Arizona COVID-19 cases

The Arizona Department of Health Services has reported 58,179 positive COVID-19 cases and 33,883 cases in Maricopa County as of June 23, 2020. Out of the 589,754 COVID-19 tests completed to date in Arizona, 8.6% have tested positive for the virus. Percent positive is the number of people with a positive test result, out of all the people CVID-19 tested completed in Arizona.

In Maricopa County, 2,227 patients (7%) have been admitted to a hospital and 506 (1%) admitted to an ICU since the county began collecting data on Jan. 22. People aged 65 or older or those who have at least one chronic health condition make up 70% of those who have been hospitalized and 94% of deaths for COVID-19. Nearly 60% of all COVID-19 infections reported have been among those under 45 years old.

Capacity update

Thank you for your continued tireless efforts and incredible teamwork as we have continued to combat what appears to be a clear surge in COVID-19 patients throughout the Abrazo Health network. As of yesterday morning, we have 144 patients in-house with 65% of our staffed ICU beds occupied by a COVID patient.

Our ICU and medical teams have done a tremendous job. Physicians continue to follow leading processes to treat our patients, and we have made all tools that we can access available for patient care. The bedside staff also deserves tremendous credit. Many of you have and continue to pick up additional shifts and are truly working harder than ever before to care for our patients and assist your teams in our greatest time of need. For this, I wanted to personally say thank you.

We wanted to take a moment to highlight several important topics which are ever changing:

- Staffing in the ICU – We have actively opened more than 35 positions for contract staffing throughout the market. A number of additional ICU nurses started yesterday, with more scheduled to come on board over the next week.

- We continue to monitor hospital staffing daily and are prepared to keep sourcing additional staff should the surge continue to grow.

- Visitor restrictions – We will continue to monitor our visitor policy on a day-to-day basis. We believe that as long as we can ensure social distancing, universal mask precautions and appropriate hand hygiene, Abrazo wants to support visitors being present for their family member who is a patient whenever possible. We expanded the visitor policy to include Emergency Department patients and patients undergoing acute surgery because we felt we could ensure compliance to our infection prevention strategies in those two venues. As our overall volume has increased along with the increased prevalence of COVID in the community, we have decided that we need to restrict visitation again in order to protect everyone's safety.

  On June 24 we are reverting back to our Level 1 visitor restriction policy which allows only one visitor per patient for end-of-life or beginning-of-life patients only. We will no longer allow a designated visitor to accompany patients having a scheduled elective procedure or one designated visitor per patient in the ED. Again, we will be monitoring this regularly and adjusting accordingly as we believe we can ensure compliance with social distancing, universal masking and appropriate hand hygiene by visitors in progressive venues or as the risk of transmitting COVID decreases based on community prevalence.

- Elective procedures – We are closely monitoring our capacity daily, and if required, may reach out to our physician partners to discuss rescheduling surgical cases that will need ICU care. At this point in time, we do not have plans to delay all elective procedures.

- Access to PPE – PPE access remains in strong supply. We just ask that you continue to support proper protection and safety of yourselves first and foremost. Secondly, we need to continue to be conservation-minded and follow the latest PPE processes that are in place to support safety and conservation.

- Surge planning – Should we continue to see an increase in COVID related patients in our ICU beds, we have plans to deal with a surge. Our first priority will be to staff all available physical ICU beds. We have approximately 24 beds that are available, but not staffed market wide. The contract nurses referenced above should allow us to begin opening some of this capacity. If patient needs extend past this, every hospital has a defined surge plan that allows us to create up to 50% more bed capacity. Examples of creating additional capacity include creating cohort units, multiple occupancy rooms or taking PACU beds and converting to ICU care areas.

- What can you do to help:
  - Social distancing – it is important to not remove your mask if you are within 6 feet of another individual. This includes in the cafeteria and breakrooms.
  - Eye protection – please wear protection for patient encounters.
  - Community – while not at work, continue to practice social distancing, wear a mask while in public and encourage those around you to do the same.

These past few months have shown how fortunate we are to have such a stellar group of physicians, nurses and hospital staff as stewards of our community's health. We will continue to closely monitor capacity and engage in frequent dialogue with our physicians and staff to manage these increasing challenges. We truly appreciate your work and are committed to continue to support our medical staff and hospital teams.

Medical Update from Dr. William Ellert, Chief Medical Officer

As an Arizona group, we are currently at the highest number of COVID positive and suspected in-patients to date. I want to again thank everyone for the care they are providing to all of our patients.

