New York State

Daily Totals: Persons Tested and Persons Tested Positive

- NYS: 49,952 tests, 941 positive = 1.9% positive rate
- Bronx: 3,997 tests, 106 positive = 2.7% positive rate
Progress Towards “Re-opening” in NY

COVID-19 Early Warning Monitoring System Dashboard - New York City

<table>
<thead>
<tr>
<th>Testing/Tracing Targets</th>
<th>New Infections</th>
<th>Severity of Infection</th>
<th>Hospital Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain 30 per 1,000 Diagnostic Tests</td>
<td>Maintain Required Case and Contact Tracing Capacity</td>
<td>% Positive Tests per Day (7-Day Rolling Avg)</td>
<td>New Cases per 100K (7-Day Rolling Avg)</td>
</tr>
<tr>
<td>24,996 / 8,399</td>
<td>4,648</td>
<td>2.9%</td>
<td>8.56</td>
</tr>
</tbody>
</table>

New cases per 100K (7-day Rolling Avg)

[Bar chart showing new cases per 100K from May 31, 2020]
Montefiore Situation Summary

- COVID+ census continues to decline
- We are welcoming patients back to our hospitals and practices, assuring safety
- Of the tests performed on 5/31/20, <8% were positive
- 5,855 COVID+ patients discharged home across MHS
NYS Updates

• **Home** quarantine recommendation now updated to match CDC
  - 10 days from date of symptom onset (or from date of test if asymptomatic)
  - 72h without fever in the absence of antipyretics
  - Symptoms significantly improving or resolved
  - Note: this does not apply to nursing homes or hospitalized patients

• **NYC Phase 1 Re-opening: June 8**
  - Construction
  - Agriculture, Forestry, Fishing and Hunting
  - Retail - (Limited to curbside or in-store pickup or drop off)
  - Manufacturing
  - Wholesale Trade

• Dental activities to resume
• Doulas permitted for L&D patients
• Visitor restrictions remain for non-pilot hospitals
Montefiore Moses Rules for Visitation Pilot

- Visiting hours will be from 2pm-6pm daily and all visitors will be asked to speak to a unit staff member before entering a patient room and to follow all staff instructions.
- Patients may have one visitor at a time. Visitors must be >18 years of age. Patients may have two designated support persons who can alternate.
- Patients who are scheduled for ambulatory procedures may each have one support person assist them.
- Visitors will be screened in the lobby for temperature, symptoms and exposure. Visitors will be asked to leave the building if they display symptoms.
- Visitors to high-risk inpatient units (Oncology and Transplant) must have proof of a negative PCR, which must be updated every seven days.
- Visitors must wear a surgical or procedural mask upon entry to the lobby and throughout their time in the hospital. If the patient is COVID+, the visitor must also wear a gown, gloves and eye protection while in the room with the patient.
- Visitors must remain in the patient’s room except for entrance and exit from the hospital.
- Visitors must practice rigorous hand hygiene.
- Visitors who do not adhere to the above will be asked to leave.
COVID-19 Infection Control Updates

- COVID-19 testing and flag MANDATORY for all patients being admitted
- Antibody testing must be ordered for all new admissions (including direct admissions/admissions for surgery)
- **New: Eye protection**
  - Eye protection (goggles, face shield, fluid shield, safety glasses) should be worn by associates when within 6 feet of a patient (EVEN COVID-negative)
- **Universal Masking: it’s not going away!**
  - Montefiore has implemented masking for all associates. This means that for your safety and the safety of all associates, you should wear a surgical mask while working unless you are alone in a room with the door closed.
  - This includes encounters with COVID-negative patients
- **Masks are for patients too!** If tolerated they must be worn by the patient at all times
- Gowns are single use at this point
Updated Isolation Category to Distinguish COVID vs Other Contact

SPECIAL PATHOGEN PRECAUTIONS
Visitor Restriction. ALL visitors must check in at nursing desk before entering.

