Patient and Operational Considerations for
Michigan Relief Healthcare Facilities and Alternate Care Sites

Description: This document is intended to provide guidance in the use of Relief Healthcare Facilities (including Relief Hospitals and Relief Long-Term Acute Care Facilities and Relief Skilled Nursing Homes) and Alternate Care Sites (ACS). This guidance may change as resource availability and demands for healthcare services change. Please be alert for revisions.

Core Components

Relief Health Care Facility: This includes licensed hospitals, skilled nursing homes, long-term acute care facilities, and other appropriate licensed healthcare facilities. Relief hospitals are intended to provide a conventional standard of care using available resources without compromising their ability to meet reasonable additional potential institutional surge needs. In general, transfer of most patients to a relief healthcare facility is preferred over transfer to an alternate care site.

- **Relief Hospital:** This includes licensed hospitals able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication with an accurate clinical description of the patient(s) and with clear acceptance by the Relief Hospital. There are currently four types of Relief Hospital statuses that may be displayed in EMResource for statewide awareness.
    - *Critical Care Bed - COVID-19:* This status is indicated for hospitals willing to accept COVID-19 patients requiring critical care, including mechanical ventilation. If hospitals are able to provide this service but are in need of a ventilator, they should contact their healthcare coalition (HCC). These patients should be able to oxygenate and ventilate effectively, not be in circulatory shock, not have multisystem failure, and (ideally) be considered to have at least a 75% potential for survival.
    - *Critical Care Bed - Non-COVID-19:* This status is indicated for hospitals willing to accept non-COVID-19 patients requiring critical care, including mechanical ventilation. If hospitals are able to provide this service but are in need of a ventilator, they should contact their healthcare coalition (HCC). These patients should be able to oxygenate and ventilate effectively, not be in circulatory shock, not have multisystem failure, and (ideally) be considered to have at least a 75% potential for survival. Patients in this category should be considered to not have COVID-*19,* ideally confirmed with laboratory testing (but not required based on clinical presentation).
    - *Non-Critical Care Bed - COVID-19:* This status is indicated for hospitals willing to accept COVID-19 patients not currently requiring critical care services or mechanical ventilation. These patients may need low to intermediate flow supplemental oxygen and basic in-patient (non-critical care) services. Patients in

this category have a potential to deteriorate quickly within the first few days of presentation. Such patients should be transferred to Relief Hospitals having critical care capability available on site or immediately nearby. Patients who have stabilized and are considered to be at low risk of acute decompensation may be considered for Relief Hospitals without critical care capability on site or immediately nearby.

- *Non-Critical Care Bed - Non-COVID-19:* This status is indicated for hospitals willing to accept non-COVID-19 patients not currently requiring critical care services or mechanical ventilation. These patients may need low to intermediate flow supplemental oxygen and basic in-patient (non-critical care) services. These patients should be appropriate for the level of care available at the Relief Hospital. This may include such things as acute chest pain, CHF exacerbation (non-COVID-19), dehydration, intractable pain, and other similar conditions. Patients in this category should be considered to not have COVID-*19*, ideally confirmed with laboratory testing (but not required based on clinical presentation).

Relief Skilled Nursing Home: This includes licensed skilled nursing facilities (SNF) able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication and clear acceptance by the Relief SNF. These facilities should declare through EMResource (as available) and/or their HCCs their willingness to accept both COVID-19 and non-COVID-19 patients and if they are willing to accept stable patients requiring long-term mechanical ventilation and considered appropriate for SNF level of care.

Relief Long Term Acute Care Facilities: This includes long-term acute care (LTAC) facilities able to accept transfers from highly impacted hospitals (and other healthcare facilities) without compromising their ability to meet reasonable additional potential hospital surge needs. No transfers should occur without physician-to-physician communication and clear acceptance by the Relief LTAC. These facilities should be willing to accept stable patients requiring mechanical ventilation considered appropriate for LTAC level of care.

