COLORADO
Department of Public Health & Environment

Application for Variance

Name of County: LOGAN

Name of Submitter: Jerry Casebolt

Phone Number of Submitter: 970-520-0991

Email of Submitter: caseboltj@logancountyco.gov

LOGAN County requests a variance from the following restrictions in Executive Order D 2020 044 and/or Public Health Order 20-28.

List the sections of Executive Order D 2020 044 and/or Public Health Order 20-28 that a variance is being sought for:

Restaurants, Public Gatherings, Places of Worship and Gyms

Summarize alternate restrictions being proposed to replace the above-referenced restrictions and indicate where in the Plan these alternate restrictions are addressed:

Allow the opening of restaurants in dining, Movie theaters, Places of Worship and Gyms With social distancing restrictions and the limitations to 30% of their capacity

Upload your county COVID-19 Suppression Plan and documentation demonstrating approval by the county commissioners, and confirmation from all impacted local hospitals that they can serve all individuals needing their care. Provide a brief summary of each of the following elements contained in the county COVID-19 Suppression Plan and indicate where in the Plan more information can be found for each element.

1. Prevalence of COVID -19 within the county

The number of daily positive COVID-19 cases has remained flat since the first positive case was reported to Logan County on 03/22/2020; there are a total of 32 non-DOC positive cases as of 05/13/2020. Since the Sterling facility started mass testing of inmates, their number of positive cases is at 448 as of 5/13/20

2. Hospital Capacity

The CEO Wade Tyrrell of the the hospital confirms that they can handle any surge that may come to the facility based upon their surge plan. Currently they have zero (0) COVID-19 cases hospitalized.

3. Local containment measures

SRMC is conducting testing of Sterling Correctional Facility staff and or Family members through the drive up testing site. Logan County recommends public use of masks as well as social distancing as stated in the Public Health Order.

4. Conditions to determine the variance is not providing adequate COVID-19 protection and the triggers for tightening restrictions.

1) keeping the proportion of positive tests to less than 10% of overall general population tests conducted when mass testing is supplied, and 2) staying below the threshold of less than 42 COVID-19 hospitalizations in our local hospital, based on Sterling Regional MedCenter Surge Plan.

DS JC Confirm that the variance requested does not lessen or eliminate the protections for Vulnerable Individuals in the Safer at Home Order and PHO 20-28.

DS JC Confirm that the county will collect and monitor data to evaluate the impacts of the variance. and make such data available upon request by CDPHE.

Additional information relevant to the requested variance

Logan County respectfully requests that CDPHE considers that even though "Logan County has the highest rate of COVID-19 in Colorado," the high rate of COVID-19 positive cases are contained in the Sterling Correctional Facility which is overseen by the Colorado Department of Corrections and for which Logan County has no jurisdiction

By signing below, I attest that I am authorized pursuant to the adoption of the COVID-19 Suppression Plan by the Board of County Commissioners to submit this variance request to CDPHE for consideration.

DocuSigned by:
Jerry Casebolt
3A9EC52C11EC4C9...

Signature

2020-05-15

Date

SAFER AT HOME LOGAN COUNTY
(Phase 1) May 15

CONDITIONS FOR LIFTING RESTRICTIONS
The World Health Organization has set forth the following guidelines for transitioning from a "scenario of community transmission to a sustainable, steady-state of low-level or no transmission:"

1. **Disease Transmission is Under Control**
   - The number of daily positive COVID-19 cases has remained flat since the first positive case was reported to Logan County on 03/22/2020; there are a total of 32 non-DOC positive cases as of 05/13/2020. Logan County respectfully requests that CDPHE considers that even though "Logan County has the highest rate of COVID-19 in Colorado," the high rate of COVID-19 positive cases are contained in the Sterling Correctional Facility which is overseen by the Colorado Department of Corrections and for which Logan County has no jurisdiction. Since the Sterling facility started mass testing of inmates, their number of positive cases is at 448 as of 5/13/2020. Sterling facility officials have confirmed that the vast majority of those cases are asymptomatic with a low probability of critical care required. Outside of the correctional facility, the greatest spike in numbers occurred in early April when five positive cases were reported for a single day. Since our first variance submittal on 4/29/2020, Logan County has occurred an increase of seven positive cases, five of which were DOC Staff at the Sterling Correctional Facility. The DOC assures us they are taking all precautions to keep their employees safe and COVID free, utilizing the use of PPE for all staff and inmates and the quarantine of positive inmates.
   - Hospitalizations: For the time period of March 21 - May 1, 2020; local hospitalization of Logan County residents has included 18 presumptive cases and 15 confirmed cases of Coronavirus.
   - Sterling Regional MedCenter has dual COVID19 testing capabilities for point-of-care (used for determination of level of care) and laboratory testing. In addition, serology testing is available on their campus.
   - Sterling Regional MedCenter's footprint includes 9 Emergency, 4 Intensive Care, and 18 Medical Surgical beds – which can be greatly expanded through their Coronavirus (COVID19) Surge Plan (See attached Surge Plan written March 24, 2020) to include 14 Emergency (acute and non-acute); 12 Intensive Care, and 42 general Med Surg beds. The hospital is supported by Board Certified Emergency Medicine Providers (24/7) as well as Board Certified Internal Medicine Hospitalists (24/7). Additional providers are available for surge volumes through their employed Family Practice providers.
   - In reference to a potential surge in patients originating from Sterling Correctional Facility; Sterling Regional MedCenter, Denver Health (who holds a transfer agreement for higher acuity inmate care), North Colorado Medical Center (Greeley), and Banner-Fort Collins (Fort Collins) and Colorado Department of Corrections have developed a surge plan to meet care demands once volumes exceed Sterling Regional's capacity.
   - Sterling Regional MedCenter has not had an admission of a potential or confirmed COVID-19 patient for the last 12 days. There are currently no COVID-19 hospitalizations.

County	1-4	5-9	10-14	15-19	20-39	40-59	60-79	80+	Unk	Total
Logan	0	0	0	0	232	189	55	4	0	*480
Morgan	3	0	2	17	187	169	101	51	2	532
Phillips	0	0	0	0	0	4	5	0	0	9
Sedgwick	0	0	0	0	0	0	0	0	0	0
Washington	0	0	0	0	2	2	4	1	0	9
Yuma	0	0	0	1	3	4	3	0	0	11
Total	3	0	2	18	424	368	168	56	2	1041

COVID-19 DEATHS BY COUNTY

	Logan	Morgan	Phillips	Sedgwick	Washington	Yuma
Cases	3	22	0	0	0	0

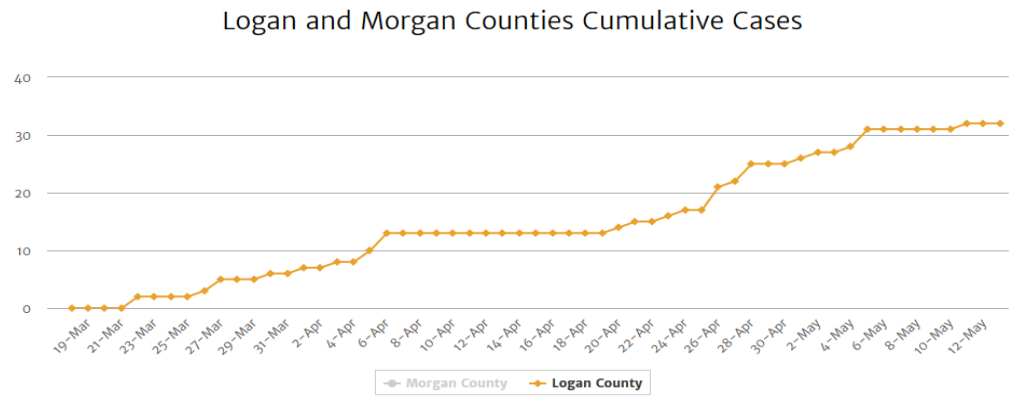
*Logan County increase is related to ongoing investigations associated with both community members and the outbreak at the Sterling Correctional Facility. The most current number of inmate cases provided by the Colorado Electronic Disease Reporting system is 448. In the coming days, as investigations are completed, numbers will be updated.