- Clean hands when entering or exiting the room
- Put on a surgical mask prior to entering
- Put on a fitted N95 mask prior to entering for aerosolizing procedure
- Put on a gown and gloves prior to entering
- Disinfect shared patient equipment
- Keep the door closed if safe

Montefiore
DOING MORE
Montefiore Guide to COVID-19 Isolation and Infection Status

- To discontinue COVID-19 isolation precautions at MMC – has to be 30 days from last positive NP swab AND 2 negative SARS-CoV-2 PCR tests 24 hours apart.
- COVID POS infection flag will remain in place for 30 days from last positive NP swab (and can only be removed by infection control physicians).
- COVID-LIKE ILLNESS (CLI) flag will remain in place for 14 days from admission or onset of symptoms.
- When retesting for discharge or disposition planning – positive NP PCR can be repeated at least 72 hours after last POSITIVE. (If two negative results are required – they should be performed 24 hours apart)
- Patients reporting positive results from outside hospital or ambulatory testing site – should only be used if confirmatory supporting documentation is available either in CareEverywhere, Bronx Rhio or scanned transfer paperwork.

New Admission or New Symptoms / exposure in a hospitalized patient

<table>
<thead>
<tr>
<th>SARS-CoV-2 PCR</th>
<th>Reason for testing</th>
<th>Infection Flag</th>
<th>Isolation</th>
<th>Cohorting</th>
<th>Repeat testing if needed for discharge or disposition*</th>
<th>Removal of isolation and Infection Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Symptoms</td>
<td>COVID POS</td>
<td>Special Pathogen Precautions</td>
<td>COVID POS</td>
<td>&gt;= 10 days from Sx onset Symptoms IMPROVING &gt;72 hours no fever (off antipyretics) &gt;10 days from onset of symptoms, or No symptoms</td>
<td>BOTH: • 30 days from onset of symptoms or positive PCR test • 2 negative NP swabs 24 hours apart</td>
</tr>
<tr>
<td></td>
<td>Screening (admit, procedure, OR)</td>
<td>(Remains for 30 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (consider COVID Ab testing)</td>
<td>Symptoms</td>
<td>COVID-Like Illness (CLI) (Remains for 14 days)</td>
<td>(Contact +Droplet or Contact +Airborne)</td>
<td>CLI</td>
<td>Second test to be done within 24 hours of admission &gt;= 10 days from Sx onset Symptoms IMPROVING &gt;72 hours no fever (off antipyretics)</td>
<td>BOTH: • 14 days from onset of symptoms • 1 negative NP swab</td>
</tr>
<tr>
<td>Negative</td>
<td>Screening</td>
<td>None</td>
<td>Standard and as needed for other infections</td>
<td>As per Infection Control isolation guidelines</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Readmission of patients previously known to be SARS-CoV-2 POSITIVE within prior 4 weeks

<table>
<thead>
<tr>
<th>SARS-CoV-2 PCR</th>
<th>Reason for admission</th>
<th>Infection Flag</th>
<th>Isolation</th>
<th>Cohorting</th>
<th>Repeat testing if needed for discharge or disposition</th>
<th>Removal of isolation and Infection Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Symptoms (new, persistent or worse) Screening Unrelated to COVID-19</td>
<td>COVID POS</td>
<td>Special Pathogen Precautions</td>
<td>COVID POS</td>
<td>&gt;=10 days symptom onset: • repeat &gt;72 hours if PCS • repeat &gt;24 hours if NEG</td>
<td>BOTH: • 30 days from onset of symptoms or positive PCR test • 2 negative NP swabs 24 hours apart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Remains for 30 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative (consider COVID Ab testing)</td>
<td>COVID related COVID unrelated Procedure – preprocedure screening</td>
<td>COVID POS from prior admission (30 days)</td>
<td>Any consideration of cohorting with COVID-pos patient has to be discussed with Infection Control</td>
<td></td>
<td>&gt;= 7 days if no symptoms (screening): • repeat &gt;72 hours if PCS • repeat &gt;24 hours if NEG</td>
<td>**Infection flag and isolation remain in place for 30 days</td>
</tr>
</tbody>
</table>

1 Nasopharyngeal SARS-CoV-2 PCR
* Immunocompromised patients may have prolonged viral shedding and repeat testing may need to be delayed
# PPE for Ambulatory Practices

<table>
<thead>
<tr>
<th>Role</th>
<th>Surgical Mask</th>
<th>N95 Mask</th>
<th>Eye Protection</th>
<th>Gloves</th>
<th>Gown‡</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTRATIVE STAFF:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSR, Front Desk and Scheduling Coordinators, Navigators, Social Worker, Care Management, Practice Management, etc.</td>
<td>YES</td>
<td>NO</td>
<td>YES (if within 6 feet of a patient)</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>CLINICAL STAFF:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Assistant, RN, LPN, NP, PA, Physician, Dentist, Dental Hygienist, Phlebotomist, etc. (Provides face to face clinical care to patients)</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>COVID-negative/low risk</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>COVID+ or Suspected</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Inside a room during an aerosol generating procedure*</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

