CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CHA COVID Webinar Questions Not Answered During Q & A 01/14/21

1. The ICU Surge Beds definition states that the count for this field, "should include any and all ICU beds in spaces not routinely used for ICU level care…". In other words, it should include counts of beds being repurposed/used differently. Is this the same for the Surge Beds field?
    - *Yes, please keep in mind that in addition to being repurposed or converted beds, they must* be either currently in use or could be *readily* used with current staff and resources. *Surge beds are all beds allocated from Surge resources.*

2. If we have surge beds that are ICU capable but are being used for medical surgical level of care, we should not count them as ICU surge beds because they are occupied and unavailable. Is this correct?
    - *Correct, the designation of a bed should be based on the patient occupying it. Because the patient is receiving med/surgical level of care, the bed is not an ICU bed.*

3. When we are overwhelmed and submit data to CHA after the daily deadline, is the state dashboard updated accordingly the following day?
    - *The daily deadline is noon each day. Additionally, CDPH allows for an hour grace period. At 1PM, CDPH pulls the SmartSheet data. Any changes made to the SmartSheet COVID tracker after 1PM will not be reflected in other sources.*
    - *If CDPH contacts you prior to 3PM to make corrections, then the changes you make will be reflected only in HHS TeleTracking.*

4. When is a patient a COVID Confirmed/Suspected Patient versus an ED and Overflow Confirmed/Suspected Patient?

    - *For ED and Overflow (EDOF) Confirmed/Suspected Patients with an admission order for an inpatient bed (currently being held in the ED or another overflow location until an inpatient bed becomes available) those patients should be counted in both the EDOF and the corresponding inpatient (ICU or Non-ICU) categories.*
    - *If a patient has an admission order for an inpatient bed and is being held in the ED or another overflow location until an inpatient bed becomes available, the patient should be counted in the Surge categories for the corresponding unit (ICU or non-ICU) by default. These admitted EDOF patients are counted in the Surge categories because they are boarding in (EDOF) locations that are not routinely used for inpatient care. These admitted EDOF patients should be counted in the Surge categories unless it is known at the time of admission that they will occupy a Non-Surge bed (e.g., they are destined for a designated non-surge COVID cohort).*

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5. Patients waiting in the ED for an ICU bed are supposed to be included in our counts of ICU beds/patients. Does the same apply for a med/surg inpatient awaiting an ICU bed?
    - *Patients waiting in the ED for an ICU bed (and currently receiving ICU level care) should be included in the ICU Beds, ICU Patients, and Total Beds categories. Furthermore, they should be counted in the Surge categories (ICU Surge Beds and Surge Bed ICU Patients) by default unless the destined ICU bed location is known (please refer to last bullet point in question 4). These admitted ED patients should be counted in the Surge categories unless it is known at the time of admission that they will occupy a Non-Surge bed.*
    - *It is rare for a medical surgical patient requiring ICU level care to be waiting in a medical surgical unit for very long. If these patients have ICU admission orders and are receiving ICU level care (they are being treated by the ICU team), while they are physically in a medical surgical unit, they should be counted in the "ICU Surge Beds," and "Surge Bed ICU patients" fields. They should be counted in the Surge categories (because they are in a space that is not routinely used for ICU level care), unless it is known at the time of admission that they are going to an ICU Non-surge bed.*

6. The definition of Occupied Non-Surge Inpatient Beds states that you should count inpatient beds currently occupied by a patient. What about patients waiting in for an inpatient bed in an outpatient area such as PACU/ED. You said that patients with admission orders in the ED should be counted as surge. This contradicts the definition. Which is it?
    - *These are EDOF patients with admission orders. As such, they should be double-counted as both EDOF patients and surge patients in their corresponding unit (ICU / non-ICU). For instance, those ED patients specifically with ICU admission orders require critical care. Even though they are physically waiting in the ED, they should be counted as ICU patients/beds given their impact on ICU resources and staff. Since they are destined for an ICU bed, they should be counted as such. At the same time, these patients occupy limited ED space and require ED staffing resources and must be captured in the "ED Overflow" fields in order to capture COVID impact on EDs.*
    - *Please refer to question 4 for surge vs. non-surge designation. Although EDOF patients with admission orders can be double counted into both EDOF and Inpatient (ICU/non-ICU) categories, these patients cannot be double counted into surge and non-surge categories. A patient should be counted into either a surge or non-surge bed. For an EDOF patient with admission orders, that patient should be counted in the Surge categories by default unless the destined ICU bed location is known at the time of admission (please refer to last bullet point in question 4*

