

Massachusetts Department of Public Health COVID-19 Resurgence Planning and Response Guidance for Acute Care Hospitals November 3, 2020, Updated November 5, 2020



I. Preamble and Purpose

Due to the public health emergency arising from the outbreak of COVID-19, in March of 2020 the Baker-Polito Administration ordered that, consistent with recommendations from the Centers for Medicare & Medicaid Services¹, and in order to protect patients and health care personnel and to conserve personal protective equipment (PPE), hospitals and ambulatory surgical centers take a number of actions, including to postpone or cancel any nonessential, elective invasive procedures.² As key public health indicators improved and the impact of COVID-19 on health system capacity began to stabilize, the Department of Public Health (DPH) implemented a three-phased approach to reopening health and human services that allowed for the incremental resumption of in-person services without jeopardizing health system capacity or the public health standards that are essential to protecting health care workers, patients, families, and the general public.

While the Phase 3 Reopening Guidance³ remains in effect for [acute care hospitals](#) and other [health care providers](#), DPH continues to prepare for the possibility of a second surge in cases that may strain health care system capacity. DPH issues this Resurgence Planning and Response Guidance for Acute Care Hospitals⁴ to establish a Regional COVID-19 Hospital Preparation and Response Planning Process (“Planning Process”). Through this Planning Process, health care leaders in a region will use region-specific data and context to collectively identify and address potential capacity constraints based on an assessment of regional capabilities, resources, and priorities, and in a way that promotes equitable access to care across all communities and patient populations. This Guidance is designed to facilitate regional collaboration among health care providers, consistent with DPH guidance, to address capacity constraints and avoid mandatory service reductions or closures wherever possible.

¹ Press Release: CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. CMS (March 18, 2020): <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>.

² Elective Procedures Order. Massachusetts Department of Public Health (March 15, 2020): <https://www.mass.gov/doc/march-15-2020-elective-procedures-order>. Memorandum: Nonessential, Elective Invasive Procedures in Hospitals and Ambulatory Surgical Centers during the COVID-19 Outbreak. Massachusetts Department of Public Health (March 15, 2020): <https://www.mass.gov/info-details/covid-19-state-of-emergency>.

³ As amended November 3, 2020.

⁴ As used in this document, “hospital” means an acute care hospital, unless otherwise specified. For the purposes of this guidance, acute care hospitals shall not include comprehensive cancer centers, as defined in G.L. c. 118E, § 8A, or freestanding pediatric hospitals, as defined in 105 CMR 130.



This Guidance applies to all hospital-licensed services except for hospital-licensed community health centers and does not apply to emergency care, which has been ongoing and will continue without limitation. DPH recognizes the importance of ensuring that this Guidance promote equitable access to care, including high-priority preventative care, across all communities and patient populations, including low-income communities, communities of color, children, individuals with behavioral health needs, and individuals with disabilities.

II. Compliance with Existing Reopen Guidance Requirements

All hospitals and hospital systems must continue to comply with the requirements outlined in the Phase 3 Reopening Guidance³, including those related to bed capacity maintenance and safety standards.

1. Hospital-Specific or Hospital System-Specific Bed Capacity Maintenance: The 7-day average of the hospital's or hospital system's available, staffed adult inpatient beds (adult ICU and adult medical/surgical⁵ beds) must be at least 20% of its total staffed adult inpatient bed capacity (including staffed surge beds) on an ongoing basis.
2. Public Health and Safety Standards: Hospitals and hospital systems must continue to be in compliance with the public health and safety standards described in Section IV of the [Phase 1 Guidance](#), including specific criteria related to: a) PPE; b) workforce safety; c) patient safety; and d) infection control and the additional standards in Section III. B of the [Phase 2 Guidance](#).

III. Participation in Regional COVID-19 Hospital Preparation and Response Planning Process

To promote regional collaboration to plan for and respond to COVID-19 and its impact on hospital capacity, DPH is establishing a regional Planning Process, facilitated by the applicable regional Health and Medical Coordinating Coalition (HMCC), in which hospitals and hospital systems within each regional HMCC should participate.⁶ The goals of the Planning Process will be to promote proactive identification and analysis of, and communication regarding, capacity

⁵ For the purposes of calculating inpatient bed availability, DPH includes adult observation beds in the adult medical/surgical category.

⁶ Regions 4AB and 4C shall be treated as a single "Region 4" for the purpose of this Resurgence Planning Guidance, and Region 4C shall convene the regional meetings.



challenges that may impact hospitals' abilities to meet the health needs of the population on an equitable basis. HMCCs must initiate this Planning Process and hold a first meeting no later than November 17, 2020, and hold regular meetings at least every other week thereafter, with increased frequency depending on the HMCC Region's Capacity Tier (see Section IV). This Planning Process will be organized and facilitated by the HMCC sponsoring organization.

