

Field/Surge Hospital and ICU Bed Expansion Responses to COVID-19 April 1, 2020

ASHP is working with its members to assist in your management of COVID-19. The below information is a consolidation of responses to questions related to preparation for field and surge hospitals including establishing new ICU beds, staffing, automation and EHRs, as well as other advice and considerations. This information was collected between March 25 – March 30, 2020 from practice sites across the country including New York, Washington, and more. The names of specific sites have been blinded in the responses.

Hyperlinks are included to ease navigation between questions. To view responses by a particular state, please select the applicable state from the following list: [California](#); [Florida](#); [Illinois](#); [Louisiana](#); [Michigan](#); [New Mexico](#); [New York](#); [North Carolina](#); [Ohio](#); [Tennessee](#); [Texas](#); [Utah](#); [Virginia](#); [Washington](#); [Wisconsin](#); or [Multi-State](#)

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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

California	We at HOSPITAL are working closely with County on all surge planning. There are plans to re-open former hospital facilities, use hotels for lower care patients such as SNF. We do not have official information from the Feds on field hospital set up nor what our role would be. We are in active surge planning.
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Florida	Tents in association with 5 EDs
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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Florida	We have tents outside of our ED for triage of patients. Each hospital has dedicated surge areas to prep for surge. Elective and non-essential cases deferred in prep for surge. All hospitals supported by the hospital pharmacy department with corporate pharmacy/procurement managing inventories of what we think will be critical medications for surge preparedness. Clinical P and T committee meets twice weekly to evaluate medication treatment case studies and truly vet what has validity and what does not based on strength of data.
Illinois	The city is considering setting up a field hospital at the convention center. It will be staffed by the Army Corps of Engineers. We are looking at expanding adult space into our pediatric hospital and also converting the post anesthetic care unit to a nursing unit for COVID patients. We have added extra Omni cells with critical care meds to med/surg units. We have also added COVID meds like hydroxychloroquine, but are controlling them like controlled substances to avoid pilferage. We are establishing an outpatient COVID and PUI clinic for ambulatory patients (e.g. cancer patients with COVID) that do not need to be hospitalized but need care. One end of the clinic is for PUIs and the other is for COVID positives. Each have their own dedicated elevator. We are still figuring out meds there.
Illinois	No, it will be within the walls of one of our hospitals.
Louisiana	Some sites investigating; working with board on virtual everything
Michigan	<p>First phase of surge plan in play: establish COVID cohorted units for COVID positive and pending results. These are in current hospitals with acute care hospitals. Adding ICU beds in pre and post op areas.</p> <p>Second phase of surge plan began executing today: 1 hospital (already has acute care pharmacy) converting to COVID hospital. Shutting down Emergency Center to turn into ICU unit, pre and post op surgery for ICU unit. Typically inpatient census is 80 patients and about 30 obs with 12 ICU beds. Ramping up to a hospital of 233 beds with 66 ICU beds.</p> <p>Third phase: utilize “large box” ambulatory buildings as “hospitals” for non-COVID stable patients. Have not executed but could. In that event, will service from Acute Care hospitals with frequent/regular deliveries to these locations.</p>
New Mexico	We stood up a drive through COVID screening area as a Virtual unit of an urgent care.
New York	Setting up one within the hospital licensed area
New York	As a virtual unit of the hospital, no board
North Carolina	Exploring both
North Carolina	We have been told to PLAN for how we would manage patients at a field hospital. Our Board Of Pharmacy has allowed us to extend our current permit for a field site.
Ohio	Currently a) virtual unit of our flagship hospital
Ohio	Planning underway for surge hospital with other Columbus, OH based health-systems; will be under a separate license from board of pharmacy and DEA

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Tennessee	Virtual unit of the hospital; State has suspended license approvals to allow patient care during this time
Texas	Yes and working on it.
Utah	Reviewed what we were doing with the Board. They will view it as part of the hospital and are considering it part of emergency situations.
Virginia	Yes, notified this week
Washington	We are creating additional surge units within the hospital and Regional medical center space. Will be supported by current pharmacy facilities. Plans underway for field hospitals in community setting but will be managed by military.
Wisconsin	First phase is expanding ICUs into other units such as PACUs. Next phase is targeting ambulatory sites such as POBs and repurposing them for non-COVID-19 patients. Last phase of escalation would be to set up temporary/pop up acute sites created in non-health care locations (e.g. hotels, etc.). When setting up the unit in the EHR, we are going to create a virtual unit in an existing hospital.
Multi-State	Yes, likely obtaining “emergency” licensure for hospital, pharmacy, DEA permit (opening a shuttered hospital).

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2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

California	No response.
Florida	Not necessary, not required.
Florida	Hospital are all on campus so we ship to normal pathways and distribute. Including mobilizing pyxis into the ED tent areas.
Illinois	Lots of drop ship from manufacturers. One new agreement for a 503B compounder.
Illinois	N/A
Louisiana	Centralizing order and receipt for entire system. Supply is for system and move as needed in state and outside state. Boards approved.
Michigan	N/A
New Mexico	N/A
New York	Mostly
New York	Yes we have good success in increased drop ships, in more bill to/ship to; and additional deliveries from our wholesaler as well as 503 bs