Alternate Care Sites: These are typically non-clinical facilities that have been repurposed to provide healthcare services when traditional healthcare facilities have insufficient capacity and/or capability to provide these services. Alternate Care Sites should strive to provide a level of care as close to conventional care as possible. However, it understood that the ability to meet the conventional standard of care in an ACS may be limited by the resources available. The table below illustrates the four ACS Tiers and describes their purpose, patient type, and considerations for ACS locations.

Alternate Care Site Tiers, Patient Types and Operational Considerations

Tier	Description	Types of Patients	Operational Considerations
1 **M** **E** **D** **I** **C** **A** **L** **S** **H** **E** **L** **T** **E** **R**	**Tier 1 ACS** houses a cohort of patients who need limited monitoring and can care for themselves (e.g., do not need assistance with medications or activities of daily living (ADLs)). These patients could be housed in a dedicated hotel or dormitory meant for this purpose (in their own rooms with their own bathroom).[1] **Tier 1-Behavioral Health** provides the same services as a standard Tier 1 but for patients with behavioral health conditions but not in need of close supervision (e.g., not considered at risk for harm to self or others).	**Patients in Need of Medical Sheltering** Patients with mild to moderate symptoms likely from COVID-19 (preferably with negative RIDP) who are able to care for themselves and would be dischargeable from an ED. • Includes homeless or live alone • Not (yet) in need of admission • Need reasonable observation and rechecks to identify early deterioration Patients who were admitted to a hospital for COVID-19 and are medically appropriate for discharge. • Includes homeless or live alone • Need reasonable observation and rechecks ED or admitted patients appropriate for discharge and not suspected to have COVID-19. • Includes homeless or live alone • Need reasonable observation and rechecks • Examples: Mild exacerbations of CHF, COPD, or exacerbation of other chronic condition	Potential Sites • Dedicated hotel • Dormitory It is always preferred for patients to have a bed over a cot. Medical Support • Dedicated home health nursing team and/or community paramedics
2	**Tier 2 ACS** houses a cohort of patients who require some level of	**Patients in Need of Medical Sheltering**	**Open Layout Sites** (preferred) • Low Capacity: 25-50 beds

[1] https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/alternative-care-sites.html

Tier	Description	Types of Patients	Operational Considerations
MEDICAL SHELTER	assistance (e.g., help with ADLs or medications) and who need a closer level of monitoring than patients in tier one. These patients may be better suited in a facility that has an open layout (e.g., school gymnasium) to allow limited numbers of healthcare personnel to more easily monitor their status.[1] **Tier 2-Behavioral Health** provides the same services as a standard Tier 2 but for patients with serious behavioral health conditions and in need of close supervision (e.g., considered at risk for harm to self or others, psychotic).	Patients with mild to moderate symptoms likely from COVID-19 (preferably with negative RIDP) who would be dischargeable from an emergency department. • Require some level of assistance (e.g., help with ADLs or medications) and • Need a closer level of monitoring than patients in tier one These might include patients who normally reside in nursing homes, assisted care, and dementia facilities who are unable to return to these facilities or patients receiving care at home from a caregiver who becomes symptomatic and may not be able to provide continued care.	• Medium Capacity: 50-200 beds • Large Capacity: >200 beds* • Super Capacity: >500 beds* *May be appropriate for non-FMS section of TCF Center if positive for COVID-19 **Residential Sites** (Alternative) • Dedicated hotel • Dormitory It is always preferred for patients to have a bed over a cot. A hospital bed is preferred but not required. **Tier 2-Behavioral Health** • Small capacity only (<25) • Should have systems in place to maximize safety of patient and others • Residential sites not recommended unless one-on-one supervision/ observation available