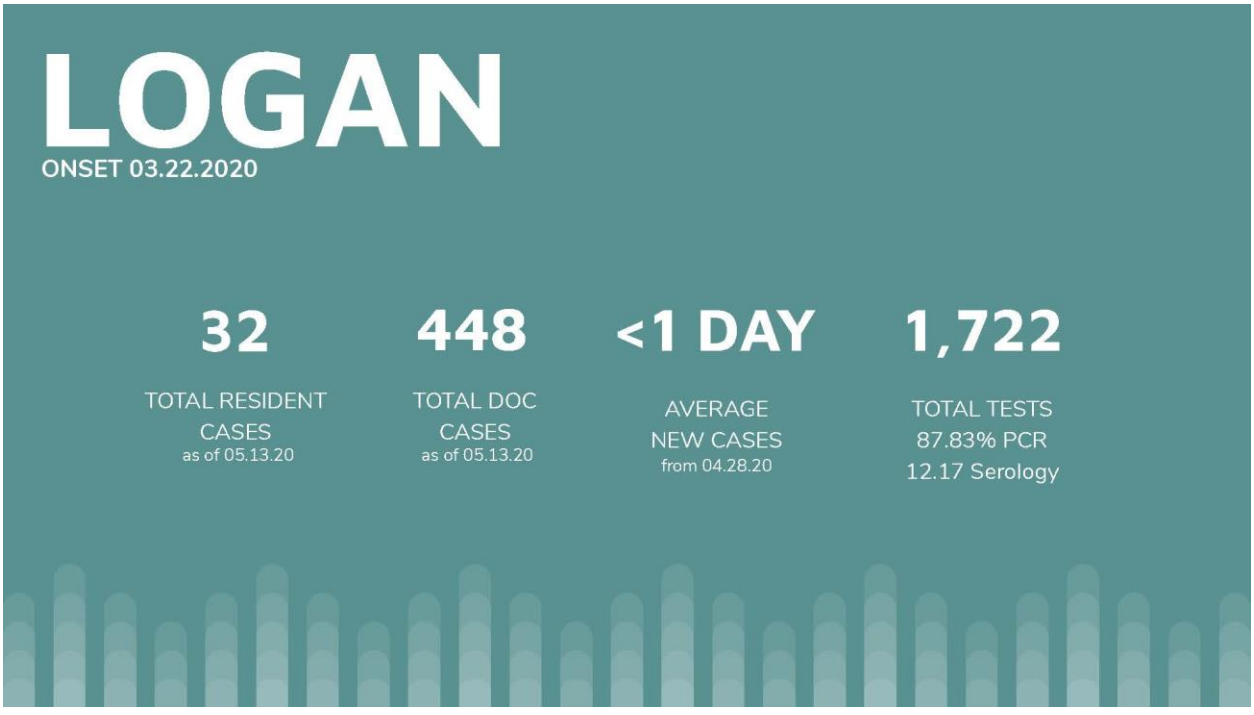
COVID-19 CASE COUNT ASSOCIATED WITH OUTBREAKS

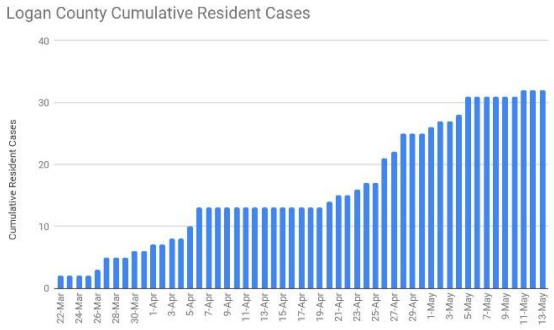
	Logan	Morgan	Phillips	Sedgwick	Washington	Yuma
Cases	*448	137	0	0	0	0

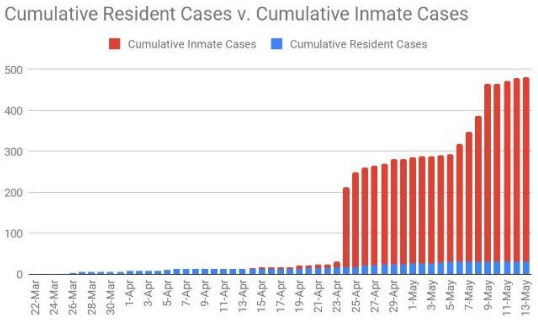
**It is sometimes necessary to adjust case numbers up or down based upon case investigations and the final determination of county of residence.

Graph data may lag behind tables by 24-48 hours because of the added time to accumulate data.









2. **There are Sufficient Health System and Public Health Capabilities**
   - Sterling Regional MedCenter has dual COVID19 testing capabilities for point-of-care (used for determination of level of care) and laboratory testing. In addition, serology testing is available on their campus.
   - Sterling Regional MedCenter's footprint includes 9 Emergency, 4 Intensive Care, and 18 Medical Surgical beds – which can be greatly expanded through their Coronavirus (COVID19) Surge Plan (See attached Surge Plan written March 24, 2020) to include 14 Emergency (acute and non-acute); 12 Intensive Care, and 42 general Med Surg beds. The hospital is supported by Board Certified Emergency Medicine Providers (24/7) as well as Board Certified Internal Medicine Hospitalists (24/7). Additional providers are available for surge volumes through their employed Family Practice providers.
   - In reference to a potential surge in patients originating from Sterling Correctional Facility; Sterling Regional MedCenter, Denver Health (who holds a transfer agreement for higher acuity inmate care), North Colorado Medical Center (Greeley), and Banner-Fort Collins (Fort Collins) and Colorado Department of Corrections have developed a surge plan to meet care demands once volumes exceed Sterling Regional's capacity.
   - Sterling Regional MedCenter has a surge plan that could increase bed capacity to 59 if needed, in less than 24 hours.
   - Northeast Colorado Health Department developed a community medical surge plan in collaboration with local hospitals. On average, the hospital has enough PPE to last two months under normal conditions. Northeast Colorado Health Department has reserved 5% of the critical PPE supplies from the local Medical Cache allocation to backfill the hospital as needed.
   - The Northeast Colorado Health Department Epidemiology team consists of three disease surveillance specialists who do contact investigations on every positive case. Case investigations are mostly completed within 24 hours. Contact tracing is also performed with people who were in direct contact with identified positive cases.
   - Among positive cases in Logan County, a large percentage been traced to a known source at the Sterling Correctional Facility.
3. **Outbreak Risks in High-Vulnerability Settings are Minimized**
   - Northeast Colorado Health Department Health address policies and procedures in nursing homes all long term care centers are not allowing any visitors into their facilities
   - Northeast Colorado Health Department Health works with childcare facilities

4. **Workplace Preventive Measures are Established**
   - Guidelines addressing prevention have been written and distributed to schools, workplaces, and other essential places as outlined in this document (Phases 1, 2, and 3)

5. **Risk of Imported Cases Managed**
   - Limits have been set for non-essential travel
   - The DOW is assessing the opening of camping after the Governor opened it up on May 12, 2020.
   - There are protocols in place related to transporting patients to Logan County hospitals from other regional hospitals
   - The Sterling Municipal Airport has protocols for handling an exposed or potentially infectious person at the airport.

6. **Communities are Fully Engaged**
   - Northeast Colorado Health Department staff are working with healthcare facilities to implement physical distancing guidelines
   - Northeast Colorado Health Department retail food licensing team, along with NCHD health educators are working with local businesses to implement physical distancing guidelines
   - Northeast Colorado Health Department staff are working with local residents on education and compliance related to physical distancing guidelines
   - Northeast Colorado Health Department is working with outdoor recreation facilities to implement physical distancing guidelines

PUBLIC HEALTH RECOMMENDATIONS FOR ALL RESIDENTS OF LOGAN COUNTY

- Maintain physical distancing (6 feet)
- Adults 65 years and older and high-risk populations should limit public interactions and stay at home as much as possible
- Use cloth face coverings for interactions where physical distancing is not possible or when entering public places
- People with symptoms should stay home and should not go to work
- Wash hands frequently with soap and water. If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol.

DETERMINING SUCCESS DURING ALL PHASES OF REOPENING

The determination on whether the social distancing policies are working will be based on: **1) keeping the proportion of positive tests to less than 10% of overall general population tests conducted when mass testing is supplied,** and **2) staying below the threshold of less than 42 COVID-19 hospitalizations** in our local hospital, based on Sterling Regional MedCenter Surge Plan. This would keep the hospital under their max capacity to have to implement their Surge Plan. If respective numbers for either of these measures exceeds the stated limit, actions will be taken to improve social distancing practices in Logan County. It may be necessary to reissue local Stay at Home orders. It is vital that everyone participate in this effort.