The Abrazo and Carondelet hospitals received an additional supply of Remdesivir from their respective counties on June 19. The amount received is sufficient to treat approximately 100 patients in Phoenix and 60 patients in Tucson for the standard 5-day dosing regimen. We are hoping to receive an additional allocation prior to July 1, but this is not confirmed yet. When prescribing Remdesivir, please remember that the U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of this unapproved product. Hence, when prescribing the medication it is important to follow the directives under the EUA and to ensure the patient or his or her surrogate consents to the use of the medication and that the signed consent is memorialized in the patient's official medical record. The pharmacy has the education material and consents required for its use and will provide it to the physicians at the time the medication is requested and dispensed. The Fact Sheet for the EUA of Remdesivir can be found at the following website: https://www.fda.gov/media/137566/download. I have also attached the Guidance for the use of Remdesivir from the Arizona Department of Health Services which outlines the prioritization of patients based on clinical criteria.

I also want to remind everyone that Convalescent Plasma has also not been approved by the FDA and that therapy is regulated as an investigational product. As such, we have registered for the Mayo Study and must follow the protocol outlined by Mayo and register all of our patients through the Mayo Website when we prescribe this treatment. Our process consists of:

1. Physicians will register the patient through the Mayo Website and obtain a patient identification number.
2. Physician will download the Mayo patient consent and review the risks, benefits and alternatives with the patient and/or their surrogate.

3. The signed consent form will be on the patient's chart and a copy will be sent to the blood bank along with the patient ID number.
4. Once the blood bank/lab has a copy of the signed consent and the Mayo ID registration number they will dispense the plasma.
5. Nursing will confirm the presence of a signed consent in the chart prior to administering the convalescent plasma.
6. Physicians will answer the follow-up surveys on the Mayo Website at the prescribed times.

Thank you for your compliance with this process. I appreciate your assistance.

Resources to help with stress/anxiety

It's important to take practical measures to protect ourselves physically but also emotionally during this outbreak. There are a few basics that may help: Make room in your schedule for some quiet time each day. Practice good communication; sharing your feelings with a trusted confidant can help decrease feelings of anxiety. Get regular exercise and sufficient sleep.

If you are experiencing overwhelming feelings of stress or anxiety, please contact our Beacon Wellbeing (EAP) hotline (866) 335-2340. Beacon Wellbeing is an employee assistance program (EAP) that guidance and support to help improve overall health and wellness. Confidential, expert support is available 24/7 at no cost to you.

HR teams are available

Hospital HR teams are now holding regular office hours. You can continue to receive services remotely if you wish by using Employee Self-Service on the eTenet portal, or scanning/emailing documents to us. Please let your hospital HR reps know if you have any questions about accessing services onsite.

Employee Health hotline

A reminder to please notify your hospital's Employee Health office if you go home sick. Employee Health staff will stay in touch daily before you return to work.

The Abrazo Employee Health hotline for COVID-19 questions is available Monday through Friday from 7 a.m. – 7 p.m., and Saturday-Sunday from 7 a.m. – 5 p.m. The hotline is for Abrazo employees only and may be reached at 602-246-5597.

If you need to visit Employee Health, please call ahead so staff can plan for your arrival.

Incident Command email

Do you have a suggestion or feedback related to the hospital's pandemic response? Please email questions or suggestions to IncidentCommand@abrazohealth.com. Your message will be routed to the appropriate person to evaluate and respond.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Remdesivir Allocation Guidance
Approved by State Disaster Medical Advisory Committee (SDMAC) - 6/12/2020

Background

With the discovery of the novel coronavirus SARS-CoV-2 and ensuing pandemic of COVID-19, there has been intense effort placed into the development, licensing and production of existing and novel therapies that effectively treat COVID-19. On February 4, 2020, the Secretary of the Department of Health and Human Services (HHS) determined that there is a public health emergency; on March 27, 2020, the Secretary declared that circumstances exist justifying the authorization of emergency use of drugs and biologics during the COVID-19 outbreak.

On May 1, 2020 the US Food and Drug Administration issued an emergency use authorization (EUA) for remdesivir (RDV). RDV is a direct acting antiviral drug that inhibits viral RNA synthesis. RDV has activity in cell culture and animal models against SARS-CoV, MERS-CoV, and SARS-CoV-2. Several randomized, double-blinded, placebo-controlled trials serve as the evidence base for the EUA, but it is still considered an investigational drug and is not currently approved for any indication.

Under the EUA, distribution of the authorized RDV is controlled by the US Government. Gilead, the drug manufacturer, supplies RDV to authorized distributors or directly to a US government agency, who then distributes to hospitals and other healthcare facilities as directed by the US Government, in collaboration with state and local government authorities. Arizona's first shipment of RDV was received at the Arizona State Public Health Laboratory on May 12, 2020. Subsequent allocations have been received and distributed to counties based on an agreed-upon allocation protocol.