Tier	Description	Types of Patients	Operational Considerations
3 **B** **A** **S** **I** **C** **M** **E** **D** **I** **C** **A** **L** **C** **A** **R** **E**	**Tier 3 ACS** houses a cohort of patients who require basic medical care which may include low flow supplemental oxygen (≤6 LPM), intravenous fluids, nutritional support, medication administration, and care, as similar as possible, to what would be received in a medical (non-monitored, non-critical care) unit of a hospital. Emergency medical capabilities should be readily available on site. **Tier-3 Limited:** This is identical to a Tier 3 ACS except has limited abilities to provide sustained oxygen flow. **Tier-3 Non-COVID-19:** This is identical to a Tier 3 ACS or Tier-3 Limited ACS except it is limited to patients who do not have COVID-19, ideally testing negative. **Tier-3 Palliative Care:** This is identical to a Tier-3 ACS but is primarily intended to provide end of life care.	**Patients in Need of Basic Medical Care** • ED/Clinic patients with moderate symptoms of COVID-19[2] including associated hypoxia responsive to low flow oxygen but without evidence of impending respiratory failure, hemodynamic instability (e.g., circulatory shock), older age, or significant co-morbid conditions. These patients would ideally be admitted to a medical (non-critical care) unit of a hospital where they would receive supplemental oxygen, intravenous fluids, medications, nutritional support, and basic hospital-level care. • Patients with moderate symptoms of COVID-19[2] and hospitalized in a medical (non-critical care) unit in a hospital for suspected or confirmed COVID-19 and considered sufficiently stable for transfer to a Tier 3 ACS for continued care, likely involving continued low flow oxygen. • Patients with non-COVID-19 related condition who are in need of basic (non-critical care) services where there is insufficient capacity at the hospital for admission. Examples include patients with cellulitis requiring IV antibiotics and patients with dehydration requiring IV fluids. These patients would NOT be house with COVID-19 patients. [2]Patients should have negative RIDP when possible	**Open Layout Sites** • Low Capacity: <50 beds • Medium Capacity:50-200 beds • Large Capacity: >200-500 beds • Super Capacity: >500 beds A Tier 3 ACS facility would be appropriate for a Federal Medical Station (FMS), or equivalent, capable of providing supplemental oxygen. It is always preferred for patients to have a bed over a cot. A hospital bed is preferred for a Tier-3 ACS. A Tier 3 ACS facility would be appropriate for a hospital-sponsored, HCC-sponsored, or jurisdictional-sponsored ACS. A Tier-3 is not intended to serve as a free-standing ED or a COVID-19 intake center.

Tier	Description	Types of Patients	Operational Considerations
4 **A** **D** **V** **A** **N** **C** **E** **D** **M** **E** **D** **I** **C** **A** **L** **C** **A** **R** **E**	**TIER-4 ACS** houses a cohort of patients requiring advanced medical care, including mechanical ventilation. It is always preferable for this type of care to be delivered in a hospital or other traditional healthcare facility (e.g., long term acute care, skilled nursing facility) accustomed to dealing with patients of this acuity and with mechanical ventilation. In addition to mechanical ventilation capabilities, a Tier 4 must have bedside (or potentially remote telemetry) monitoring, oxygen delivery systems, and the personnel needed to provide this level of care, including intensivisist/pulmonologists (may be available by telemedicine), physicians experienced in critical care (e.g., emergency medicine, internal medicine; including senior residents), nurses with critical care experience, respiratory therapists (augment by RT students), patient care technicians, and pharmacists and pharmacy technicians.	**It is always preferable for this type of care to be delivered in a hospital or other traditional health care facility (e.g., long term acute care, skilled nursing facility) accustomed to dealing with patients of this acuity and with mechanical ventilation.** Patients for a Tier-4 ACS should be patients requiring mechanical ventilation who are: • oxygenating and ventilating well (require FIO@ $\leq$50%, $\leq$12 PEEP) • are hemodynamically stable • not demonstrating signs of multi-system organ failure • not requiring (or expected to require dialysis) • expected to have at least a 75% probability of recovery Patients should be excluded from a Tier-4 ACS who are: • in circulatory shock (elevated lactate, hypotensive) • demonstrating difficulty in ventilating or oxygenating (e.g., FIO2 >50%, PEEP >12) • have multiple comorbid conditions • require (or expected to require dialysis • considered to have less than 50% survival probability	**Potential Sites** • Free-standing surgery endoscopy) center or similar healthcare facility (preferred) • Other facility with open design that can be adapted for this purpose **Patient Capacity:** Because of the high level of care that may be required at a Tier 4 ACS, these facilities should have low capacity, ideally 10-15 patients. If a site has the ability for 20 or more patients, they should consider dividing into two smaller units to allow more focus of effort. They should operate under a joint incident command system. A hospital bed is required for a Tier-4 ACS.

