency, cohorting options, patient flow, and procedural deferment

	Tier 1 – Low Prevalence	Tier 2 – Medium Prevalence	Tier 3 – High Prevalence
Inpatient Surge Capacity La Jolla & Hillcrest	**COVID cohorting:** Use primary COVID cohort unit per COVID surge plan **Overall hospital census:** Census Management Committee meets as needed	**COVID cohorting:** Use additional COVID cohort units per COVID surge plan **Overall hospital census:** Census Management Committee meets bi-weekly; evaluate for non-traditional bed space to increase capacity	**COVID cohorting:** Use additional COVID cohort units per COVID surge plan **Overall hospital census:** Census Management Committee meets daily; utilize approved non-traditional space to increase capacity
Flexible Staffing Models	Normal operations and staffing plans	***Bi-weekly*** Census Management Committee meetings Re-deploy available staffing to prioritize acute care needs where needed Nursing and ancillary service labor pools as directed by the ICC	***Daily*** Census Management Committee meetings Re-deploy available staffing to prioritize acute care needs where needed Nursing and ancillary service labor pools as directed by the ICC
Case Deferment	Normal operations and case loads	***Bi-weekly*** Census Management Committee meetings with perioperative leadership to review case schedules	***Daily*** Census Management Committee meetings with perioperative leadership to review case schedules

Outpatient Capacity and Telehealth Operations & Supply Chain

The workstream outlines our telehealth approaches and strategies for maintaining access during future surges.

Outpatient Capacity and Telehealth Operations			
	Tier 1 – Low Prevalence	**Tier 2 – Medium Prevalence**	**Tier 3 – High Prevalence**
Outpatient Volume Transition to Telehealth	**Telehealth Volume**: Standard	**Telehealth Volume**: Increase telehealth where operationally feasible	**Telehealth Volume**: Significantly increase telehealth (target >50% of visits) where operationally feasible
Acute Care Access w/in 48Hrs	**Volume Capacity**: Standard	**Volume Capacity**: Increase capacity where operationally feasible	**Volume Capacity**: Increase capacity where operationally feasible
OP Elective Surgery Scheduling Protocol	**OP Elective Surgery Scheduling**: Standard	**OP Elective Surgery Scheduling:** Standard	**OP Elective Surgery Scheduling Review:** Review carefully, consider targeted pause if necessary
Staff Call Out Rates	**Staff Call Out Rate >10%**: Flex Staffing	**Staff Call Out Rate >20%:** Activate Overtime	**Staff Call Out Rate >30%:** Activate Float Pool
Supply Chain			
	Tier 1 – Low Prevalence	**Tier 2 – Medium Prevalence**	**Tier 3 – High Prevalence**
Equipment Stockpiles & Supplies	**Stockpile Maintenance & Distribution Channels:** Daily maintenance of AB2537 (Emergency) Stockpile Inventory **Market Strategy:** Market watch for distribution constraints	**Stockpile Maintenance & Distribution Channels:** Assessment of market potential for secondary distribution channels **Market Strategy:** Implementation of conservation strategies	**Stockpile Maintenance & Distribution Channels:** Activation of emergency stockpile & tertiary distribution channels **Market Strategy:** Implementation of extreme conservation strategies
Staffing Policies & Protocols	**Staffing Protocol**: Standard	**Staffing Protocol:** Approval of overtime for key support areas	**Staffing Protocol:** Activate "crisis staffing" agency use for key support areas