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

North Carolina	Not done this, but looking to move product from existing facilities to support any new site of care.
North Carolina	No response
Ohio	Not yet; Baxter reluctant due to number of requests
Ohio	Agreed to setup account; still working to expedite the process to get account established
Tennessee	Suppliers have been supportive and are meeting our needs based on what is in the supply chain.
Texas	Working on it
Utah	We haven't addressed this. We have everything shipped to our main facility and will distribute as needed. Partnering with community home care service to provide hospice/palliative care to patients in hotels and other outlying areas.
Virginia	Have not addressed this yet
Washington	Some vendors have required a single location for the system for special drug programs and not hospital specific (e.g. TEVA Hydroxychloroquine).
Wisconsin	Will likely have them ship to a nearby hospital and then we would transport the shipment to the new pharmacy.
Multi-State	Not yet, but confident

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3. How have you executed your modeling for the Field/Surge Hospital(s):
(a) Number of patients?
(b) Number of weeks?
(c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

California	No response
Florida	(a) Variable, not an issue of excessive volume yet (b) Set up this week (c) Small selection of medications (5)
Florida	(a) Monitoring ICU beds with vent capacity. (b) Patient volumes; and turning non ICU areas into cohort areas with equipment for COVID surge of critical care for supportive care. (c) All in house. With decreases in current volumes by 30 percent these should offset. But looking at critical care support drugs based on a team of formulary management subcommittee that meets twice weekly.

3. How have you executed your modeling for the Field/Surge Hospital(s):
 (a) Number of patients?
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 (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Illinois Both HOSPITAL and NIEGHBORING HOSPITAL are doing daily modeling. We both predict having our beds entirely full between Monday and Wednesday. The city of Chicago predicts about three days longer.

Illinois (a) Yes, expect surge by end of next week in our state
 (b) No response
 (c) Yes, critical care drugs

Louisiana Worked with wholesalers and suppliers to obtain relief on allocations for non-controlled and controlled substances to ensure overall supply continuity.
 (a) No response
 (b) No response
 (c) Have prepared to be able move drug across state lines as well as when under common ownership facilities. Have worked with MS and LA Boards of Rx for approvals

Michigan See above surge plan (note: our business intelligence group at HOSPITAL has completed modeling to identify the surge volume of patients including ICU breakdown).
 (a) No response
 (b) No response
 (c) Several of our pharmacy team members are completing assessment of historical drug use, current use, and projected used based on surge predictions described above.

New Mexico N/A

New York (a) Yes - estimate of 30% daily increase in patient volume
 (b) No response
 (c) Yes and utilizing Vizient's 200 critical list to prepare ADCs

New York Based on future projection models – request to increase beds by 50% made my governor
 (a) No response
 (b) No response
 (c) Some but the reality is that these patients are super ill and require relatively few drugs – a lot of ICU drugs: fentanyl, midazolam, pressors, crash cart meds, as well as IL6 drugs like tocilizumab

North Carolina Our surge plan is to cover 40% above normal volumes. Not discussed weeks of duration. Set aside one month of normal drug utilization and track above that quantity to allocate for COVID patients and convert the quantities into number of COVID patients we could treat with supply on hand.

North Carolina (a) 1000-plus
 (b) Unknown
 (c) Not much history available assuming COVID patients, just knowledge of drugs expected for supportive care

3. How have you executed your modeling for the Field/Surge Hospital(s):

(a) Number of patients?

(b) Number of weeks?

(c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Ohio

- (a) Up to 250 beds
- (b) TBD - some are saying up to 12
- (c) We pulled all current PUIs/COVID-positive patients across our care sites and analyzed what types of medications they are using to get an initial core inventory estimation. Working on validating assumptions now.

Ohio

- (a) Facility will be able to handle 200-300; entire facilitate in the 600-800 range adding in other health-system beds, this is on top of expansion within the hospitals
- (b) No response
- (c) No response

Tennessee

- (a) Based off statistical models for patients and duration.
- (b) No response
- (c) No response

Texas

- (a) No response
- (b) No response
- (c) Using NY as a model

Utah

Work in constant process. Yes, we refine the estimate each week (at this point but more frequently as we surge) and adjust purchasing from there.

Virginia

- (a) Up to 175 patients (5 floors, 35 patients per floor)
- (b) Unknown
- (c) No response

Washington

- (a) Based on state projections and they are now taking active role in balancing COVID patients distribution to area hospitals
- (b) Dependent on ability impact the trend
- (c) No response

Wisconsin

- (a) Unsure how many patients yet
- (b) Unsure how many weeks yet
- (c) Yes, critical care medications and COVID-19 therapeutic medications available in these new locations if for COVID-19 patients.

Multi-State

- (a) Yes
- (b) Not yet
- (c) It will be a COVID pop, but we know there will be co-morbidities, so don't have any history

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4. What is your model for establishing number of new ICU beds?

(a) In your current facilities?

(b) In your current or planned Field/Surge Hospital(s)?

California No response

Florida Creating COVID-19 Units at each hospital

(a) Yes

(b) No

Florida

(a) Yes. # of vents we have and ability to possibly use vents on multiple patient with similar settings being evaluated if we need to double up because of vent shortages.

(b) ICU beds for surge. Each hospital.

Illinois

(a) We use our med-surg beds when we run out of ICU beds. We have added extra UBC with critical care meds to med/surg units. We are fortunate that in our new hospital we can convert all of our rooms to negative pressure.

(b) No response

Illinois

(a) Be able to double, with plans for more beyond that capacity

(b) Within current space of hospital

Louisiana

No response

Michigan

(a) Converted all pre-op and post-op locations as ICUs, converted hospital to focus on COVID (described above) will also convert Emergency to ICU unit

(b) No response

New Mexico

Using predictive analytics from CDC

New York

(a) Converting other units

(b) 50% increase but only in one of our hospitals. Our main hospital has an old tower where many units were closed so these are being re-opened.