GUIDELINES FOR ALL SECTORS:

- Perform frequent environmental cleaning and disinfection (concentrate on high touch surfaces like tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc.)
- Employees and contracted workers whose duties include close contact with members of the public shall wear a non-medical cloth face covering over the nose and mouth
- Employees are encouraged to wear a non-medical cloth face covering over the nose and mouth while working, except where doing so would inhibit the individual’s health

- Maintain at least six feet distance from each other
- Monitor workforce for compatible symptoms
- Implement or maintain return to work policies

SPECIFIC RECOMMENDATIONS BY SECTOR

Public gatherings

- Allow public gatherings of no more than 10 people
- Maintain at least six feet distance from each other
- Movie Theaters can open if they can meet the requirements of 30% capacity as long as social distancing can be used, patrons should wear mask as well, with the facility posting the appropriate signage on the recommendations
- No festivals or other large gatherings until at least June 12, at which time the situation will be evaluated with our local health department to determine when and if outdoor festivals and other types of large gatherings can resume
- Large indoor venues shall remain **closed.**

Offices

- Encourage telework, wherever possible
- Maintain at least six feet distance from customers and each other
- Desks, work stations, and other work areas should be separated by at least six feet. If fixed stations exist, separate employees or clients by leaving one station in between. Workstations separated by walls that are six feet or higher can remain as they are
- Implement or maintain physical barriers for high-contact settings (e.g. reception areas)
- Implement physical distance protocols in common areas (separate tables and chairs by at least six feet)
- Place markings on the floor to maintain at least six feet distance in customer lines; try to establish one-way passage as much as possible
- Only essential travel is allowed
- Consider return to work in phases as applicable
- Implement or maintain flexible sick leave policies and practices
- Consider accommodations for high-risk individuals or populations
- Employees and contracted workers whose duties include close contact with members of the public shall wear a non-medical cloth face covering over the nose and mouth
- All employees are encouraged to wear a non-medical cloth face covering over the nose and mouth while working, except where doing so would inhibit the individual's health

Retail and personal services (as applicable)

- Critical businesses that were open under the stay at home order should maintain the same precautions and physical distancing practices
- As much as possible, continue curbside delivery while phasing into public opening
- Personal services (salons, tattoo parlors, dog grooming, etc.) and non-critical can open under the following guidelines.
    - Spread people out so there is at least six feet distance between individuals throughout
    - Limit the number of clients to 30% of the facility's capacity
    - Separate workstations (tables, chairs, etc.) by six feet. If fixed stations exist, separate clients by leaving one station in between. Workstations separated by walls that are six feet or higher can remain as they are
    - Implement or continue early opening for high-risk individuals
    - Implement or maintain physical barriers for high-contact settings (e.g. cashiers)
    - Implement or maintain one-way entry/exit and aisles if possible

  - Employees and contracted workers whose duties include close contact with members of the public shall wear a non-medical cloth face covering over the nose and mouth
  - Implement or maintain curbside services in businesses as a preferred method
  - Stagger shifts if feasible to decrease the number of employees at the business
  - Maintain at least six feet physical distancing in waiting areas
  - Place markings on the floor to maintain at least six feet distance in customer lines
  - Implement touchless payment methods when possible
  - Encourage the public to wear cloth face coverings to enter the businesses

Restaurants

- Bars shall remain **closed,** including those that are part of restaurants, however if patrons are dining in with all the below measures met alcohol may be served at their table
- Restaurants may open if they meet the requirements of limiting to 30% of your indoor capacity
- Continuing takeout and delivery is highly encouraged
- As much as possible, continue curbside delivery while phasing into public opening
- Spread people/tables out so there is at least six feet distance between individuals throughout
- Place markings on the floor to maintain at least six feet distance in customer lines
- Implement touchless payment methods when possible
- Implement or maintain physical barriers for high-contact settings (e.g. cashiers)
- Stagger shifts if feasible to decrease employee numbers at the business
- In-room dining shall follow strict physical distancing
- Group parties should be limited to no more than six people. People within a party should be family members or acquaintances who have previously been in contact with each other and there is limited risk of disease transmission
- Don't allow public sharing of utensils or condiments
- Buffets shall have an employee serving the food, no self-serving allowed
- Self-serving stations shall remain **closed** (drinking stations, bulk dry, etc.)
- Maintain physical distancing (six feet) in waiting areas
- Employees and contracted workers whose duties include close contact with members of the public shall wear a non-medical cloth face covering over the nose and mouth
- Encourage the public to wear cloth face coverings to enter the businesses

Elective, Medical and Health Services

- Visitation to hospitals and senior living facilities is **prohibited** at this time
- Sterling Regional MedCenter is in full compliance with Colorado Department of Public Health and Environment (CDPHE) Order 20-29 and requires both swab and serology testing for pre-operative medically necessary elective cases. A risk-stratified algorithm is used for determination of priority and provision of care:

Low = PCR/IgG "-" or Equiv and Asymptomatic

Low = PCR "-"/IgG "+" and Asymptomatic

Moderate = PRC "+" and Asymptomatic

High Risk = PCR "+" and Symptomatic

- Elective health services can reopen while adhering to the following precautions
  - Use adequate PPE that protects the provider and the client
  - Implement one-way entry/exit and aisles
  - Use an appointment system to minimize the time in waiting rooms
  - Maintain physical distancing (six feet) in waiting rooms

- Implement or maintain physical barriers for high-contact settings (e.g. front desk)
- Encourage the public to wear cloth face coverings to enter the businesses
- Employees and contracted workers (other than providers) whose duties include close contact with members of the public shall wear a non-medical cloth face covering over the nose and mouth

Recreation

- Maintain physical distancing in outdoor settings (6ft while hiking, 15ft while running or biking)
- Open outdoor recreation facilities where adequate controls can be implemented to ensure physical distancing (six feet)
- Limit public gatherings to no more than 10 people
- Perform frequent cleaning and disinfection of bathrooms and high-touch surfaces
- Only essential travel allowed; avoid traveling outside of your county or local community for recreation

Education

- Limited in-person learning for specific settings (e.g. technical college)
- Limit classrooms to no more than 10 people
- Maintain at least six feet distance from each other
- Higher education, K-12, and organized youth activities shall remain **closed**
- Child cares can reopen with the following precautions
  - Perform frequent environmental cleaning and disinfection (concentrate on high touch surfaces like playgrounds, toys, tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc.)
  - All employees shall wear a non-medical cloth face covering over the nose and mouth while working with children
  - Maintain at least six feet distance from coworkers
  - Implement physical distance protocols in common areas (separate tables and chairs by at least six feet)
  - Symptomatic children should be excluded from care
  - To the extent possible, limit the sharing of utensils, toys, and classroom materials
  - To the extent possible, limit shared spaces to one classroom at the time (e.g. playgrounds)

Real Estate

- In-person home showings can resume
- Maintain at least six feet distance from customers and each other
- Cloth face coverings are highly encouraged
- Prior to a showing, ensure clients are not experiencing respiratory symptoms
- Open houses are **prohibited** at this time

Places of Worship

- Continue online or drive-by services as much as possible
- When offering on-site services:
  - Limit the number of participants to 30% of your capacity is strongly encouraged
  - Encourage all attendees who are 65 and above to stay at home and watch the services online, or provide a “senior service” exclusively for attendees 65 and above to attend in person as long as the social distancing can be obtained
  - Ask all attendees who have an underlying at-risk health condition to stay home and watch the services online
  - Operate with strict physical distancing practices

- Spread people out so there is at least six feet distance between families throughout
- Place markings on the floor to maintain at least six feet distance where lines form
- Implement or maintain one-way entry/exit and aisles
- Implement touchless offering options as much as possible
- Encourage employees and the public to wear cloth face coverings
- Discourage people from attending if they are experiencing any symptoms
- Perform frequent cleaning and disinfection of bathrooms and high-touch surfaces

Gyms

- Can operate IF the following physical distancing and cleaning practices are possible
  - Limit the number of clients to 30% of your capacity
  - Spread people out so there is at least six feet distance between individuals throughout
  - Group classes are not allowed
  - Food/drink bars shall remain closed
  - Locker Rooms Facilities and Showers will remain closed

BOARD OF COUNTY COMMISSIONERS
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Wade Tyrrell, CEO

Sterling Regional MedCenter
Coronavirus (COVID-19) Surge Plan
March 24, 2020

Introduction

In a proactive response to the depth of the current prevalence of Coronavirus (COVID-19) the leadership of Sterling Regional MedCenter have drafted our initial surge plan – a very fluid plan – to strategically move the organization forward while meeting the needs of our community during this challenging time. Segments of our plan incorporate the Centers for Disease Control and Prevention (CDC) Comprehensive Preparedness Checklist for Coronavirus Disease 2019 (COVID19).