A. Hospital Participation

Each hospital or hospital system should designate a senior leader with clinical experience and operational perspective (e.g., Chief Medical Officer, Chief Nursing Officer or other senior clinical leader) to participate in the regional Planning Process and provide the name of such designee to their HMCC sponsoring organization no later than November 17, 2020. If a hospital system's hospitals are located in multiple HMCC regions, the hospital or hospital system should designate senior leader representatives for each HMCC region in which at least one of its hospitals is located. If a hospital system has multiple hospitals located in a single HMCC region, the hospital system should designate either a senior leader representative from each hospital in the region or a single senior leader representative who can address each of the required agenda items (see Section III.B) for each of the system's hospitals in the region.

Each hospital or hospital system may elect to designate an additional hospital-level participant, such as an emergency manager or coordinator or other appropriate individual, to join the designated senior leader in the regional Planning Process.

B. Agenda

Each HMCC sponsoring organization shall work with DPH to establish the agenda for the meetings. Hospital participants should be prepared to share, discuss, and develop coordinated regional action steps about:

- 1) Regional and statewide indicators related to COVID-19 disease progression, health system capacity, and other public health considerations;
- 2) Hospitals' real-time capacities and constraints in the following domains:
 - Total hospital bed capacity (e.g., available medical/surgical beds and ICU beds);
 - Resources (e.g., testing capacity, supplies, equipment, and PPE);
 - Staffing and workforce capacity and needs;
 - Unique patient clinical needs (e.g., number of patients requiring ventilator support);
 - Ability to accept or the need to make patient transfers;
 - Ability to safely, and in a timely manner, place patients awaiting care in the emergency department; and
 - Ability to safely, and in a timely manner, discharge patients to other appropriate settings of care (e.g., long-term acute care hospitals, nursing facilities, behavioral health providers, and other congregate care settings);



- 3) Specific clinical and operational strategies hospitals and hospitals systems are deploying to prevent and reduce hospital emergency department visits and admissions related to COVID-19 or other influenza-like illness; and
- 4) Specific clinical and operational strategies hospitals and hospital systems are deploying to address current or anticipated constraints on acute care bed capacity (e.g., load balancing).

As appropriate or as directed by DPH, the HMCC sponsoring organizations may convene additional meetings with the appropriate regional participants to address other priority areas. Such additional meetings may address such topics as COVID-19 and influenza testing, vaccination planning, vaccination implementation, patient flow across the care continuum, information about known clusters and capacity constraints in congregate care settings, equitable access to care, efforts to support other providers and organizations in the region with critical resource and access needs, and other region-specific issues.

C. DPH Participation and Reporting

Representatives from DPH and/or the Executive Office of Health and Human Services may attend regional Planning Process meetings. Following each meeting, the HMCC sponsoring organization shall maintain a summary of the meeting in a manner and form required by DPH and shall report to DPH as required (see Section V).

IV. Regional and Statewide Capacity Tiers and Escalation Framework

DPH will prepare and the HMCC sponsoring organizations will distribute a weekly dashboard of key COVID-19 disease indicators (e.g., COVID-19 cases, hospitalizations, deaths), health system capacity indicators (e.g., ICU and medical/surgical bed availability, use of surge capacity), and other relevant public health indicators (e.g., influenza hospitalizations). Based on its assessment of the dashboard indicators, DPH will designate each region a color-coded Capacity Tier.

- Tier 1 (Gray) indicates that the assessed measures suggest low risk for health system access or capacity constraints in the near future.
- Tier 2 (Green) indicates moderate risk for constraints in the near future.
- Tier 3 (Yellow) indicates high risk for or active constraints.
- Tier 4 (Red) indicates active, ongoing constraints warranting DPH intervention.

DPH will regularly review and assess tier designations and may escalate or deescalate the region at any time based on the most recently available data as well as information from the Planning



Process meetings. Tier designations will be based on an overall assessment of the key indicators, however, in any of the following circumstances, a region may be automatically designated as a tier as described.

1. **Statewide Bed Capacity**

- a. Statewide ICU Bed Capacity: If the 7-day average of the number of available, staffed adult ICU beds statewide is less than 25% for five consecutive days, DPH may designate one or more regions as Tier 3.
- b. Statewide Inpatient Bed Capacity: If the 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) statewide is less than 25% for five consecutive days, DPH may designate one or more regions as Tier 3.

2. **Regional Bed Capacity**

- a. Regional Inpatient Bed Capacity: If the 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) in the region is less than 25% for five consecutive days, the region shall be designated as Tier 2. If the 7-day average is less than 20% for five consecutive days, the region shall be designated as Tier 3.

3. **Escalation to Tier 4**

- a. If a region persists in Tier 3 for more than seven days and/or the strategies employed during Tier 3 have not resulted in improvements in capacity, the region will be designated as Tier 4 and DPH may issue additional guidance, which may include but is not limited to, the required reduction or suspension of in-person elective, non-urgent services and procedures in the region.

In addition to the foregoing, DPH will consider all relevant data and trends in adjacent regions and statewide and, based on its assessment of current or anticipated health system access or capacity constraints, may escalate one or multiple regions to Tier 4 at any point.