New York

(a) As many as we can literally get in the hospital

(b) No response

North Carolina

Have not been part of the modeling of ICU beds, but it has been discussed at the executive and CMO levels.

North Carolina

No response

Ohio

(a) Looking to create additional ICU capacity at all sites, while also evaluating changing one community hospital to an all-ICU facility (newer 150 bed community hospital has capability for all rooms to be ICU rooms if needed). Currently anticipating needing up to 250 additional ICU beds across a system of 14 hospitals (normal average daily census is 2600 patients total)

(b) Our surge hospital will not support ICU patients, with the exception of having a crash cart(s) available for rapid decline emergencies.

Ohio

No response

4. What is your model for establishing number of new ICU beds?

(a) In your current facilities?

(b) In your current or planned Field/Surge Hospital(s)?

Tennessee (a) Started with ICU capable beds and expanded from there.
(b) Based off statistical models for patients and duration.

Texas No response

Utah (a) New ICU beds will be in the main hospital. Part of plan is to change PACU, ORs to ICU units. Then we have some general medicine units that can be moved to negative pressure and turned into ICU beds.
(b) Not planning this as ICU at this time except for admitting ER evaluations.

Virginia Using OR rooms for ICU beds; some have been converted to negative pressure
(a) Yes, in the current hospital
(b) No ICU's planned for the surge hospital

Washington (a) Number of neg air rooms with CCU capability, Total capacity for ventilators. Vents will support 2 patients each, also adding in Anesth vents if required
(b) Located in current main hospital, old wing

Wisconsin (a) Converting PACU units to COVID-19 units
(b) Medical office buildings that are connected to hospitals first. Then associated ambulatory sites near current hospitals for non-COVID-19 patients.

Multi-State (a) Depends on specialty mix and surgery mix
(b) It will be based upon available equipment

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5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

California No response

Florida WIFI in tents and iPads

Florida ADC outside of our ED in triage areas currently. Purchased IPADS for telehealth management and prevention of spread as strategy wherever possible.

Illinois N/A

Illinois ADC

Louisiana The tent field will probably use like home/outpt model. We are expanding in existing facilities or refitting.

Michigan Only what we already have at the site

New Mexico Standing up a few ADCs, but will have to use locking cabinets if needed

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

New York	Number of IT staff is the same. Our ADC manager is overwhelmed as new units continue to open
New York	Minimal – no time and no wireless- so old fashioned cart based
North Carolina	From pharmacy looking to move Unit Based Cabinets in surplus (from new purchases) to the facility to support. IS is separate from Pharmacy.
North Carolina	We have not assessed. Just about to begin planning.
Ohio	So far, 4 ADCs per 250 beds.
Ohio	Same EMR, ADCs
Tennessee	Leveraging wireless workstations for IT and equipment ordered for cabinet replacement at a hospital in the system.
Texas	Cabinets and EHR
Utah	Yes, planning for ADCs. Preparing drug lists now.
Virginia	We discussed today about repurposing some clinic ADCs to this building; reaching out to BD/Pyxis about quotes and availability and timing
Washington	New surge units had ADC's added, no longer any devices in organizational inventory for any additional surge units but there is proximal access to other devices.
Wisconsin	Will relocated available ADCs to these locations if there are identified excess. If not, then will support these locations with a cart fill from a nearby hospital.
Multi-State	Don't know yet – likely in our case we will not have UBCs

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6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

California	No response
Florida	N/A, staying in EDs and Lee Pharmacy locations with Meds to Curbs service
Florida	Evaluating only necessary personnel to be in areas needed. Telehealth support. We need to have drugs in ADC for patient demand and need. Stocking up for surge is the proactive step now.
Illinois	N/A
Illinois	We are cohorting COVID patients to primarily 1 of our hospitals, so we would flex from non-COVID hospital to that location
Louisiana	Consistently assessing staffing demands and modeling across system. Also worked with nursing obtain waivers for nurses to titrate ketamine which wasn't allowed in LA,

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Michigan	Eliminating med history, medication education (may do remotely), post discharge for warfarin education, eliminating narcotic monitoring, eliminate unit inspections, centralized team working virtually for order verification, central IV compounding (off load some work from the acute care hospitals), utilizing individuals from employee “pools” established by emergency command in functions that do not require a technician training/license (example: medication deliveries to patient care areas)
New Mexico	Training for ICU level now
New York	Not yet. Mostly due to the fact that all the am care areas are closed so tapping into that resource.
New York	Using med students as pharm techs, pulling infusion staff to pharmacy, using virtual staff, using virtual pool, setting up centralized order verification site at home office to avoid staff going into hospital space, increasing per diems
North Carolina	Working in teams to limit exposure with 7 on 7 off schedule with the concept of remote order verification in acute care space to reduce teammate exposure and keep employees “fresh”. Staging from existing staff with concept of rotating OT usage of those on 7 day off schedule.
North Carolina	We have not determined this as we are just about to begin plans
Ohio	TBD; would love to hear from others on this
Ohio	Still under development
Tennessee	Layered approach using extended shifts, management, clinical staff, ambulatory support staff, business operations staff, local College of pharmacy faculty, recent retirees.
Texas	No response
Utah	Using our PACE plan. The plan is developed what if we have a reduction in 80%, 60%, 40% in services and or staff, how would we contract? Then we say if we have double the beds, what would that look like? What if we have triple the beds? We will move to central distributive services at that time.
Virginia	Not planning additional FTEs; will shift from outpatient pharmacies
Washington	Very dynamic, hospital census is lower than normal currently also with closed clinics and reduced clinic volumes clinic provider pharmacists are being redeployed. Workforce has to be very dynamic and be able to flex to where the need is.
Wisconsin	Will redeploy from areas that are not busy (retail, ambulatory care, etc.) to the hospitals. Will recruit recently retired pharmacists in our networks. Will decrease the amount of clinical responsibilities of our pharmacists to allow them to take care of all patients. May centralize more services to be done remotely for hospitals that need more assistance.
Multi-State	Telepharmacy, borrowing from other facilities, attempting to find temps/retirees/etc.