Executive Summary

Facility Overview

Sterling Regional MedCenter is a 25-bed prospective payment, rural-referral hospital located in Sterling, Colorado – along the eastern plains. Our organization is a part of the Western Division of Banner Health. A rich 80-plus year history finds our primary service area extending in a 30-mile radius of Logan and adjoining counties; with our secondary service area extending as far as 60-miles. We are rural in geographic location only and take great pride in our scope and outcomes. We hold a Level III Trauma Center designation. Our Emergency Department sees 11,000 patients annually with Board Certified Emergency Medicine providers. We offer full scale imaging (digital film; 64 slice CT; 1.5 Tesla MRI; Nuclear Med; Bone Density; Mammography; PET-CT; and invasive procedures). Laboratory services include full range diagnostics; Microbiology; Pathology; and Blood Bank. Perioperative services include general surgery; orthopedic surgery – including Total Joint Replacement; obstetric, GYN, podiatry, and ophthalmology. The David Walsh Cancer Center provides comprehensive radiation and medical oncology. Inpatient care is provided in our 18-bed Medical Surgical Unit; our 4-bed Intensive Care Unit (with Banner e-ICU support); as well as a 3-bed Labor/Delivery/Recovery/Post-Partum Unit. Inpatient is supported through an Internal Medicine Hospitalist on a 24/7 basis. Full range Cardiopulmonary/RT (both inpatient and outpatient) including Sleep Study; Wound Care; and full range Rehab Therapy (PT/OT/ST) provide comprehensive inpatient and outpatient support.

We value the integration of our three clinics: two rural health-designated Family Practice Clinics (one adjoining the hospital; the other approximately two miles from campus) and one specialty clinic (for general surgery, cardiology, orthopedics, women's health, and visiting specialties).

We have a strong and growing medical staff who are actively engaged in our mission, processes, and outcomes. In 2017, we welcomed second and third-year residents as a National College of Family Medicine program site, and serve as a clinical site for health occupation, nursing, rehab therapy, pharmacy, anesthesia, and radiology programs.

Tertiary referrals are supported through transfer to Banner Health Northern Colorado (North Colorado Medical Center or McKee Medical Center); Denver Health; Presbyterian St. Luke's (Maternal/Child); University of Colorado Children's Hospital (Maternal/Child); and others, at patient request.

Outbound intrahospital transports are provided through Banner Paramedics (ground) and Med-Evac (rotor) as our primary partners.

Hospital Incident Command

In proactive response to the growing incidence of Coronavirus (COVID-19) the Hospital Incident Command Center (ICC) was implemented on the afternoon of March 13, 2020. The ICC consists of a blend of leaders and staff serving in the following areas: Incident Commander, Operations, Planning, Public Information, Financial, and Logistics. The ICC is actively supported by our Infection Preventionist, our Laboratory Lead, our Plant Operations Lead and other key stakeholders in the ICC process. To date, the ICC has stood in virtual form with twice daily "operations" and "next day" huddles to share knowledge and collaborate in our ongoing emergency management plan. In addition, when situations warrant, called meetings of the ICC or key members are held with new information and plan adjustments cascaded outward.

Cohort Status

On the evening of Saturday, March 21, 2020 a two-hour planning meeting with an abbreviated ICC (the Incident Commander, Operations primary and secondary Leads) supported by our Laboratory Leader, Imaging Leader (who also represented our Cardiopulmonary Leader), and Infection Preventionist was held to finalize plans for activating our Acute Respiratory Unit (ARU) for cohorting of confirmed or suspect COVID-19 patients. The unit opened with the start of our 7a shift on March 22. The ARU consists of four rooms on a dedicated unit (full ventilator capabilities) and is supported by two reverse isolation rooms (one for procedures; one as a downgrade or overflow room). Staffing is provided on a 1:2 Nurse:Patient ratio with full Respiratory Therapy support. Full Extended Precautions are implemented and continue up to the time of hospital discharge. To date, the ARU has provided care to five patients.

Projected Surge Status

Predictive modeling projects a surge in COVID-19 volume beginning approximately mid – April 2020. With that knowledge, the ICC has developed our Coronavirus (COVID-19) Surge Plan to effectively expand our total inpatient volume by 100%; or a full capability of 50 – plus patients of mixed classification and acuity.

Resource Considerations

As one might anticipate availability of resources (equipment, supplies, providers, clinical and support team members) is essential to the success of our surge plan. The facility has focused on conservation of supplies – especially personal protective equipment (PPE) and COVID-19 test kits/media. Lower volume in our Emergency, Inpatient, and Outpatient departments as a result of imposed public restrictions has aided in this process.

We are fortunate to be supported by Banner Health's extensive supply chain network. Availability and inventory of supply resources are communicated outward through a variety of system calls and facility huddles.

A cache of Emergency Management bedside equipment remains in storage and we are in the process of completing an inventory of those items.

Availability of medication and infusions are closely monitored by our Pharmacy Leader with that information shared in our "next day" huddles, as well as with our providers.

Focus on availability of fresh and frozen foods to meet expanded patient and staff demand remains a priority – as is the possibility of providing expanded culinary hours for our employees. U.S. Foods, our primary vendor, has not projected food shortages (though we are currently experiencing a shortage on paper and Styrofoam products) as of this writing.

Potential equipment needs are included on Addendum 7.

Our most valued resource are our team members. With the guidance and assistance of our Human Resource partners, at the Division and local levels, we are developing a plan to repurpose many clinical and non-clinical staff, where volume and acuity allows.

Repurposing simply reallocates a team member based on their skill level, additional training required, and availability. As areas within the facility experience a decrease in volumes (examples: Perioperative Services, Imaging, Rehab Therapies, Patient Access) secondary to a reduction in service or imposed public restrictions, staff potentials will be re-evaluated, additional education or training provided – and the co-worker reassigned. Ideally, this will be a fluid process to meet demand.

We are fortunate that within nursing (roughly 65 frontline team members), more than 30% are currently cross-trained in one or more clinical areas.

Initially, we will seek additional hours from part-time co-workers, or an additional shift per payroll period from full-time co-workers, with a continued focus on preventing physical and emotional fatigue. There will also be a realignment of nurse:patient ratio in those areas of moderate to lower acuity, partnering with a nursing assistant or 'Helping Hands' assistant.

Additionally, our plan seeks to utilize clinical co-workers who are currently not working in a clinical role – as well as former or retired nurses; faculty members of our local nursing program; nurses within the community who may not be currently working; respiratory therapists and other health-related students to supplement our team members.

One consideration that will be available to our team members is flexibility in shifts: four-hour, eight-hour, and twelve-hour as we build our daily schedules.

Staffing

Each phase of the surge plan demonstrates both the recommended staffing per 12-hour shift, as well as the fulltime equivalents (FTE) required at capacity for that phase. FTE requirements for RN, NA/Helping Hands, and RRT for individual phases include:

RN:

Phase	Maximum FTE
Phase 2a ED: Main and Overflow	16.56
Phase 2a ARU / ICU / MS / LDRP	28.98
Phase 2a OBS Overflow	4.14
Phase 2b Clinic / Rehab	16.56
House Supervisor	4.14
Total Projected RN FTE Need:	70.4
Projected RN FTE Available:	70.4
Net	0.0

NA/Helping Hand:

Phase	Maximum FTE
Phase 2a ED: Main and Overflow	8.24
Phase 2a ARU / ICU / MS / LDRP:	12.42
Phase 2a OBS Overflow	4.14
Phase 2b Clinic / Rehab	16.56

Total Projected NA/Helping Hand FTE Need:	41.4
Projected NA/Helping Hand FTE Available:	13.95
Net	(27.45)

RRT:

Phase	Maximum FTE
Phase 2a ED and Overflow/ARU/ICU/ MS/OBS Overflow/LDRP/Clinic/ Rehab	8.18
Phase 2b	No Additional
Total Projected RRT FTE Need:	8.18
Projected RRT FTE Available:	7.3
Net	(0.88)

Staffing and FTE requirements are illustrated at "best case" scenarios and could easily be impacted by team member illness or other factors. The duration of surge volume must also be considered. NOTE: The RN FTE listing excludes perioperative RN team members to allow for on-call/callback coverage.