‡Gowns should be worn if significant splashing or when in contact with bodily fluids/wounds

*Aerosol-generating procedures = nebulizer treatments/substances, sputum induction, open suctioning of airways, dental procedures, endoscopic procedures (other than those limited to the nasopharynx) including GI
COVID Testing

• Diagnosis: Nasopharyngeal PCR
  – Several different machines with shorter/longer run times
  – Cepheid turnaround is shorter but cartridges in VERY short supply
    • Prioritizing for OB and Emergency Surgery
  – Saliva testing is approved at the state lab but not yet on site/commercially
  – We do not use antigen testing (due to sensitivity)

• Antibody testing is available
  – Abbott platform
  – Not able to use for decision-making at this time

• Build for both PCR and antibody testing orders complete

COLLECT BOTH NP AND OP
(Same process for inpatient or ambulatory collection)

1. OBTAIN KIT WITH 2 SWABS IF POSSIBLE (ONE SKINNY ONE FAT)
2. STICK THE FAT ONE IN THE BASE OF THE THROAT AND OBTAIN A GOOD SPECIMEN
3. STICK THE SKINNY ONE IN THE DEEP NARES, HOLD FOR 3 SECONDS, THEN SWIRL AROUND FOR 15 SECONDS; REPEAT ON EACH SIDE! (This is for adults, anything you can for pediatric patients)
4. IF KIT HAS ONLY 1 SWAB, FIRST STICK IN THE THROAT, THEN STICK THE SAME SWAB IN BILATERAL NARES AS ABOVE
Ordering COVID19 Testing

OB, Emergency Surgery ONLY

ED/Inpatient/other
Occupational Health

• Associates with COVID may return to work 10 days after symptom onset, 72 hours after resolution of fever, and improvement of symptoms, whichever is longest
  – Associates must wear a mask for 14 days after symptom onset upon return
  – Hospitalization: note from personal MD clearing to return to work
  – The spectrum of COVID-19 symptoms and duration varies; return to work time is often longer than 7 days and is determined by OHS to ensure associates are physically ready and healthy for work

• Updated OHS/Infectious Disease Collaborative Guidance on Intranet

• Associates may request testing from OHS at any time if there is concern for an exposure
Antimicrobial Stewardship Program
COVID-19 Guidelines

• Guidance based on spike in antimicrobial utilization seen during COVID-19 surge

• Created by the Antimicrobial Stewardship Program, Infectious Diseases, and Pharmacy and intended to help guide clinicians caring for hospitalized COVID-19 patients with suspected secondary bacterial and fungal infections.

• Separate recommendations from COVID-19 treatment with experimental agents/clinical trials (e.g. remdesivir, convalescent plasma, hydroxychloroquine, sarulimab, etc.)
COVID-19 Drug Therapy Trial Decision Tree

Please answer the following questions to determine if your patient is eligible for any open studies at Montefiore.

If you have any feedback regarding the tool, please contact vahemmg@montefiore.org.

Which study or studies would you like to screen your patient for?

- Remdesivir (note: ACTT2 randomized trial of remdesivir + baricitinib vs remdesivir+placebo is open at Moses; open label remdesivir is available at other Montefiore sites and at Moses for patients who are ineligible for the trial)
- Sarilumab vs placebo (active at Moses and Weiler)
- Leronlimab vs placebo (active at Moses and at outpatient MAP clinic)
- Plasma vs placebo (active at Moses, Weiler, and Wakefield)
- HCQ vs placebo (note: no need to refer to this trial as your patient will automatically be approached by study staff if enrollment criteria are met)

Multiple choices allowed

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Remdesivir Access

Until production has expanded, there are a number of pathways to access the limited supply of remdesivir at the Montefiore Health System (MHS):