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7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

California	All 4 SYSTEM hospitals have Surge Tents set up outside the ED's primarily for screening, not care.
Florida	N/A
Florida	Same Hospital. County may be standing up a tented hospital run by the county.
Illinois	N/A
Illinois	Making our 40 bed ED to ICU, move ED to ambulatory surgery/peri-op area. Ability to replicate if needed at another hospital.
Louisiana	No response
Michigan	See response above
New Mexico	Only thing we have stood up so far is a drive through screening area. Planning for unused space in our hospitals and medical office buildings.
New York	No response
New York	All of the above. Surging into PACU, OR space, unused office space, space that had been vacated to be demolished soon for new hospital, parking lot.
North Carolina	Medical Office Building and a facility that we would retrofit (2 x 125 bed facilities is being discussed now)
North Carolina	Not at this time
Ohio	Evaluating arena as well as convention center
Ohio	Convention center
Tennessee	Currently only looking at open hospital space. Expecting other options to be on the table based on patients.
Texas	Evolving now – will know soon
Utah	Front lawn; hotels; new hospital that hasn't opened yet
Virginia	Previous hospital, converted to dorm rooms, still has the infrastructure in place
Washington	Previous closed units in older hospital wing.
Wisconsin	Locations include medical office buildings and new surgery centers that were not opened yet.
Multi-State	Right now, previously closed hospitals (in partnership with other health systems, i.e. one system provides IT, another pharmacy, another nursing, etc.)

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8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

California	No response
Florida	ED tents set up
Florida	IV compounding rooms in hospitals for mixing and follow hospital protocol for emergency mixing; maximized premixed drugs wherever possible.
Illinois	N/A
Illinois	No changes, out of central pharmacy
Louisiana	No response
Michigan	We are setting up a central sterile compounding location in a recently vacated “old central pharmacy”. They relocated to a new area/pharmacy in the hospital and the old pharmacy was still intact. No need to obtain license as same physical address as existing acute care pharmacy on that hospital campus. We completed through clean, established staffing, stocked, secured refrigerator/freezers and determined distribution process to our other 7 hospitals over the last 4 days. Compounding begun on day 4. The goal it to batch prepare IV products that we do a significant volume of at our acute care sites, freeing up their IV compounding resources to assist with increasing volumes. For example: we are starting with Vancomycin bags.
New Mexico	Will use hospital pharmacy IV rooms and transport. Will make immediate use when necessary.
New York	Around the clock use of clean room. We've had 3 pharmacists compounding all night long.
New York	Increased 503b support
North Carolina	Move clean room supplies to service the unit as SCA.
North Carolina	TBD
Ohio	Considering immediate use compounding versus standing up a modular clean room. Anticipate current number of available vendors that can install pre-fab clean rooms quickly will not meet demand. Also considering relocating unused glove boxes.
Ohio	Still under development
Tennessee	Plan to support from existing infrastructure, depending on availability of PPE.
Texas	Depending how far from an existing hospital, may make there and move over
Utah	Centralize everything then deliver
Virginia	No pharmacy planned; will prepare and dispense from the main hospital under emergency regulations from the state
Washington	Centralized main facilities

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Wisconsin	Putting plans together to support IV compounding at another facility and deliver a cart fill to the surge hospital.
Multi-State	Probably transferring from nearby hospital(s), in progress now

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9. Other advice?

California	No response
Florida	No response
Florida	No response
Illinois	We are moving to universal cloth masking tomorrow in all non-COVID and non-PUI areas. The purpose is to protect others from you and enhance our social distancing efforts. B.) Very happy we had a good number of spare UBC and jacks where we can plug them in. It would be difficult to manage the med needs without them.
Illinois	No response
Louisiana	No response
Michigan	Time to great creative and innovative! Not business as usual. Team approach. Needs regular/constant communication across health system (in pharmacy have every other day Director calls, and 2 times per week calls with all our pharmacy buyers/managers/directors focused on supplies updates/issues)
New Mexico	No response
New York	Medical gases being used quite a lot now
New York	Having a plan for the investigational drugs and the treatment of cytokine storm – agreement between ID, ICU, oncology specialists in CRS. Updating treatment plans for all staff – new staff, folks doing different jobs, etc. to an intranet site or to be printed and posted places. Establishing a virtual COVID inventory in Willow inventory to use for stocked drugs at one central location so other sites can ‘purchase’ from it when ABC is short. Establishing a lead person to coordinate sharing among sites and logistics for stat deliveries – much more than we’ve ever done before. Assisting with HOSPICE kits for discharging from ED/hospital or from virtual visits – Hospices are not going into COVID + homes and family members don’t want family. To die alone in hospital – so new process for dispensing kits with morphine/lorazepam/Haldol/atropine drops to be delivered to patient homes or dispensed from rx.
North Carolina	No response
North Carolina	No response

9. Other advice?

Ohio	Pulled drug utilization and LOS data for ARDS patients for 12 months to anticipate amount of inventory needed to scale up the critical care beds (similar to what we did for the non-ICU surge hospital planning). Will need to layer in potential COVID-19 treatments.
Ohio	No response
Tennessee	No response
Texas	No response
Utah	No response
Virginia	It's a work in progress; be flexible and rise to the occasion!
Washington	No response
Wisconsin	Decisions need to be made more rapidly from top down to allow quick planning, but don't make decisions in fear. We have daily calls from the pharmacy leaders to communicate critical COVID-19 business. Have clear and frequent communication (emails, webinars, etc.) to front line employees to lessen amount of separate emails they receive.
Multi-State	Keep asking! Lots of unknowns right now.