Addendum 8 illustrates a table of current active team members at their current, and projected Phase 2a and Phase 2b FTE status. Addendum 9 illustrates a table of Banner-employed nurses based at our facility that currently do not work in a bedside role; a listing of nursing program faculty (from Northeastern Junior College) who could potentially support us; a listing of retired nurses within the community who could possibly support us; and a retired Registered Respiratory Therapist who is currently licensed and has offered to support us. Nursing Assistant staffing needs may be supplemented by students in the Northeastern Junior College nursing program and or retired/non-licensed nurses as "Helping Hands".

Anticipating volume increases in the Emergency Department as well as our inpatient areas (specifically serial chest films, and others) our Imaging Department will transition to a 24/7 schedule rather than our current after-hour "on-call/callback" schedule to increase response and efficiency. This will be accomplished without the need for additional staffing resources. Addendum 10 illustrates this scheduling process.

Transitioning Patient Placement

Even with the most solid plan, transitioning scope and placement while maintaining quality and patient experience is a delicate and complex balancing act when considering spatial constraints; availability of resources; availability of staffing; community awareness; regulatory considerations; flexibility of nurse:patient ratio; flexibility in shifts; and other considerations.

Fluidity and flexibility will be the key to the success of our plan. To maintain that focus, we will assess/reassess the current state on an every-four-hour basis through Phase 1 (our normal operation status) and advance to an every-two-hour basis with the onset of Phase 2a. Ongoing triage of patient status and "top of mind" awareness in relocating patients based on acuity is essential.

Attaining and Maintaining that 5000-Foot Collaborative Perspective

Ideally, maintaining a strong collaborative and forward focus requires consistency in shift leadership with diligent monitoring and communication of ongoing activities. While the ICC leads oversight of our plan and activities, we will challenge our department leaders and House Supervisors with ownership of round-the-clock activity, communication, monitoring and compliance. We will continue our current huddles; communication through leadership rounding; emails; Workforce Messaging; and our virtual Town Hall sessions. We will call formal

meetings of the ICC when necessary to review ongoing evaluations of status, as well as triggers to move forward to the next phase. Administrative assistants in our Administration area will assist with staff scheduling and cascading of updates and information to team members.

Phased Status: Emergency/Trauma

While the primary focus of the plan is to increase inpatient/observation capabilities, the fact remains that the largest portion of our admissions originate in our Emergency Department. While the department has experienced a decrease in daily volumes since the onset of Coronavirus (COVID-19) we can expect that volume will increase in advance of inpatient/observation volumes.

Emergency Department: **Phase 2a:** (see Addendum 1) supplements the main Emergency Department during peak volume by triaging lower acuity patients (e.g., "treat and street") to an additional five-bed site within the Pre-Op/Perianesthesia area.

Even with these additional beds, an active process of staffing a dedicated triage RN in the main Emergency Department will be essential during these times. Supplementing nursing staff per zone, or per patient ratio, will also assist the function and flow within the department.

We will continue to work closely with leadership from Team Health (our provider partners) related to provider staffing.

The potential of additional phases will be evaluated consistently. Should the need arise we will consider an alternative site location adjacent to the main campus or a temporary tent structure.

Phased Status: Inpatient/Observation/Acute Respiratory Unit

Inpatient transition will be accomplished strategically through the implementation of four stages, over two phases, to achieve a maximum inpatient/observation census of 59 (an increase of roughly 140%) with an additional tier to an alternative care site, if necessary.

Phase 2a – (see Addendum 2) brings the dual focus of transitioning four additional existing beds to Acute Respiratory Unit beds (for higher acuity cohorted patients) as well as enhancing the Medical/Surgical Unit by five beds. Here the Hospitalist will oversee 25 patients which may stretch their span of control. Total net increase: 5 beds/Total beds: 30

Phase 2a – (see Addendum 3) opens a five-bed observation/lower acuity area for patients with an anticipated stay of 24 hours or less; non-respiratory; non-infectious; by utilizing a large portion of the Perianesthesia area. Based on observation/lower acuity, provider coverage may be supported by an employed Family Practice provider during rounding (with supplemental "on-call"). Total net increase: 5 beds/Total beds: 35

Phase 2b – (see Addendum 4) is our largest transition, adding 18 beds in our adjoining Family Care Clinic. We will relocate all clinic activity to the Banner Health Center (102 Hays) and utilize this space for lower acuity patients with an anticipated stay of four days or less. Volume includes non-respiratory infectious diagnoses only. This phase will be the most difficult to transition related to space and equipment needs. Based on scope, provider coverage may be supported by two or more employed Family Practice providers during rounding (with supplemental "on-call"). Total net increase: 18 beds/Total beds: 53

Phase 2b – (see Addendum 5) will occur with the anticipated decrease in Therapy services. The East and West gymnasiums will be combined, with the West gymnasium used for lower acuity, non-infectious patients. This area lacks a great deal of the basics for providing care but can be retrofitted with advance notice. Total net increase: 6/Total beds: 59

The potential of an additional phase will be evaluated consistently and, based on our inability to stretch further, will be in collaboration with our local Emergency Management officials. Should the need arise we will consider an alternative site location at our 777 Building (see Addendum 6)

Continuum of Care

Patient movement along the continuum of care is essential to our plan with the flexibility of moving affected patients into the various levels of our Acute Respiratory Unit (ARU). Should we exceed ventilator capabilities (in either the ARU or the ICU) we will arrange transfer to a tertiary center (either by ground or air; as appropriate to the individual case). Ground transport of intubated patients will require a transport team of 1 RN and 1 RRT (Banner Paramedics cannot transport intubated patients independently).

As patient condition improves, we will downgrade patient status and or location when appropriate. Throughout the process collaborative discharge planning and ongoing communication with family; primary provider; post-acute care, home health partners, and home medical equipment (HME) partners; as well as third-party managed care Case Managers is essential.

Discharge Process

The discharge process for all patients will involve virtual instruction and teach-back education to family/care providers, supplemented by printed instruction. Post-acute follow-up with a primary care provider will be arranged. Follow-up telephone calls within the first 24-hours of discharge will be provided for all patients. Care Management and Social Service protocols and guidelines will be utilized.

Should we reach a point where volume outpaces space, we will utilize our Logan/Pawnee Conference Room space to establish a Discharge/Departure Lounge utilizing Banner Health guidelines.

End of Life Considerations

End of life considerations will be based on Banner Health guidelines with every consideration given to the patient's spiritual wishes and presence of family members (within the confines of community and facility restrictions) whenever possible.

Sterling Regional MedCenter is not equipped with a morgue. The Logan County Coroner owns one of the two funeral homes in the community. Generally, a funeral home is contacted to receive a body shortly after death. Should the need arise, we have an opportunity to obtain a refrigerated storage unit (through memorandum of understanding) to assist with safely holding the deceased.

Demobilization

As the prevalence of Coronavirus (COVID19) subsides, demobilization will be as equally challenging and fluid in our planning. Ongoing assessment of all resources will ensure that as we begin scaling back, we will continue to be well-equipped and well-staffed. With a focus on patient experience, we will reverse our plan by closing Phase 2b locations initially and, as space allows, begin transitioning patients in those locations back into the main hospital locations. Once Phase 2b locations close we will continue to utilize Phase 2a locations until such time as the determination has been made to close the Acute Respiratory Unit (ARU).

The State's plan to offer Safe Haven for patients transitioning post-discharge may also impact our demobilization plan.

Call to Action

Communicating Volume, Acuity, and Bed Availability: Stoplight Report

We will communicate our volume, acuity, and bed availability – both internally and externally – via a stoplight report (green/yellow/red) utilizing the following levels:

Care Area			
Phase 2a: Emergency Department (15)	0-5	6-9	>9 patients
Phase 2a: Acute Respiratory Unit (10)	0-3 patients	4-6 patients	>6 patients
Phase 2a: Intensive Care Unit (2)	0 patients	1 patient	2 patients
Phase 2a: Medical Surgical (16)	0-10 patients	11-15 patients	>15 patients
Phase 2b: Medical Surgical (40)	0-20 patients	21-35 patients	>35 patients

As typically practiced, GREEN will indicate that we can safely accept admission of all patients; YELLOW will indicate that we have the ability to accept patients but we are cautiously nearing full capacity and potentially a stretch of our resources; RED will indicate that we are at or near our maximum capacity and utilization of resources – we will accept admission up to maximum capacity, but not without collaboration between providers, nursing leaders, and clinical leaders to ensure quality care is provided within our scope of care.