1. Montefiore Moses and Einstein campuses are study sites for the ACTT2 trial studying outcomes in patients who receive remdesivir alone, or remdesivir plus baricitinib
2. The Moses and Einstein campuses have been granted limited access to remdesivir through Gilead’s Expanded Access Program (EAP)
3. For pregnant patients and pediatric patients (<18 years old), remdesivir can be requested through direct application to Gilead for its Individual Compassionate Use Program, on a case-by-case basis
4. MHS has been issued a limited supply of remdesivir under the EUA program
Remdesivir Algorithm

NOTE: remdesivir by EUA is a non-preferred and last option for remdesivir access due to limited supply; all other options must be explored first.
Trial Enrollment

• Einstein site is now open for ACTT2
• Review criteria to ensure inclusions are met without exclusions.
• Discuss the trial with the patient and/or legal representative to determine interest in enrolling (and willingness to potentially transfer hospitals if not at a study site).
  – Not being willing to participate in a trial is NOT an exclusion for other remdesivir or treatment programs; please be cautious of any sense of coercion
• **Please note that neither transfer nor enrollment in a study is guaranteed, and that only study staff can officially consent any patient for a study.**
Wellness Checks and PPE

• Wellness checks and PPE distribution will continue at each hospital entrance until a more long-term strategy is implemented
• Additional PPE is still available on the units when needed
• Fit testing available
  – Small masks, multiple models available
• Please wear a mask while working
  – It’s for your safety and the safety of your colleagues!
Workplace Safety Recommendations

• Social distancing will remain critical as New York opens to prevent clusters
• Masks are a permanent accessory—we still have transmission events between associates
• During breaks and meals at work, maintain 6 feet separation, limit number of people in a space
• Wear a mask at all times you are not alone with the door closed
• As sites re-open or increase activity, we can’t operate as we used to—please be understanding, flexible, and creative
• Create seating arrangements to allow for distance
• Meetings=tele-conferences
• Avoid unnecessary travel
  – CDC still has quarantine regulations in effect for return from international travel
Re-opening and Getting to New Normal

• New signs from marketing are coming
• Ambulatory Guide Book for expanding services and COVID prevention on the intranet
  – Social distancing
  – Physical space and engineering
  – PPE
  – Screening/testing
  – Risk mitigation
• Non-clinical sites
  – Hand washing
  – Separate workspaces
  – Alternate work schedules if needed
  – Masks
• Supply chain will continue to be a limiting factor
  – New challenges are presented every week
  – Globally demand is not decreasing
• Pre-operative workflows final and in use
• Focus on high-risk areas and activities
• Visitation pilot then we will reassess next steps
ReCOVery

- Elective surgeries and procedures at MMC have not yet resumed—must wait for the green light from NY State
- Slowly expanding outpatient visits for those not appropriate for telehealth
  - Specific strategies for different specialties based on risk and space
- COVID-negative inpatient units are not likely to be a long-term strategy with dropping COVID+ census
- Learning from our experiences is critical to growth and preparing for whatever the future holds—we have asked leaders to gather your input, observations, and ideas in the wake of the surge
- Focus groups and interviews are coming
- Be patient
Communication

• Continuously updated Intranet COVID19 page
• Community-facing internet page
• Hotline
• Email - COVID19@Montefiore.org
• Infection Prevention assigned to your site/area
• OHS
Summary

• In this moment of relative calm, we are strengthening our foundation and preparing for what’s next using lessons learned and innovation

• Re-opening ≠ The old way of doing things

• Healthcare worker and patient safety remain #1

• Protect yourself—the pandemic is still here

• Please maintain social distancing at work and at home! It matters. Don’t stop!

• Please call OHS if you feel unwell

• We are in this together
We Need To Talk
The COVID Racial Data Tracker

COVID-19 is affecting people of color the most. We’re tracking the data in real time.

The COVID Racial Data Tracker is a collaboration between the COVID Tracking Project and the Antiracist Research & Policy Center. Together, we’re gathering the most complete race and ethnicity data on COVID-19 in the United States.

We’ve lost at least 21,750 Black lives to COVID-19 to date.

Black people account for:

13% of the US population vs. 24% of deaths where race is known

This means Black people are dying at a rate nearly 2 times higher than their population share.
George Floyd
Breonna Taylor
Ahmaud Arbery
Christian Cooper
We Need To Talk

We have witnessed and experienced so much loss, suffering and moral injury

We are not ok
This is not ok
This is **wrong**

I see you
I hear you
Humility, Honesty, and the Path Forward
Racial Health Disparities and Covid-19 — Caution and Context

Merlin Chowkwanyun, Ph.D., M.P.H., and Adolph L. Reed, Jr., Ph.D.