Since the initial Arizona distribution, RDV has been received at hospitals around the state for treatment of patients with COVID-19. The RDV covered by the EUA is only intended to treat adults and children with suspected or laboratory confirmed COVID-19 and severe disease defined as $SpO2 \leq 94\%$ on room air, requiring supplemental oxygen, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO). This is consistent with recommendations from the NIH COVID-19 Treatment Guidelines, which recommends against RDV for the treatment of mild or moderate COVID-19 outside of a clinical trial.

Even with this restrictive use, hospitals have had to further refine their criteria for use in order to apply this limited resource to their large patient population. As the distribution of RDV has been organized by the state and local public health departments, hospitals and hospital organizations have asked for a shared protocol for RDV use so that a patient has equal access to RDV across all facilities ensuring that patients are treated equitably between hospitals

Recommendation

Given the lack of readily available RDV throughout the nation and the state of Arizona, the following criteria have been developed to allocate and prioritize the limited supply of RDV to the highest priority patients.

Adapted from the Minnesota Department of Public Health:
Ethical Framework for Allocation of Remdesivir in the COVID-19 Pandemic

Allocation within institution

Ethical strategy for distribution within a facility:

Clinical prognosis should ground allocation decisions. Prognosis should be understood to include both need for the resource (i.e., risk of serious morbidity or mortality if the patient were not to receive the resource), and the likelihood that the patient will benefit from access to the resource by recovery to hospital discharge. Substantial differences in prognosis are what is ethically relevant in differentiating between patients; small differences should be viewed as morally equivalent and should not be used to allocate resources to or withhold resources from patients.

Highest Priority Patients

The patients receiving the highest priority for allocation of RDV are:

- Patients with laboratory-confirmed COVID-19 (by RT-PCR testing on a respiratory specimen) who are not already on RDV (e.g., for clinical trials or compassionate use) and who have three of the four characteristics:
    - < 94% oxygen saturation on room air
    - Respiratory rate > 30
    - Lung infiltrates on imaging
    - Using supplemental oxygen
- Patients should meet other clinical inclusion criteria as specified by the FDA EUA for RDV (GFR ≥30ml/min, ALT < 5 times upper limit of normal).
- Based on the EUA and the Gilead open-label trial, the recommended dose for adults and pediatric patients weighing >40 kg not on mechanical ventilation or ECMO is a single loading dose of 200mg on Day 1 followed by 100mg once daily for Days 2 through 5 (for a total 5-day course). At five days, patients who are not mechanically ventilated or on ECMO can be evaluated for possible continuation of RDV if needed, for a possible total 10-day course.

Second Highest Priority Patients

If facilities have met the needs of the highest priority group of patients, facilities should then allocate RDV based on the following criteria:

- Patients with laboratory-confirmed COVID-19 (by RT-PCR testing on a respiratory specimen) who are not already on RDV (e.g., for clinical trials or compassionate use) and who have been
    - mechanically ventilated for 5 days or less,
    - or are on ECMO for 5 days or less,
- Patients should meet other clinical inclusion criteria as specified by the FDA EUA for RDV (GFR ≥30ml/min, ALT < 5 times upper limit of normal).
- Under the EUA for RDV, the recommended dose for adults and pediatric patients weighing >40 kg on **mechanical ventilation or ECMO** is a single loading of 200mg on Day 1 followed by 100mg once daily for Days 2 through 10 (for a total 10-day course).

In both priority groups, in addition to prognosis of surviving current illness to hospital discharge, allocation decisions should consider whether the patient is imminently and irreversibly dying, with life expectancy under 6 months and/or currently under hospice care. Given the scarcity of supply of RDV, patients in this group should not currently receive priority for access.

When patients are otherwise of equal priority within a priority group of patients (i.e., there is no substantial difference in risk and likelihood of benefit) and there is not sufficient RDV for all patients in that group, the Triage Officer or Team should use a random process to allocate the resource.

In order to maximize the benefit of this resource, no courses should be held in reserve for future use. All courses should be allocated assuming all patients need a 10-day course of treatment. At five days, patients who are not mechanically ventilated or on ECMO should be evaluated for discontinuation of RDV with extra doses reallocated to other patients.

Allocation decisions should not consider or be based upon:

- Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status;
- Ability to pay;
- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication of likelihood to survive to hospital discharge);
- Disability status or comorbid condition(s) as a criterion in and of itself (this does not limit consideration of a patient's physical condition in clinical prognostication of likelihood to survive to hospital discharge);
- Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis), unless the patient is imminently and irreversibly dying and/or under hospice care;
- First-come, first-served (should not distinguish between patients when treatment has not yet been started on equivalent patients);
- Judgments that some people have greater "quality of life" than others;
- Judgments that some people have greater "social value" than others.