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CALIFORNIA

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

We at HOSPITAL are working closely with County on all surge planning. There are plans to re-open former hospital facilities, use hotels for lower care patients such as SNF. We do not have official information from the Feds on field hospital set up nor what our role would be. We are in active surge planning.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

No response

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
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No response

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

No response

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

No response

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

All 4 SYSTEM hospitals have Surge Tents set up outside the ED's primarily for screening, not care

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

No response

9. Other advice?

No response

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FLORIDA (2 responses)

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Tents in association with 5 EDs

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Not necessary, not required

Hospital are all on campus so we ship to normal pathways and distribute. Including mobilizing pyxis into the ED tent areas.

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- (a) Variable, not an issue of excessive volume yet
- (b) Set up this week
- (c) Small selection of medications (5)

- (a) Monitoring ICU beds with vent capacity.
- (b) Patient volumes; and turning non ICU areas into cohort areas with equipment for COVID surge of critical care for supportive care.
- (c) All in house. With decreases in current volumes by 30 percent these should offset. But looking at critical care support drugs based on a team of formulary management subcommittee that meets twice weekly.

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 - (a) In your current facilities?
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Creating COVID-19 Units at each hospital

- (a) Yes
- (b) No

- (a) Yes. # of vents we have and ability to possibly use vents on multiple patient with similar settings being evaluated if we need to double up because of vent shortages.
- (b) ICU beds for surge. Each hospital.

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

WIFI in tents and iPads

ADC outside of our ED in triage areas currently. Purchased IPADS for telehealth management and prevention of spread as strategy wherever possible.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

N/A, staying in EDs and Lee Pharmacy locations with Meds to Curbs service

Evaluating only necessary personnel to be in areas needed. Telehealth support. We need to have drugs in ADC for patient demand and need. Stocking up for surge is the proactive step now.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

N/A

Same Hospital. County may be standing up a tented hospital run by the county.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

ED tents set up

IV compounding rooms in hospitals for mixing and follow hospital protocol for emergency mixing; maximized premixed drugs wherever possible.

9. Other advice?

No response

No response

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ILLINOIS (2 responses)

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

The city is considering setting up a field hospital at the convention center. It will be staffed by the Army Corps of Engineers. We are looking at expanding adult space into our pediatric hospital and also converting the post anesthetic care unit to a nursing unit for COVID patients. We have added extra Omni cells with critical care meds to med/surg units. We have also added COVID meds like hydroxychloroquine, but are controlling them like controlled substances to avoid pilferage. We are establishing an outpatient COVID and PUI clinic for ambulatory patients (e.g. cancer patients with COVID) that do not need to be hospitalized but need care. One end of the clinic is for PUIs and the other is for COVID positives. Each have their own dedicated elevator. We are still figuring out meds there.

No, it will be within the walls of one of our hospitals

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Lots of drop ship from manufacturers. One new agreement for a 503B compounder.

N/A

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Both HOSPITAL and NIEGHBORING HOSPITAL are doing daily modeling. We both predict having our beds entirely full between Monday and Wednesday. The city of Chicago predicts about three days longer.

- (a) Yes, expect surge by end of next week in our state
- (b) No response
- (c) Yes, critical care drugs

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

Creating COVID-19 Units at each hospital

- (a) We use our med-surg beds when we run out of ICU beds. We have added extra UBC with critical care meds to med/surg units. We are fortunate that in our new hospital we can convert all of our rooms to negative pressure.
- (b) No response

- (a) Be able to double, with plans for more beyond that capacity
- (b) Within current space of hospital

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

N/A

ADC

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

N/A

We are cohorting COVID patients to primarily 1 of our hospitals, so we would flex from non-COVID hospital to that location

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

N/A

Making our 40 bed ED to ICU, move ED to ambulatory surgery/peri-op area. Ability to replicate if needed at another hospital.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

N/A

No changes, out of central pharmacy

9. Other advice?

We are moving to universal cloth masking tomorrow in all non-COVID and non-PUI areas. The purpose is to protect others from you and enhance our social distancing efforts. B.) Very happy we had a good number of spare UBC and jacks where we can plug them in. It would be difficult to manage the med needs without them.

No response

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LOUISIANA

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Some sites investigating; working with board on virtual everything

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Centralizing order and receipt for entire system. Supply is for system and move as needed in state and outside state. Boards approved.

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Worked with wholesalers and suppliers to obtain relief on allocations for non-controlled and controlled substances to ensure overall supply continuity.

- (a) No response
- (b) No response
- (c) Have prepared to be able move drug across state lines as well as when under common ownership facilities. Have worked with MS and LA Boards of Rx for approvals

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

The tent field will probably use like home/outpt model. We are expanding in existing facilities or refitting.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Consistently assessing staffing demands and modeling across system. Also worked with nursing obtain waivers for nurses to titrate ketamine which wasn't allowed in LA.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

No response

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

No response

9. Other advice?

No response

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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

First phase of surge plan in play: establish COVID cohorted units for COVID positive and pending results. These are in current hospitals with acute care hospitals. Adding ICU beds in pre and post op areas.