Patient Considerations for Placement in Traditional Healthcare Facilities and Alternate Care Sites

1. **Low Acuity Patients Suspected/Confirmed COVID-19 Appropriate for Care at Home or at Tier-1 or Tier-2 ACS**

   A. Patients presenting to a clinical facility (e.g., ED, clinic, telemedicine) and are determined to likely be demonstrating clinical symptoms and signs of COViD-19 and are not in need of hospitalization (would be appropriate for discharge to home) but are at risk for rapid decompensation but in whom rapid decompensation is not anticipated within 24 hours.

   B. Patients who are hospitalized (including Tier-3 ACS) with COVID-19 and considered sufficiently stable for hospital (including Tier-3 ACS) discharge.

   Preferred Destination: Home with self (family) -care and isolation or return to residential care facility for isolation.

   Alternative Destination: Type-1 or Type 2 ACS

   - This would be appropriate for patients who are homeless, for elderly patients who live alone, for patients dependent upon others for care who do not have care providers

2. **Low or Intermediate Acuity COVID-19 Patients Requiring Basic Medical Care at Hospital or Tier-3 ACS**

   A. Patients presenting to a clinical facility (e.g., ED, clinic, telemedicine) and are determined to likely be demonstrating clinical symptoms and signs of COVID-19 and are in need of hospitalization to a non-critical care unit and require low flow oxygen, intravenous (or oral) hydration, medication administration, nutritional support, and/or management of co-morbid conditions.

   B. Patients who are currently hospitalized in non-critical care units with COVID-19 (confirmed or PUI) who are considered to be sufficiently stable for transfer to another healthcare facility (including a Tier-3 ACS) in order to create additional hospital capacity for more seriously ill patients (including expanding critical care services).

   Preferred Destination: Transfer to a Relief Hospital for continued conventional level of care. May be at a distant site.

   Alternative Destination: Type-3 ACS

   - This would be appropriate when transfer to a Relief Hospital is not feasible or for relatively more stable patients allowing for more

seriously ill patients of this type to preferentially be transferred to a Relief Hospital.

3. **High Acuity COVID-19 patients (including those requiring mechanical ventilation) and Preferentially Cared for in a Hospital**

   A. Patients currently hospitalized with suspected or confirmed COVID-19 and require critical care services (including mechanical ventilation) who are determined to be sufficiently stable for transfer to a Relief Hospital (preferred) or to a Tier-4 ACS. These patients include those that are oxygenating and ventilating adequately ($\leq$12 PEEP, FIO2<50%), not in circulatory shock, not in multi-organ system failure, and anticipated to have at least a 75% survival rate. See additional inclusions and exclusions in Table above.

   B. Patients presenting to the Emergency Department with suspected or confirmed COVID-19 and requiring critical care services (including mechanical ventilation) who are determined to be sufficiently stable for transfer to a Relief Hospital (preferred) or to a Tier-4 ACS (only as last resort). These patients include those that are oxygenating and ventilating adequately ($\leq$12 PEEP, FIO2<50%), not in circulatory shock, not in multi-organ system failure, and anticipated to have at least a 75% survival rate. See additional inclusions and exclusions in Table above.

   Preferred Destination: Transfer to a Relief Hospital critical care unit for continued conventional level of care. May be at a distant site.

   Alternative Destination: Type-4 ACS

   - This would be appropriate when transfer to a Relief Hospital is not feasible or for relatively more stable patients allowing for other more seriously ill patients of this type to preferentially be transferred to a Relief Hospital critical care unit. Because of the potential for rapid deterioration in the acute period, ED patients should be transferred to a Tier-4 facility only as a last resort.

4. **Non-COVID Patients:** Non-COVID patients may be transferred to a Relief Hospital (preferred when medically indicated) or to an appropriate Tier ACS based on the above guidance. However, non-COVID-19 patients should never be cohorted with COVID-19 patients at the same ACS facility. When COVID-19 status is uncertain, high priority testing should be completed prior to transfer to a non-COVID-19 Relief Hospital unit or ACS.