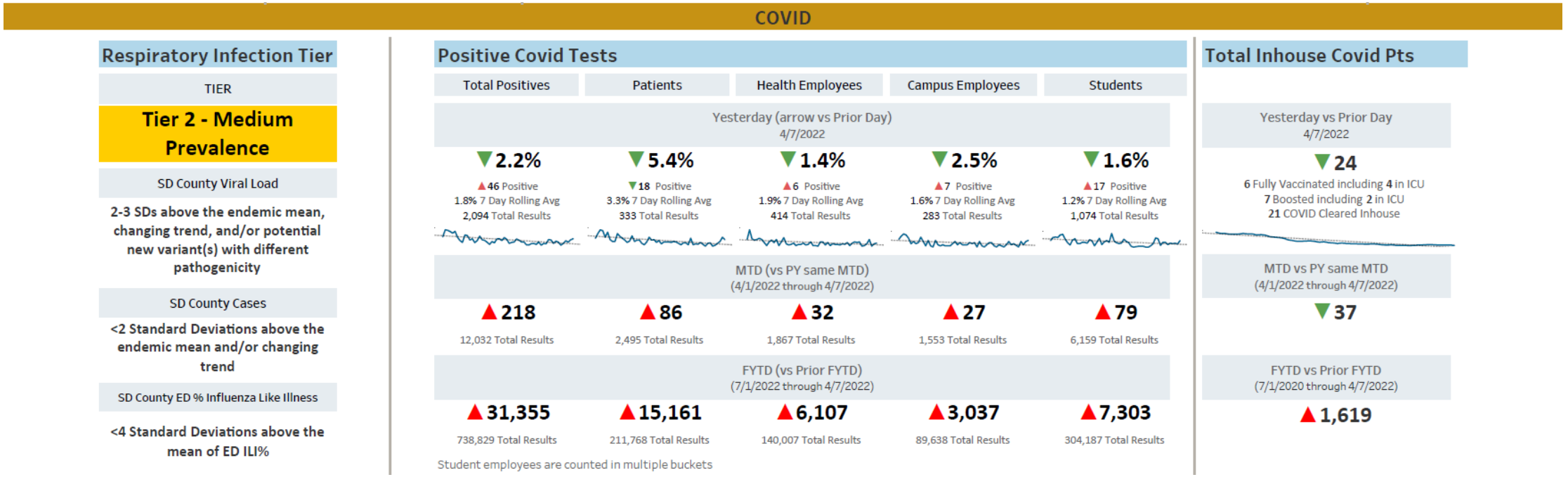
Vaccine Strategies and Medical Countermeasures

This workstream outlines our Covid Clinic Operations and strategies for maintaining up-to-date COVID therapeutic and vaccine access

	Tier 1 – Low Prevalence	Tier 2 – Medium Prevalence	Tier 3 – High Prevalence
COVID Clinic Operations	**Sessions**: 5 days a week/10 clinic session • Physician on-call	**Sessions**: 6 days a week/ 20 clinic sessions with potential ramp up from ICC. • Physician on Call Implement ***bi-weekly*** Clinic DES meetings to focus on review of staffing, space, and resource prioritization across all areas	**Sessions**: 7 days a week/ 34 clinic sessions • Physician on Call Implement **daily** Clinic DES meetings to focus on review and allocation of staffing, space, and resource prioritization across all areas
Therapeutic and Vaccine Operations	Therapeutic Task Force convened as needed based on novel EUA non-FDA approved drugs, therapeutics, vaccine to evaluate data and guide institution in use and prioritization strategies ID/ASP/Pharmacy group works to acquire novel therapeutics, educate providers with regards to strategy in their use, support logistics/distribution of drugs, patient communications and education, and required reporting		

New Normal started **Monday March 21st** at UC San Diego Health

- A daily dashboard email includes a new UCSD Health Readiness dashboard with COVID Readiness metrics (will eventually include our charts and internal metrics)
- Daily symptom screening continues to be required for healthcare workers by CDPH and employees by CalOSHA



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Lessons Learned and Q&A

Communication is Key

- The tiers were developed with simplicity and flexibility. There was a goal that we need to focus on guidelines that are easy to understand and implement

Wastewater Monitoring Frequency and Data Availability

- We want to normalize predictive models like wastewater in public health (hepatitis A in homeless population or influenza outbreaks)

Best Practice Framework Infrastructure

- We need to base our models on statistics regionally and nationally

Rapid Repurposing Required

- The New Normal implies that stable restructuring will occur (example Covid Ops and testing teams were shifted) to emphasis a sustained instead of reactive response