In early April, Wisconsin and Michigan released data showing stark racial disparities in rates of Covid-19 cases and deaths. In those states, many media outlets noted that the percentages of affected people who were black were more than twice as high as the proportion of blacks in the overall population. Similar disparities have since been reported elsewhere, sometimes along with overrepresentation of additional racial minority groups.

Racial disparities have thus become central in the national conversation about Covid-19. Front-page headlines in the New York Times and the Los Angeles Times have highlighted the issue, as have elected officials at all levels of government. U.S. Senator Elizabeth Warren (D-MA) and Representative Ayanna Pressley (D-MA) have called for more thorough collection of racial data, and in an open letter they fault the government for “currently failing to collect and publicly report on the racial and ethnic demographic information of patients tested for and affected by Covid-19.” Soon after their statement, several states and municipalities began releasing data sets incorporating this demographic detail.

To gain a maximally precise picture of how vulnerability is distributed, it is indeed crucial to collect more data along these lines. The experience of past epidemics — and recent natural disasters — suggests that the most socially marginalized populations will suffer disproportionately.

It is equally important, however, that in documenting Covid-19 racial disparities, we contextualize such data with adequate analysis. Disparity figures without explanatory context can perpetuate harmful myths and misunderstandings that actually undermine the goal of eliminating health inequities. Such clarifying perspective is required not just for Covid-19 but also for future epidemics. There are several key dangers of insufficient contextualization, but researchers, journalists, public health officials, and policymakers can take a few important steps to address them when discussing racial disparities, especially in the public sphere.

First, data in a vacuum can give rise to biologic explanations for racial health disparities. Such explanations posit that congenital qualities unique to specific racial minorities predispose them to higher rates of a particular disease. Lundy Braun, a professor of pathology and laboratory medicine as well as Africana studies, has, for example, documented an enduring strand of medical discourse that assumes there are biologic differences between the respiratory organs of black people and white people. A well-establish-
Caution and Context

“It is equally important, however, that in documenting Covid-19 racial disparities, we contextualize such data with adequate analysis. Disparity figures without explanatory context can perpetuate harmful myths and misunderstandings that actually undermine the goal of eliminating health inequities.”

1. Racial health disparities are NOT biologic
2. Racial health disparities are NOT due to behavior
3. Beware territorial stigmatization when analyzing geographic data

We must now truly seek to understand these inequities so we can effectively address them
Montefiore Mission and Values

**Mission:** To heal, to teach, to discover and to advance the health of the communities we serve.

**Values:** Our values define our philosophy of care.

- **Humanity:** We see our patients as people first, with a set of values, beliefs and experiences that shape their needs and our care.
- **Innovation:** We are never satisfied with the status quo and are always challenging ourselves to elevate to a new level of patient care.
- **Teamwork:** By bringing together multidisciplinary teams and involving patients and their families throughout the treatment process, we improve the quality of patient care, enhance patient safety and provide the broadest range of expertise possible.
- **Diversity:** We embrace our diverse workforce and community, knowing that it is an intrinsic part of who we are. Montefiore is proud of its heritage, serving residents of the Bronx, and the surrounding New York metropolitan area, as well as patients from across the nation and around the globe. Different backgrounds bring new contributions to patient care and medical advances. We seek to recruit and retain candidates with a breadth of experiences and backgrounds.
- **Equity:** Our actions are the result of a deep belief in fairness to those we serve. We are committed to offering access to vital programs and exceptional care to all patients regardless of social or economic status, ethnicity, creed, gender, and sexual preference. Montefiore also advocates for government policies that ensure equitable access to all care – both primary and advanced specialty care.
Structural Racism is a Public Health Crisis

We commit to ending white supremacy and dismantling systems of oppression to advance the health and safety of our community
We are #MonteStrong

We will continue to strive make Montefiore a safe space where all feel welcome, empowered, and secure. We must continue to listen, educate ourselves, seek to understand, change, and actively build systems that advance the health of our patients and community. THANK YOU for being here, for showing up, for caring and for living our values.

O, let my land be a land where
Liberty
Is crowned with no false patriotic wreath,
But opportunity is real, and
Life is free,
Equality is in the air we breathe.

- Langston Hughes -