Triggering Phase Advances

The decision to advance to a higher phase of service will originate with the ICC based on their collaboration with the Logan County Department of Health; the Logan County Office of Emergency Management; the Colorado Department of Public Health and Environment (CDPHE); Banner Western Division Leadership; and Banner corporate.

Without a strong sense of prevalence versus timing, the trigger to prepare to advance to the next phase of service will be when the prior phase is activated (example: when Phase 2a is activated, planning for transition to Phase 2b will begin). This may be heavily influenced on an anticipated versus an actual surge of volume.

Other Considerations

During these early stages, our Surge Plan is not all encompassing – serving as a strong foundation from which to evolve with attention to external and internal forces. Any exclusion of departments is not a reflection of their importance in participating or the success of our plan.

Addendums

- Addendum 1: Emergency Department: Phase 2a: Utilization of Pre-Op/Perianesthesia Area
- Addendum 2: Inpatient/Observation/Acute Respiratory Unit: Phase 2a: Main Patient Units (Second Floor)
- Addendum 3: Inpatient/Observation Capacity: Phase 2a: Utilization of Perianesthesia Area
- Addendum 4: Inpatient/Observation Capacity: Phase 2b: Transitioning to the Family Care Clinic
- Addendum 5: Inpatient/Observation Capacity: Phase 2b: Additional Capacity in the Therapy Gymnasium
- Addendum 6: Inpatient/Observation Capacity: Phase 3 and 4: Relocation to an Alternative Care Site
- Addendum 7: Resource Needs: Equipment
- Addendum 8: Resource Needs: Staffing Resources – FTE Current vs Projected
- Addendum 9: Resource Needs: Staffing Resources – Repurposing
- Addendum 10: Resource Needs: 24/7 Imaging Coverage and Staffing

Addendum 1

Phased Status: Emergency Department

Emergency Department: Phase 2a – ED Overflow		
Scope: To supplement the main Emergency Department during peak volume by triaging lowest acuity patients to an additional site within the Pre-op/Perianesthesia Area.		
Leadership: Elizabeth Gardiner (and relief designee)		
Net increase of total beds: 5 (14)	**Equipment needs:** Additional call light or substitutes: 5 Additional phone/phone access: may not be essential Share defibrillator with IP/Observation side	**Staffing considerations:** N:P Ratio: 1:5 NA /Helping Hands: 1:5
Other considerations: Main ER: Dedicated triage RN Ideal for the "treat and street" type patient No behavioral patients in this area No CDOC patients this area Transportation necessary from point of triage to this area Preference for non-infectious patients Leaves three PACU beds for urgent/emergent cases Automated dispensing cabinet available Heplock or buretrol infusions Adjoins 5 overflow IP/Observation beds (physically separated) Shared toileting A bit of a distance for lab and diagnostics	**Provider needs:** We may consider staffing this with a resident with oversight by the ED provider	**Staffing required at capacity:** 1 RN 1 NA / Helping Hands <u>Main ED</u>: 1 Triage RN 2 RN 1 NA/Helping Hands **Total FTE required at capacity:** RN: 0.9 X 2.3 x 2 = 4.14 NA/Helping hands: 0.9 x 2.3 x 2 = 4.14 <u>Main ED</u>: RN: 0.9 x 3 x 2 x 2.3 = 12.42 NA/Helping Hands: 0.9 x 2 x 2.3 = 4.14

Emergency Department: Phase 3 & 4 – Relocation to an Alternative Care Site (The First English Lutheran Church)		
Scope: Unsure of the eventual trajectory of Emergency Department volume relevant to prevalence, we will consider additional ED services at an alternative site.		
Leadership: Elizabeth Gardiner – supported by designee as necessary (and relief designee)		
Net increase of total beds: TBD	**Equipment needs:** TBD	**Staffing considerations:** TBD
Other considerations: TBD	**Provider needs:** TBD	**Staffing required at capacity:** TBD

Addendum 2

Phased Status: Inpatient/Observation/Acute Respiratory Unit

<table>
<tr><th colspan="3">Inpatient: Phase 2a– Main Patient Units (Second Floor)</th></tr>
<tr><td colspan="3">Scope: Dual focus of adding one additional bed to two former prior semi-private rooms to increase our lower acuity capability in the ARU (total ARU beds: 10) and adding one additional bed in each of three former semi-private rooms to increase general MedSurg (total of 13). Brings a significant shift to the respiratory processes.</td></tr>
<tr><td colspan="3">Leadership: Alicia Conover (and relief designee)</td></tr>
<tr><td>Net increase of total beds: 5 (30 total)

Acute Respiratory Unit: 10 (including procedure room) [4 for ventilator high acuity; 1 procedure room; 1 downgrade room; 4 low acuity)

Medical/Surgical: 13
Intensive Care: 2
LDRP: 3
Post-Partum Overflow: 2</td><td>Equipment needs:

Additional ventilators: 2 (at minimum)
Additional beds: 5
Additional bedside and overbed tables: 5 each
Additional bedside commode: 2 (for ARU)
Additional IV Pumps: 5
Additional call light or substitutes: 5
Additional phone/phone access: may not be essential
Additional PPE racks (TBD)
Additional bedside chairs: 5</td><td>Staffing considerations:

N:P ratio for ventilated ARU: 1:2
N:P ratio for non-ventilated high acuity or downgrade ARU: 1:2 or 1:3
N:P ratio for lower acuity ARU: 1:4
N:P ratio for ICU: 1:2
N:P ratio for MS: stretch to 1:6 with NA/Helping Hands 1:6
N:P ratio for LDRP/Overflow: 1:2 early labor; 1:1 advanced labor; 1:2 couplets postpartum/overflow</td></tr>
<tr><td>Other considerations:

RN to draw in ARU</td><td>Provider needs:

Hospitalist has potential of 25 patients</td><td>Staffing required at capacity:

ARU: 3 RN / 1 RRT / 1 NA
MS: 2 RN / 2 NA
LDRP: 2 RN (possibly 3 depending on labor status)
RRT: 1 House

Total FTE required at capacity:

<u>ARU</u>:
RN: 0.9 x 3 x 2 x 2.3 = 12.42
RRT: 0.9 x 2.3 x 2 = 4.14
NA: 0.9 x 2 x 2.3 = 4.14
<u>MS</u>:
RN: 0.9 x 2 x 2 x 2.3 = 8.28
NA: 0.9 x 2 x 2 x 2.3 = 8.28
ICU:
RN: 0.9 x 2 x 2.3 = 4.14
<u>LDRP</u>:
0.9 x 2 x 2.3 = 4.14
<u>RRT:</u>
0.9 x 2 x 2.3 = 4.14
House:
0.9 x 2 x 2.3 = 4.14</td></tr>
</table>

Addendum 3

Inpatient: Tier 2a – OBS Overflow		
Scope: Utilization of a large portion of the Perianesthesia area brings additional capacity geared toward observation/lower acuity patient with an anticipated stay at 24 hours or less; non-respiratory; non-infectious		
Leadership: Alicia Conover (and relief designee)		
Net increase of total beds: 5 (35 total)	**Equipment needs:** Additional call light or substitutes: 5 Additional phone/phone access: may not be essential Share defibrillator with ED side	**Staffing considerations:** N:P ratio: 1:6 NA or Helping Hands 1:6
Other considerations: Leaves three PACU beds for urgent/emergent cases Automated dispensing cabinet available Heplock or buretrol infusions Adjoins 5 overflow ED beds (physically separated) Does provide one negative pressure room though the preference would be for non-infectious patients Shared toileting No shower facilities Favorable proximity for lab and diagnostics	**Provider needs:** Based on observation/lower acuity status, may be supported by FP rounding only (and on-call availability)	**Staffing required at capacity:** 1 RN / 1 NA or Helping Hands **Total FTE required at capacity:** RN: 0.9 x 2 x 2.3 = 4.14 NA/Helping Hands: 0.9 x 2 x 2.3 = 4.14