7. As HHS does not have the surge data fields, how does a hospital account for patients in surge areas (e.g. ED) with IP orders in the data to ensure that they are appropriately reflected in the HHS data upload?
    - *Because these patients would be counted in both the Surge and the ED and Overflow categories in the SmartSheet tracker, they will also be counted for the ED and Overflow fields in the HHS COVID data portal.*

8. We are an acute care hospital focused on pediatric and maternal services. To ease pressure on adult hospitals in our county we have been accepting med/surg patients up to 25. We do not

have an adult ICU and these are not ICU patients. We have not had to use surge staff/resources to accomplish this. We have a mix of licensed pediatric and unspecified beds. Is this viewed as repurposing and if it is, how would we report it?

- *Any patients ages 18+ placed in a pediatric bed should count as an adult patient in an adult bed.*
- *If this repurposing is not a part of your surge plan then you should not count these beds as surge beds. Surge beds are beds allocated from Surge resources.*

9. We do not have licensed or designated Pediatric beds. Occasionally a pediatric patient is admitted. We have licensed adult beds and licensed NICU beds. So if we enter a pediatric patient in the pediatric field, we get an error report on the Smart Sheet. What should we do?
    - *If you are placing a pediatric patient in an adult bed then you will need to count them as a pediatric patient in a pediatric bed. Your count for pediatric beds should increase to accommodate this patient. This will help you avoid triggering an error.*

10. One hospital has started giving vaccines to EMS workers and some vendors. The new fields specify hospital staff and patients. The hospital is wondering where EMS and vendors, and even volunteers fall?

    - *Healthcare personnel include all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials. Employees are expected to be counted in all locations where they work.*
    - *Previous Week's COVID Vaccine Doses is an operational count and the rest of the personnel questions are about the status of employees regardless of where they are vaccinated.*
    - *"Patients" in the vaccination context includes anyone provided a vaccination, not just inpatients, or admitted patients.*

11. For the COVID vaccine fields, should we enter COVID vaccine data only for vaccines issued and/or administered at our facility? Or should we also include those vaccines issued to our County but administered by our providers/staff at COVID vaccination super centers?
    - *Response from HHS incoming….*

12. For Total number of current healthcare personnel, can you clarify what "the facility" means in the reporting guidance? Should they include all hospital inpatient and outpatient staff on the medical center campus (i.e., all services on the hospital license)? Should the count include distinct part services?
    - "*The facility" refers to the hospital.*
    - *Yes, include all staff*
    - *Yes, the count should include all distinct part services (e.g., acute psych unit)*

13. How should we report on the vaccine fields when we have two facilities with the same CCN? Do we report for both facilities or designate a main one that we report on? Many staff work interchangeably between the two sites.

- *If the two campuses share the same CCN and the staff move interchangeably between the two, the vaccines and staff can be reported under one of the facilities.*
- *If the facilities have different CCNs, then you would double count the staff under each facility.*

14. Many of the per diem employees will receive the vaccine at another facility where they work full time. How should this be tracked?
    - *Where the vaccine was administered is not relevant for the fields Unvaccinated Personnel, Personnel Receiving a Partial Series, Personnel Receiving a Complete Series, and Total Personnel. It is asking about their vaccine status regardless of where the shot was given.*

15. How should physicians be counted? They may work at multiple hospitals. Are reporters supposed to distribute the number of physicians vaccinated among the 5 hospitals?
    - *Employees should be counted in all locations where they work. If physicians work at multiple hospitals, count at each facility.*

CHA COVID Webinar Questions Not Answered During Q & A 11/19/20

1. Is there any clarification on if/when the new influenza fields will become required instead of optional?
   - *Not at this time. We will communicate this to the field when we learn of an exact date.*