V. Additional Requirements for Hospitals in HMCC Regions Based on Tier 2, Tier 3, or Tier 4 Designation

HMCC Regions that have been designated as Tier 2, 3, or 4 may be close to or currently experiencing capacity constraints that could negatively impact patient access to high-quality care, and hospitals within such HMCC regions must therefore take additional steps to collaboratively and equitably implement strategies to address such constraints.



	Tier 1	Tier 2	Tier 3	Tier 4
Description	Low risk as determined by key indicators	Moderate risk as determined by key indicators	High risk as determined key indicators	<i>Persistently</i> high risk as determined by key indicators
Meeting Frequency	At least every other week	At least weekly	At least twice weekly	At least daily
Strategies	Hospitals develop strategies to identify and address potential future constraints	Hospitals begin activating their strategies to address the worsening epidemic, e.g., increasing testing capacity, staff surveillance, expanding respiratory clinic capacity, performing targeted outreach to all congregate care settings in region, increased public health messaging, increasing staffed surge beds, voluntarily reducing in-person elective, non-urgent procedures and services. Hospitals within the region may move to activate their Tiered Resurgence Plans (see Section VI)	Hospitals continue implementing their strategies; each hospital in the region is required to activate its Tiered Resurgence Plan (see Section VI) and take steps to incrementally reduce in-person elective, non-urgent procedures and services	DPH issues additional regional or hospital or hospital system-specific guidance, which may include the required reduction or suspension of in-person elective, non-urgent services and procedures



<p>Reporting to DPH</p>	<p>After each meeting, the HMCC sponsoring organization submits a report containing the elements required by DPH</p>	<p>After each meeting, the HMCC sponsoring organization submits a report containing the elements required by DPH</p>	<p>After each meeting, the HMCC sponsoring organization submits a report containing the elements required by DPH</p>	<p>Same as Tier 3, plus mandatory additional reporting, as prescribed by DPH</p>
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VI. Tiered Resurgence Plan

All hospitals must, no later than November 17, 2020, attest that they have developed a Tiered Resurgence Plan to guide their response to capacity constraints with the implementation of gradual and dynamic reductions in elective, non-urgent procedures and services, as needed. The plan may be developed at the hospital system level but should identify hospital-specific details in accordance with this section. The Tiered Resurgence Plan should identify, at a minimum:

- The number of tiers and threshold capacity measures for each tier;
- The process for determining whether the hospital should implement tier-specific reductions, including identification of the decision-making person or body and the data and information used to determine when the hospital or hospital system will progress to the next tier;
- The type(s) of services or procedures that will be reduced or suspended in each tier;
- The total volume reduction expected to be achieved in each tier and the impact on the hospital’s overall bed availability;
- The plan to increase testing capacity in each tier for patients and staff surveillance;
- The type(s) of services or processes that will be implemented to prevent and reduce hospital emergency department visits and admissions related to COVID-19 or other influenza-like illness;
- The expected impact of each tier of reduction on PPE management, workforce management plans, and infection control, as applicable; and
- The expected impact of each tier of reduction on patient access, including an assessment of potential disparate impacts on vulnerable populations and communities of color and the strategies for mitigating such potential impact and disparities.

The plan must incorporate a written prioritization policy for determining which services or procedures should be reduced in each tier. Such policy should promote equitable access to care for all populations, without regard for patient's insurance type, and should be consistent with the criteria outlined in [Phase 2 Guidance](#) (Section 3).



Each hospital or hospital system must maintain its Tiered Resurgence Plan and must update and maintain written policies and protocols consistent with the Plan and this Guidance. The Tiered Resurgence Plan and such policies, protocols, and documentation must be regularly updated and made available to DPH upon request at any time.

All hospitals and hospital systems must attest, on a form prescribed by DPH, that it has completed a Tiered Resurgence Plan that meets the standards outlined in this section. The [Resurgence Planning and Response Attestation](#) must be signed by the chief executive officer or by the compliance leader responsible for internal compliance with these criteria. Hospitals must maintain the signed [Resurgence Planning and Response Attestation](#) and make it available upon request of DPH at any time. If the HMCC region has been designated as Tier 3, per Sections IV and V above, the hospital or hospital system must activate its Tiered Resurgence Plan, consistent with the signed attestation. Additionally, any hospital that has determined it necessary to activate its Tiered Resurgence Plan prior to its HMCC region being designated as Tier 3 must immediately notify the DPH 24/7 on-call Duty Officer at pager number 617-339-8351.

VII. Compliance

All acute care hospitals must continue to comply with the requirements outlined in the Phase 3 Reopening Guidance⁷, including those related to bed capacity maintenance, clinical prioritization, and public health and safety standards.

DPH will monitor and assess compliance and may issue additional guidance or require additional remedial action or the required reduction or suspension of in-person elective, non-urgent services and procedures as warranted. DPH may issue additional guidance at any time.

⁷ DPH Phase 3 Reopening Guidance for Acute Care Hospitals is available here: <https://www.mass.gov/doc/dph-phase-3-reopening-guidance-acute-care-hospitals>.