Addendum 4

<table>
<tr><th colspan="3">Inpatient: Phase 2b – Additional Inpatient Capacity</th></tr>
<tr><td colspan="3">Scope: Transition all clinic visits to the Banner Health Center (102 Hays); transitioning staff to BHC or repurposing. Additional focus on inpatient status of lower to moderate acuity with anticipated stay at 3 days or less; will accept non-respiratory infectious</td></tr>
<tr><td colspan="3">Leadership: Elizabeth Kuntz (and relief designee)</td></tr>
<tr><td>Net increase of total beds: 18 (53 total)</td><td>Equipment needs:

Additional beds or stretchers: 18
Additional pillows: 18 (minimum)
Additional overbed tables: 18
Additional bedside commode: 6
Additional IV Pumps: 6
Additional call light or substitutes: 18
Additional phone/phone access: may not be essential
Portable suction: 6
Portable oxygen tanks: 9 (estimated) and refills
Additional thermometer: 3
Relocation of a defibrillator and essentials
Additional WOW or utilization of downtime forms
Cache of general care supplies (oral care, bath care, emesis basins, Foley catheters, measuring devices, and others)
Additional linens
Additional PPE
IV poles or wall hooks for fluids: 18</td><td>Staffing considerations:

N:P ratio 1:6
NA or Helping Hands: 1:6</td></tr>
<tr><td>Other considerations:

Entire area is not sprinkled
Provides individual rooms
No easy method of controlling medication inventory or controlled substances
Shared toileting
No shower facilities but individual sinks in rooms
Central nursing/staff area
Place portable x-ray unit
Place satellite lab draw equipment
Consider utilization of downtime documentation
Consideration of dirty utility areas
Centrally located defibrillator
Method for dietary needs/supplements
Significant distance for Respiratory
No red plugs/emergency power</td><td>Provider needs:

Supported by 2 or 3 FP rounding only (and on-call availability)</td><td>Staffing required at capacity:

3 RN / 3 NA or Helping Hands

Consider additional Security Officer

FTE Required at Capacity:

RN: 0.9 x 3 x 2.3 x 2 = 12.42
NA/Helping Hands: 0.9 x 3 x 2.3 x 2 = 12.42</td></tr>
</table>

Addendum 5

<table>
<tr><th colspan="3">Inpatient: Phase 2b: Additional Inpatient Capacity</th></tr>
<tr><td colspan="3">Scope: With anticipated decrease in outpatient Therapy services, the East and West gymnasiums will be combined, and the West gymnasium will be used for lower acuity inpatient cases. No active isolation cases.</td></tr>
<tr><td colspan="3">Leadership: Elizabeth Kuntz (and relief designee)</td></tr>
<tr><td>Net increase of total beds: 6 [all non-infectious] (Total: 59)</td><td>Equipment needs:

Additional beds or stretchers: 6
Additional bedside or overbed tables: 6
Additional bedside commode: 2
Additional IV Pumps: 3
Additional call light or substitutes: 6
Additional phone/phone access: may not be essential
Portable suction: 2
Portable oxygen tanks: 3 (estimated) and refills
Additional thermometer: 1
Relocation of a defibrillator and essentials
WOWs are available
Cache of general care supplies (oral care, bath care, emesis basins, Foley catheters, measuring devices, and others)
Additional linens
Privacy screens
IV poles or wall hooks for fluids: 6</td><td>Staffing considerations:

N:P ratio 1:6
NA or Helping Hands: 1:6</td></tr>
<tr><td>Other considerations:

Entire area is not sprinkled
Lack of privacy; would require screens to divide
No easy method of controlling medication inventory or controlled substances
Shared toileting (down the main hallway) or BSC other
Lack of sinks in general area
Lack of nursing/staff area
Consideration of dirty utility areas
No easy storage of clean utility or supplies
Significant distance for diagnostics or Respiratory
Method for dietary needs/supplements
No easy method of controlling medication inventory or controlled substances
Install doors (in existing frame) into the main area
Therapy equipment will need to be downsized and relocated to the West Gym
Cardiac/Pulmonary Rehab will be discontinued
Verify red plugs/emergency power
No inline oxygen, air, suction</td><td>Provider needs:

Supported by 1 FP rounding only (and on-call availability)</td><td>Staffing required at capacity:

1 RN / 1 NA or Helping Hands

FTE Required at Capacity:

RN: 0.9 x 2 x 2.3 = 4.14
NA/Helping Hands: 0.9 x 2 x 2.3 = 4.14</td></tr>
</table>

Addendum 6

Inpatient: Phase 3 & 4 – Relocation to an Alternative Care Site (The 777 Building)		
Scope: Unsure of the eventual trajectory of prevalence, we will open and utilize the 777 building (roughly 40,000 square feet – though not all usable) to cohort inpatients.		
Leadership: TBD		
Net increase of total beds: TBD	**Equipment needs:** TBD	**Staffing considerations:** TBD
Other considerations: TBD	**Provider needs:** TBD	**Staffing required at capacity:** TBD

Addendum 7

Equipment Needs		
Equipment	Quantity	Area/Phase
Call Light or Substitutes	10 5 18 6	ED Phase 2a IP/Obs/ARU Phase 2a IP/Obs Phase 2b IP/Obs Phase 2b
Ventilators	2 (at minimum)	IP/Obs/ARU Phase 2a
Patient Beds	5	IP/Obs/ARU Phase 2a
Bedside or Overbed Tables	5 18 6	IP/Obs/ARU Phase 2a IP/Obs Phase 2b IP/Obs Phase 2b
IV Pumps (Main)	5 6	IP/Obs/ARU Phase 2a IP/Obs Tier 2b
IV Pumps (Individual Modules)	10 12	IP/Obs Phase 2a IP/Obs Phase 2b
PPE Racks (Door)	5	IP/Obs/ARU Phase 2a
Bedside Chairs	5	IP/Obs/ARU Phase 2a
Beds/Stretchers/Cots	24	IP/Obs Phase 2b
Bedside Commode	2 8	IP/Obs/ARU Phase 2a IP/Obs Phase 2b
Portable Suction	8	IP/Obs Phase 2b
Portable Oxygen Tanks (excludes refills)	12	IP/Obs Phase 2b
Thermometers	4	IP/Obs Phase 2b
IV poles (or wall hooks for fluids)	24	IP/Obs Phase 2b

Addendum 8

Name	Unit	FTE	2A	2B	Training	Assignment
RN Anderson, Karalee	DWCC	1.0E	1.0E	1.0E		
RN Erb, Pamela	DWCC	1.0	1.0	1.0		
RN Batt, Joy	DWCC	0.6	0.6	0.6		
RN Korf, Connie	DWCC	0.75	1.05	1.05		
RN Kropp, Lisa	DWCC	0.75	1.05	1.05		
RN Byczkowski, Theresa	Wound	0.8	1.05	1.3		
RN Conover, Alicia	MSICU	1.0E	1.0E	1.0E		
RN Koehler, Theresa	ICU	0.9	1.05	1.3		
RN Simants, Rhonda	ICU	0.9	1.05	1.3		
RN Norcott, Jennifer	ICU	0.9	1.05	1.3		
RN Barco, Paige	ICU/ER	0.9	1.05	1.3		
RN Erickson, Patricia	MS	0.9	1.05	1.3		
RN Morton, Amy	MS	0.9	1.05	1.3		
RN Barber, Jill	MSICU	0.9	1.05	1.3		
RN Sweet, Debbie	MS	0.9	1.05	1.3		
RN Hidalgo, Emily	MS	0.9	1.05	1.3		
RN Vorderberg, Sarah	MS	0.9	1.05	1.3		
RN Dennis, Emily	MSICU	0.9	1.05	1.3		
RN Meier, Kendall	MS	0.9	1.05	1.3		
RN Breidenbach, Danielle	MS	0.9	1.05	1.3		
RN Rothell, Ingrid	MS	0.6	0.9	1.15		
RN Debus, Sydney	MS	0.9	1.05	1.3		
RN Sanchez, Rajsha	MS	0.9	1.05	1.3		
RN Bevel, Stephanie	MS	0.9	1.05	1.3		
RN Cudd. Terrilyn	MSICU/WC	0.9	1.05	1.3		
RN Dowis, Marci (*has 2E)	Trauma	0.8E	0.9	1.15		
RN Hornung, Sommer	CRehab	0.8	0.9	1.15		
RN Gardiner, Elizabeth	ED	1.0E	1.0E	1.0E		
RN Cox, Yvette	ED	0.9	1.05	1.3		
RN Etl, Mary	ED	0.6	0.9	1.0		
RN Lind, Kimberly	ED/RN Adj	0.9	1.05	1.3		
RN Routzon, Becca	ED	0.9	1.05	1.3		
RN Amen Piel, Tara	ED	0.9	1.05	1.15		
RN Sepulveda, Ashley	ED	0.9	1.05	1.3		
RN Dalton, Taylor	ED	0.9	1.05	1.3		
RN Jones, Brenna	ED	0.9	1.05	1.3		
RN Tharp, Carly	ED	0.9	1.05	1.3		
RN Davis, Valerie	ED	0.9	1.05	1.3		
RN Helgoth, Phylis	EH/V/WC	0.8	0.9	1.0		
RN Fuller, Julie	OccH	1.0	1.05	1.3		
RN Hughes, Lisa	WIS	1.0	1.0	1.0		
RN Herrboldt, Carol	WIS	0.9	0.9	1.0		
RN Koester, Miranda	WIS	0.6	0.6	0.7		
RN Klinger, Loretta	WIS	0.9	0.9	1.0		
RN Sherman, Traci	WIS	0.6	0.6	0.7		
RN Cecil, Kristen	WIS	0.6	0.6	0.7		
RN Brackhan, Jill	WIS	0.9	0.9	1.0		
RN Karg, Neha	WIS	0.9	0.9	1.0		
RN Gareis, Tessa	WIS	0.9	0.9	1.0		
RN Watts, Shelby	WIS	0.9	0.9	1.0		
RN Klemt, Anthony	HS	0.9	1.05	1.3		
RN Kuntz, Elizabeth	HS	0.9	1.05	1.3		
RN Query, Lorrie	HS	0.9	1.05	1.3		
RN Robinson, Jane	HS	0.9	1.05	1.3		