Second phase of surge plan began executing today: 1 hospital (already has acute care pharmacy) converting to COVID hospital. Shutting down Emergency Center to turn into ICU unit, pre and post op surgery for ICU unit. Typically inpatient census is 80 patients and about 30 obs with 12 ICU beds. Ramping up to a hospital of 233 beds with 66 ICU beds.

Third phase: utilize “large box” ambulatory buildings as “hospitals” for non-COVID stable patients. Have not executed but could. In that event, will service from Acute Care hospitals with frequent/regular deliveries to these locations

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

N/A

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

See above surge plan (note: our business intelligence group at HOSPITAL has completed modeling to identify the surge volume of patients including ICU breakdown).

- (a) No response
- (b) No response
- (c) Several of our pharmacy team members are completing assessment of historical drug use, current use, and projected used based on surge predictions described above.

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Converted all pre-op and post-op locations as ICUs, converted hospital to focus on COVID (described above) will also convert Emergency to ICU unit
- (b) No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Only what we already have at the site

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Eliminating med history, medication education (may do remotely), post discharge for warfarin education, eliminating narcotic monitoring, eliminate unit inspections, centralized team working virtually for order verification, central IV compounding (off load some work from the acute care hospitals), utilizing individuals from employee “pools” established by emergency command in functions that do not require a technician training/license (example: medication deliveries to patient care areas)

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

See above

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

We are setting up a central sterile compounding location in a recently vacated “old central pharmacy”. They relocated to a new area/pharmacy in the hospital and the old pharmacy was still intact. No need to obtain license as same physical address as existing acute care pharmacy on that hospital campus. We completed through clean, established staffing, stocked, secured refrigerator/freezers and determined distribution process to our other 7 hospitals over the last 4 days. Compounding begun on day 4. The goal it to batch prepare IV products that we do a significant volume of at our acute care sites, freeing up their IV compounding resources to assist with increasing volumes. For example: we are starting with Vancomycin bags.

9. Other advice?

Time to great creative and innovative! Not business as usual. Team approach. Needs regular/constant communication across health system (in pharmacy have every other day Director calls, and 2 times per week calls with all our pharmacy buyers/managers/directors focused on supplies updates/issues)

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NEW MEXICO

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

We stood up a drive through COVID screening area as a Virtual unit of an urgent care

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

N/A

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

N/A

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

Using predictive analytics from CDC

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Standing up a few ADCs, but will have to use locking cabinets if needed

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Training for ICU level now

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Only thing we have stood up so far is a drive through screening area. Planning for unused space in our hospitals and medical office buildings.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Will use hospital pharmacy IV rooms and transport. Will make immediate use when necessary.

9. Other advice?

No response

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NEW YORK (2 responses)

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Setting up one within the hospital licensed area

As a virtual unit of the hospital, no board

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Mostly

Yes we have good success in increased drop ships, in more bill to/ship to; and additional deliveries from our wholesaler as well as 503 bs

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Yes - estimate of 30% daily increase in patient volume
- (b) No response
- (c) Yes and utilizing Vizient's 200 critical list to prepare ADCs

Based on future projection models – request to increase beds by 50% made my governor

- (a) No response
- (b) No response
- (c) Some but the reality is that these patients are super ill and require relatively few drugs – a lot of ICU drugs: fentanyl, midazolam, pressors, crash cart meds, as well as IL6 drugs like tocilizumab

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Converting other units
- (b) 50% increase but only in one of our hospitals. Our main hospital has an old tower where many units where closed so these are being re-opened

- (a) As many as we can literally get in the hospital
- (b) No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Number of IT staff is the same. Our ADC manager is overwhelmed as new units continue to open.

Minimal – no time and no wireless- so old fashioned cart based

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Not yet. Mostly due to the fact that all the am care areas are closed so tapping into that resource.

Using med students as pharm techs, pulling infusion staff to pharmacy, using virtual staff, using virtual pool, setting up centralized order verification site at home office to avoid staff going into hospital space, increasing per diems.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

No response

All of the above. Surging into PACU, OR space, unused office space, space that had been vacated to be demolished soon for new hospital, parking lot.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Around the clock use of clean room. We've had 3 pharmacists compounding all night long.

Increased 503b support

9. Other advice?

Medical gases being used quite a lot now

Having a plan for the investigational drugs and the treatment of cytokine storm – agreement between ID, ICU, oncology specialists in CRS. Updating treatment plans for all staff – new staff, folks doing different jobs, etc. to an intranet site or to be printed and posted places. Establishing a virtual COVID inventory in Willow inventory to use for stocked drugs at one central location so other sites can ‘purchase’ from it when ABC is short. Establishing a lead person to coordinate sharing among sites and logistics for stat deliveries – much more than we’ve ever done before. Assisting with HOSPICE kits for discharging from ED/hospital or from virtual visits – Hospices are not going into COVID + homes and family members don’t want family. To die alone in hospital – so new process for dispensing kits with morphine/lorazepam/Haldol/atropine drops to be delivered to patient homes or dispensed from rx.

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NORTH CAROLINA (2 responses)

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Exploring both

We have been told to PLAN for how we would manage patients at a field hospital. Our Board Of Pharmacy has allowed us to extend our current permit for a field site.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Not done this, but looking to move product from existing facilities to support any new site of care.