2. Is it possible to get a confirmation/validation of successful upload from CDPH/CHA daily?
   - *Hospitals can login to TeleTracking at any time and see the data that CDPH has uploaded on their behalf. Typically, CDPH uploads data for hospitals by mid-afternoon.*

3. Should fields that don't apply to my hospitals be left blank (e.g. we don't have an ICU)?
   - *No, fields should never be left blank — if a hospital leaves fields blank, HHS might record this as missing data. If a field isn't applicable to your hospital, then either enter a zero, select "no" in the drop-down menu, or select "N/A" in the drop-down menu. The only exception is for fields that are only required on Wednesdays; these fields can be left blank all other days.*

4. Where should a hospital go with questions?
   - *Please email covidtracker@calhospital.org with questions.*

5. If a hospital discovers an error in data from a previous day, how should they proceed? Can they correct previous days' data in the Notes field in the CHA COVID Tracking Tool?
   - *Data should be corrected in two areas: the federal HHS TeleTracking portal and with the state. Data should not be corrected in the Notes fields in the CHA COVID Tracking Tool.*
   - *To make a correction with HHS, log in to TeleTracking and fix the data entry. Data can be corrected in TeleTracking for the previous seven days.*
   - *To correct data submitted to the state, email your corrected data for the previous day(s) to CDPH at COVID-19-CHCQData@cdph.ca.gov, notifying them of the corrections. You can also email covidtracker@calhospital.org and CHA will notify CDPH. Please only reach out with corrections for the state if the error was substantive.*

6. If data are reported to SmartSheet, are all data reporting requirements met?
   - *Reporting data into CHA's COVID Tracking Tool fulfills state and federal COVID reporting requirements. By default, CDPH will submit data from the CHA COVID Tracking Tool to the HHS TeleTracking portal. However, facilities may opt out of having their data reported to HHS by CDPH. Hospitals that opt out will have to report to both the CHA COVID Tracking Tool and the HHS TeleTracking portal.*
   - *Some counties have additional COVID reporting requirements that must be completed separately. In addition, hospitals with in-house labs will need to report the lab data to the state separately.*

7. Do the "total vents" fields include all the vent types listed in the "routine use" fields?
   - *Yes, "total vent" fields include the machines described in the "routine use" fields.*

8. For the relevant COVID fields, do positive tests confirming COVID diagnosis need to have been performed within the hospital or is it acceptable to consider tests from outside the hospital?
   - *Generally, COVID patients should only be recorded if the testing was performed in-house. However, there is some leeway that allows hospitals to count individuals who had a positive test recorded in an affiliated clinic or provider office shortly before being admitted to the hospital.*

9. Please clarify the "surge bed" definition. What if hospitals have the supplies and beds but not the staff?

- *A surge bed must be able to be equipped and staffed within 72 hours. If the bed is not currently staffed and equipped but is usable and has the potential to be staffed and equipped under the hospital's established surge plan, it should be counted.*

10. Where should psychiatric hospitals report their data?

- *Psychiatric hospitals are required to enter data weekly, on Wednesdays, per HHS requirements. These types of facilities should enter data directly into the TeleTracking portal.*

11. Where should freestanding psychiatric hospitals direct questions?

- *Psychiatric hospitals should reach out directly to TeleTracking.*

12. If a patient arrives in the ED with a cough but tests negative for COVID-19, should this person still be included in the section "ED Visits in previous day COVID related"?

- *No. Only include those who had a visit related to COVID (meets suspected or confirmed definition or presents for COVID diagnostic testing).*

13. If a patient who was COVID-positive and was discharged returns days or weeks later and dies, is it counted as a COVID-related death?

- *No, please only include patients in this field who were both COVID-positive and died during a single hospital stay.*

14. If a recovered patient dies, should this patient be counted as a COVID-related death?

- *A recovered patient should only be counted as a COVID-related death if COVID contributed to their death.*

15. If a patient is admitted for an acute condition and is COVID-positive, has a long stay and recovers from COVID but needs to stay at the hospital for chronic health conditions, should this patient continue to be included in COVID counts?