RN Ross, Sarah	HS	0.8	.09	1.15		
RN Stumpf, Adrian	HS	0.9	1.05	1.3		
RN Wilson, Sallie	**Periop**	**1.0E**	**1.0E**	**1.0E**		
RN Gumbir-Nienhuser, Jodeanna	Periop	0.8	0.9	1.15		
RN Nickel, Ann	Periop	0.8	0.9	1.15		
RN Simants, Kori	Periop	0.8	0.9	1.15		
RN Frankenfeld, Amber	Periop	0.8	0.9	1.15		
RN Marrinan, Tiffany	Periop	0.8	0.9	1.15		
RN Dorney, Sara	Periop	0.8	0.9	1.15		
RN Groshans, Jamie	Education	0.8E	0.9	1.15		
RN Sarah Grauberger	Education	0.8E	0.9	1.15		
RN Barber, Lona	CIC	1.0E	0.9	1.15		
RN Bacon, Alicia	BSS	0.0	0.9	0.9		
RN Rubottom, Kendall	Education	0.4E	0.3	0.3		
RN Powell, Sheila	BSS	0.0	0.3	0.6		
RN Nelson, Chandra	BSS	0.0	0.3	0.6		
RN McKenzie, Laurie	BSS	0.0	0.3	0.6		
RN Tyrrell, Wade	**Admin**	**1.0**	**1.3**	**1.6**		
RN Totals	>>>>>>>	51.3	59.4	70.4		
NA Mekelburg, Lindzy	MS	0.9	1.05	1.35		
NA Koenig, Amber	MS	0.9	1.05	1.35		
NA Ryles, Felisa	MS	0.9	1.05	1.35		
NA Harryman, Cindy	MS	0.9	1.05	1.35		
NA Cure, Halie	ED	0.9	1.05	1.35		
NA Ruiz Sosa, Vanessa	ED	0.9	1.05	1.35		
NA Hahn, Andrea	ED	0.9	1.05	1.35		
NA Probst, Holly	ED	0.9	1.05	1.35		
NA Goff, Nicole	Periop	0.8	1.05	1.35		
NA Schoenfeld, Zeth	BSS	0.0	0.3	0.6		
NA Schmidt, Monika	BSS	0.0	0.3	0.6		
NA Knight, Shayln	BSS	0.0	0.3	0.6		
NA Totals	>>>>>>>	8.0	10.35	13.95		
RRT Dutton, Chad	**CardioRT**	**1.0E**	**1.0E**	**1.0E**		
RRT McLeish, Ryan	CardioRT	0.9	1.05	1.5		
RRT Wunsch, Oliver	CardioRT	0.9	1.05	1.5		
RRT Polenz, Kellie	CardioRT	1.0	1.05	1.5		
RRT Robbins, Joshua	CardioRT	0.9	1.05	1.5		
RRT Harman, Bradford	BSS	0.0	0.3	0.3		
RRT Totals	>>>>>>	4.7	5.5	7.3		

Key:
Yellow: Leaders who are in an exempt status (Note: all except Anderson and Tyrrell have 2nd Exempt Status)
Blue: Leaders who are in hourly status
Green: Team members from the David Walsh Cancer Center who are not included in the FTE computation
Orange: Team members who are currently on leave

Addendum 9

Staffing Resources - Repurposing					
Name	Current Role	Status	Licensed	Training	Assignment
RN Coody, Rosemary	RN – Quality	Corporate-E	Y		
RN Guenzi, Tara	RN – Regulatory	Corporate-E	Y		
RN Brower, Julie	RN	NJC	Y		
RN Mahaffey, Samantha	RN	NJC	Y		
RN Marostica, Ashley	RN	NJC	Y		
RN Kind, Jody	RN	NJC	Y		
RN Carpenter, Paulette	RN - APP	Retired	Unknown		
RN Rose, Jan	RN	Retired	Unknown		
RN Lechtman, JoMarie	RN	Retired	Unknown		
RN Farrell, Jenny	RN	Retired	Unknown		
RN Lininger, Jeanette	RN	Retired	Unknown		
RN Roark, Nancy	RN	Retired	Unknown		
RN Zwirn, Nancy	RN	Retired	Unknown		
RN Lambert, Cindy	RN	Retired	Unknown		
RN Martin, Shirley	RN	Retired	Unknown		
RRT Muggli, Mary	RRT	Retired	Y	Onboarding	RRT
RN Cummings, Diana (522-7641)	RN	Retired	Y		

*Potential for additional NA or Helping Hands through the NJC Nursing Students
*Potential for additional Culinary support from Sodexho (the NJC culinary provider)
*Potential for additional EVS support from NJC, the RE1 system, or local hospitality services

Addendum 10

	DAY	JOHN	DANA	NICOLE	JAMIE	TANYA	CHAD	LISA	ROSA	ASH	KATY	TECH	CALL
29	SUN		7am	7pm									
30	MON		7am	7pm		7am	8-430	7pm					
31	TUE	7am	7am	7pm			8-430		7pm				
1	WED				7pm	7am	8-430	7pm					
2	THUR	7am			7pm		8-430		7pm				
3	FRI				7pm	7am	8-430	7pm					
4	SAT	7am							7pm				
5	SUN	7am							7pm				
6	MON	7am	7am	7pm			8-430		7pm				
7	TUE	7am			7pm	7am	8-430		7pm				
8	WED		7am	7pm			8-430	7pm					
9	THUR				7pm	7am	8-430	7pm					
10	FRI		7am	7pm			8-430	7pm					
11	SAT				7pm	7am							
12	SUN				7pm	7am							
13	MON	7pm		7am	7pm	7am	8-430						
14	TUE		7pm		7pm	7am	8-430	7am					
15	WED	7pm		7am			8-430		7pm				
16	THUR		7pm				8-430	7am	7pm				
17	FRI	7pm		7am			8-430		7pm				
18	SAT		7pm					7am					
19	SUN		7pm					7am					
20	MON		7pm		7am	7pm	8-430	7am					
21	TUE	7pm	7pm	7am			8-430	7am					
22	WED				7am	7pm	8-430		7pm				
23	THUR	7pm		7am			8-430		7pm				
24	FRI				7am	7pm	8-430		7pm				
25	SAT	7pm		7am									
26	SUN	7pm		7am									
27	MON	7pm		7am	7am		8-430	7pm					
28	TUE	7pm		7am		7pm	8-430		7am				
29	WED		7pm		7am		8-430	7pm					
30	THUR		7pm			7pm	8-430		7am				