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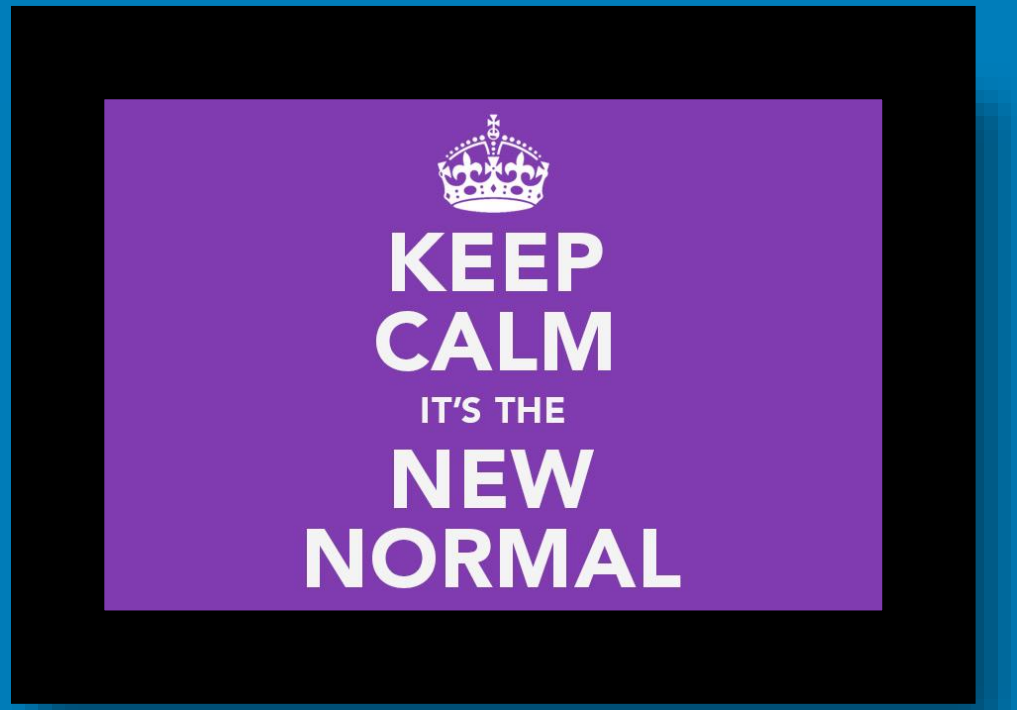
Thank you!



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Acknowledgements

The UC San Diego Health New Normal Workgroup was a multi-disciplinary group of stakeholders brought together in Feb and March of 2022. Special thanks to Matt Jirsa for facilitation, along with all of our workgroup members including Shira Abeles, Leah Adrid, Margarita Baggett, Gabriel Barriga, Daniel Bouland, Theodore Chan, Brian Clay, Melissa Craig, John Cressler, Charles Daniels, Lori Daniels, Lisa Erickson, Kimberlee Eskierka, Joshua Glandorf, Nicole Goldhaber, Steven Gonias, Kris Henderson, Jennifer Holland, Lucy Horton, Lydia Ikeda, Marcia Isakari, Ellington Jones, Janet Kamerman, Christopher Kane, Rob Knight, Brendan Kremer, Del Lali, Louise Laurent, Binh Ly, Tracy Magee, Jess Mandel, Amy Markley, Michael May, Patricia Maysent, Jarrod McDonald, Michael McHale, Ronald Mclawhon, David Melendez, Samantha Meyerhoff, Mobe Montesa, Frank Myers, Shannon Needoba, Robert Neuhard, Brad Ouellet, Cynthia Palmer, Emily Perrinez, Dean Pham, Gerard Phillips, David Pride, Daniel Rawlins, Sharon Reed, Lisa Rhodes, Michele Ritter, Matthew Satre, Robin Schaefer, Stefan Tica, Allen Tran, Chad VanDenBerg, Gary Vilke, Ruth Waterman, Crystal Wiley Cene, Terri Winbush, Nancy Yam, Yvonne Zazueta, and Carl Zika.

Questions?

Discussion questions

- Is your system thinking about COVID-19 in a similar way?
- What are your health system's top priorities as you begin to rebuild from COVID?

Wrap-up

Upcoming SNI Learning Opportunities

Integrating Navigation and Virtual Care: How to Improve Patient Access and Sustain Virtual Care Teams

April 14, 12-1pm

Please Register Here

eVisit Transformation: Billable Medical Advice through EHR Messaging

May 26, 11am-12pm

Please Register Here

Thank you!

Please don’t forget to fill out the survey