No response

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Our surge plan is to cover 40% above normal volumes. Not discussed weeks of duration. Set aside one month of normal drug utilization and track above that quantity to allocate for COVID patients and convert the quantities into number of COVID patients we could treat with supply on hand.

- (a) 1000-plus
- (b) Unknown
- (c) Not much history available assuming COVID patients, just knowledge of drugs expected for supportive care

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

Have not been part of the modeling of ICU beds, but it has been discussed at the executive and CMO levels.

No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

From pharmacy looking to move Unit Based Cabinets in surplus (from new purchases) to the facility to support. IS is separate from Pharmacy.

We have not assessed. Just about to begin planning.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Working in teams to limit exposure with 7 on 7 off schedule with the concept of remote order verification in acute care space to reduce teammate exposure and keep employees “fresh”. Staging from existing staff with concept of rotating OT usage of those on 7 day off schedule.

We have not determined this as we are just about to begin plans

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Medical Office Building and a facility that we would retrofit (2 x 125 bed facilities is being discussed now)

Not at this time

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Move clean room supplies to service the unit as SCA.

TBD

9. Other advice?

No response

No response

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OHIO (2 responses)

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Currently a) virtual unit of our flagship hospital

Planning underway for surge hospital with other Columbus, OH based health-systems; will be under a separate license from board of pharmacy and DEA

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Not yet; Baxter reluctant due to number of requests

Agreed to setup account; still working to expedite the process to get account established

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

(a) Up to 250 beds

(b) TBD – some are saying up to 12

(c) We pulled all current PUIs/COVID-positive patients across our care sites and analyzed what types of medications they are using to get an initial core inventory estimation. Working on validating assumptions now.

(a) Facility will be able to handle 200-300; entire facilitate in the 600-800 range adding in other health-system beds, this is on top of expansion within the hospitals

(b) No response

(c) No response

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

(a) Looking to create additional ICU capacity at all sites, while also evaluating changing one community hospital to an all-ICU facility (newer 150 bed community hospital has capability for all rooms to be ICU rooms if needed). Currently anticipating needing up to 250 additional ICU beds across a system of 14 hospitals (normal average daily census is 2600 patients total).

(b) Our surge hospital will not support ICU patients, with the exception of having a crash cart(s) available for rapid decline emergencies.

No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

So far, 4 ADCs per 250 beds

Same EMR, ADCs

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

TBD; would love to hear from others on this

Still under development

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Evaluating arena as well as convention center

Convention center

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Considering immediate use compounding versus standing up a modular clean room. Anticipate current number of available vendors that can install pre-fab clean rooms quickly will not meet demand. Also considering relocating unused glove boxes.

Still under development

9. Other advice?

Pulled drug utilization and LOS data for ARDS patients for 12 months to anticipate amount of inventory needed to scale up the critical care beds (similar to what we did for the non-ICU surge hospital planning). Will need to layer in potential COVID-19 treatments.

No response

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TENNESSEE

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Virtual unit of the hospital; State has suspended license approvals to allow patient care during this time.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Suppliers have been supportive and are meeting our needs based on what is in the supply chain.

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Based off statistical models for patients and duration.
- (b) No response
- (c) No response

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Started with ICU capable beds and expanded from there.
- (b) Based off statistical models for patients and duration.

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Leveraging wireless workstations for IT and equipment ordered for cabinet replacement at a hospital in the system.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Layered approach using extended shifts, management, clinical staff, ambulatory support staff, business operations staff, local College of pharmacy faculty, recent retirees.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Currently only looking at open hospital space. Expecting other options to be on the table based on patients.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Plan to support from existing infrastructure, depending on availability of PPE.

9. Other advice?

No response

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TEXAS

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Yes and working on it

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Working on it

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) No response
- (b) No response
- (c) Using NY as a model

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

No response

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Cabinets and EHR

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

No response

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Evolving now – will know soon

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Depending how far from an existing hospital, may make there and move over

9. Other advice?

No response

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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Reviewed what we were doing with the Board. They will view it as part of the hospital and are considering it part of emergency situations.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

We haven't addressed this. We have everything shipped to our main facility and will distribute as needed. Partnering with community home care service to provide hospice/palliative care to patients in hotels and other outlying areas.

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

Work in constant process. Yes, we refine the estimate each week (at this point but more frequently as we surge) and adjust purchasing from there.

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) New ICU beds will be in the main hospital. Part of plan is to change PACU, ORs to ICU units. Then we have some general medicine units that can be moved to negative pressure and turned into ICU beds.
- (b) Not planning this as ICU at this time except for admitting ER evaluations.

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Yes, planning for ADCs. Preparing drug lists now.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Using our PACE plan. The plan is developed what if we have a reduction in 80%, 60%, 40% in services and or staff, how would we contract? Then we say if we have double the beds, what would that look like? What if we have triple the beds? We will move to central distributive services at that time.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Front lawn; hotels; new hospital that hasn't opened yet

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Centralize everything then deliver

9. Other advice?

No response

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Yes, notified this week

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Have not addressed this yet

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Up to 175 patients (5 floors, 35 patients per floor)
- (b) Unknown
- (c) No response

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

Using OR rooms for ICU beds; some have been converted to negative pressure

- (a) Yes, in the current hospital
- (b) No ICU's planned for the surge hospital

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

We discussed today about repurposing some clinic ADCs to this building; reaching out to BD/Pyxis about quotes and availability and timing.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Not planning additional FTEs; will shift from outpatient pharmacies.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Previous hospital, converted to dorm rooms, still has the infrastructure in place.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

No pharmacy planned; will prepare and dispense from the main hospital under emergency regulations from the state.