- *Yes, once a patient is COVID-positive, this individual should remain in hospital COVID counts until discharge. The exception is the "hospital onset" field. Patients should only be recorded in this field until they have been removed from isolation precautions.*

16. Does data have to be submitted seven days a week and on holidays?

- *Yes, data must be entered into the CHA COVID Tracking Tool seven days a week.*

17. For the ICU confirmed or suspected COVID fields, should hospitals report the count for patients still occupying an ICU bed even if their level of care has been lowered (e.g., stepdown)?

- *No, please only include patients in ICU counts that are in the ICU.*

18. Should labor and delivery units be included in adult bed counts?

- *Yes, except for the nursery beds — those should be included in pediatric counts.*

19. When will the HHS compliance data be refreshed?

- *Based on current timetables communicated by HHS, compliance reports will be refreshed once a week on Tuesdays and feature data for the week starting from Friday to Thursday. (e.g., a compliance report updated on 11/17/20 will include data from Friday 11/6 – Thursday 11/12).*
- *Please note that compliance reports are a point in time snapshot of your data when the report was created only. The compliance reports are not updated based on changes made to your data in the TeleTracking portal.*

20. If a hospital has issues regarding the data featured in the compliance report, how should they address them?
- *Hospitals have two options. If help is needed with interpreting the reports, please reach out to CHA at covidtracker@calhospital.org. If an error was spotted and the data are disputed, corrections can be made directly in TeleTracking. For additional assistance with TeleTracking please contact HHS at hhs-protect@teletracking.com or call 1-877-570-6903 and press 7.*

21. Are staffing questions still required as these fields are not mandated by HHS?
- *Yes. Though these questions are not required by HHS, they are required by CDPH and should be completed daily.*

22. If a patient with a history of COVID is transferred to a hospital, should that patient be recorded as COVID-positive in the Tracker?
- *This depends on whether the infection is active. Patients who are known to be COVID-positive who are being transferred to your facility should be recorded as COVID-positive in the Tracker. Per question 8, the positive test doesn't necessarily need to be performed at the receiving facility if the patient had a positive test just prior to transfer. If a patient's COVID is resolved and the patient then transferred for an unrelated condition, this individual should not be included in the receiving facility's COVID counts.*

23. How should the PPE fields be handled on days other than Wednesday? Should the data be cleared from the Tracker?
- *It is not necessary to clear the PPE fields between Wednesday reports. The only day your data will be viewed by state and federal agencies is Wednesday.*

24. For bed counts, do hospitals need to report staffed bed figures, not just the physical beds?
- *Correct — inpatient bed counts should include beds that have "the potential to be staffed and equipped using routine available hospital resources and staffing." We encourage everyone to read the COVID Tracker Data Dictionary, which can be found here.*

25. Even though Smartsheet doesn't allow previous submitted data view, does CHA save all hospitals' submitted daily data into another platform?
- *All data entered into the SmartSheet platform is recorded daily by CHA. These data are not publicly available, but if you have any questions regarding data previously entered into the Tracker, please email covidtracker@calhospital.org.*

26. Who should we count for the "Previous Day" COVID fields?
- *The purpose of the Admits in Previous Day Confirmed/ Suspected fields is to capture the status of previous day admits at the time of admission. Therefore, if someone was admitted at 1 p.m. and was COVID-positive, they would be included in the previous day's confirmed counts. If the patient*

was symptomatic at 1 p.m. but there was no positive test, this patient would be included in the previous day's suspected counts. They should be included in these counts even if you learn later in the day that the patient was positive.

- *The Previous Day's Conversions to COVID Confirmed field is the number of total patients in the facility (irrespective of when they were admitted) whose status changed to COVID-19 confirmed positive on the previous calendar day. This includes individuals who, on the previous day, had laboratory results returned to confirm a COVID diagnosis where previously their diagnosis was unconfirmed.*

27. Why is HHS marking us as non-compliant for some of the weekly supply fields that ask if we can maintain a three-day supply? We are entering data into this field weekly.

- *Please check to see that you are not inadvertently leaving these fields blank.*
- *When entering data for these fields in the CHA COVID Tracking Tool you can use the pull-down options to select "Yes", "No", or "N/A."*
- *The TeleTracking portal can be selective about the responses it receives. It will accept a response of "N/A" but will not accept "NA". You can find the acceptable TeleTracking portal responses here.*