9. Other advice?

It's a work in progress; be flexible and rise to the occasion!

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WASHINGTON

1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

We are creating additional surge units within the hospital and Regional medical center space. Will be supported by current pharmacy facilities. Plans underway for field hospitals in community setting but will be managed by military.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Some vendors have required a single location for the system for special drug programs and not hospital specific (e.g. TEVA Hydroxychloroquine)

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Based on state projections and they are now taking active role in balancing COVID patients distribution to area hospitals
- (b) Dependent on ability impact the trend
- (c) No response

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Number of neg air rooms with CCU capability. Total capacity for ventilators. Vents will support 2 patients each, also adding in Anesth vents if required.
- (b) Located in current main hospital, old wing.

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

New surge units had ADC's added, no longer any devices in organizational inventory for any additional surge units but there is proximal access to other devices.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Very dynamic, hospital census is lower than normal currently also with closed clinics and reduced clinic volumes clinic provider pharmacists are being redeployed. Workforce has to be very dynamic and be able to flex to where the need is.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Previous closed units in older hospital wing.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Centralized main facilities

9. Other advice?

No response

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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

First phase is expanding ICUs into other units such as PACUs. Next phase is targeting ambulatory sites such as POBs and repurposing them for non-COVID-19 patients. Last phase of escalation would be to set up temporary/pop up acute sites created in non-health care locations (e.g. hotels, etc.). When setting up the unit in the EHR, we are going to create a virtual unit in an existing hospital.

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Will likely have them ship to a nearby hospital and then we would transport the shipment to the new pharmacy.

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Unsure how many patients yet
- (b) Unsure how many weeks yet
- (c) Yes, critical care medications and COVID-19 therapeutic medications available in these new locations if for COVID-19 patients.

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Converting PACU units to COVID-19 units
- (b) Medical office buildings that are connected to hospitals first. Then associated ambulatory sites near current hospitals for non-COVID-19 patients

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Will relocated available ADCs to these locations if there are identified excess. If not, then will support these locations with a cart fill from a nearby hospital.

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Will redeploy from areas that are not busy (retail, ambulatory care, etc.) to the hospitals. Will recruit recently retired pharmacists in our networks. Will decrease the amount of clinical responsibilities of our pharmacists to allow them to take care of all patients. May centralize more services to be done remotely for hospitals that need more assistance.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Locations include medical office buildings and new surgery centers that were not opened yet.

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Putting plans together to support IV compounding at another facility and deliver a cart fill to the surge hospital.

9. Other advice?

Decisions need to be made more rapidly from top down to allow quick planning, but don't make decisions in fear. We have daily calls from the pharmacy leaders to communicate critical COVID-19 business. Have clear and frequent communication (emails, webinars, etc.) to front line employees to lessen amount of separate emails they receive.

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1. Are you setting up your Field/Surge Hospital(s) pharmacy(s) as (a) virtual unit of a hospital or (b) obtaining Board of Pharmacy approvals to separately license?

Yes, likely obtaining “emergency” licensure for hospital, pharmacy, DEA permit (opening a shuttered hospital)

2. Have you been successful in obtaining new supplier agreements or “ship to” for new site of care if needed?

Not yet, but confident

3. How have you executed your modeling for the Field/Surge Hospital(s):
 - (a) Number of patients?
 - (b) Number of weeks?
 - (c) Assessment of historic drug use on patient population(s) to be placed in Field/Surge Hospital(s)?

- (a) Yes
- (b) Not yet
- (c) It will be a COVID pop, but we know there will be co-morbidities, so don't have any history

4. What is your model for establishing number of new ICU beds?
 - (a) In your current facilities?
 - (b) In your current or planned Field/Surge Hospital(s)?

- (a) Depends on specialty mix and surgery mix
- (b) It will be based upon available equipment

5. What are your IT and technology asset commitments to the Field/Surge Hospital(s)? (e.g. ADC)

Don't know yet – likely in our case we will not have UBCs

6. How are you planning for and staging pharmacy workforce for Field/Surge Hospital(s)?

Telepharmacy, borrowing from other facilities, attempting to find temps/retirees/etc.

7. Can you share where you are planning for Field/Surge Hospital(s) (e.g. medical office buildings, previously closed hospital, etc.)?

Right now, previously closed hospitals (in partnership with other health systems, i.e. one system provides IT, another pharmacy, another nursing, etc.)

8. Can you share plans for sterile compounding support for the Field/Surge Hospital(s)?

Probably transferring from nearby hospital(s), in progress now.

9. Other advice?

Keep asking! Lots of unknowns right now.

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The information contained in this document is based on data that are emerging and rapidly evolving because of ongoing research and, as such, is subject to the professional judgment and interpretation of the practitioner due to the uniqueness of each practitioner's and, if applicable, his or her medical facility's approach to the care of patients with COVID-19 and the needs of individual patients. ASHP provides this information to help practitioners better understand current approaches related to treatment and care. ASHP has made reasonable efforts to ensure the accuracy and appropriateness of the information presented. However, any reader of this information is advised that ASHP is not responsible for the continued currency of the information, for any errors or omissions, and/or for any consequences arising from the use of the information contained in the document in any and all practice settings. Any reader of this document is cautioned that ASHP makes no representation, guarantee, or warranty, express or implied, as to the accuracy and appropriateness of the information contained in this document and will bear no responsibility or liability for the results or consequences of its use.