PUSH-BASED ALLOCATION PLAN

Personal Protective Equipment

Background

The Oregon Health Authority (OHA) developed its Personal Protective Equipment (PPE) distribution process in partnership with the COVID-19 Medical Advisory Group.

Through Monday, March 23, PPE allocation from OHA was distributed based on counties and tribes putting in requests for distribution of PPE. This process was not optimal in that it added time between when the request went in and when the requests were filled. Therefore, the Medical Advisory Group changed the process to a bulk shipment of PPE to counties and the tribes based on an approved allocation formula.

Improved Process

Upon approval by the advisory group, the process was changed to recurring bulk shipments of received, purchased, and donated PPE items to all counties and tribes. This improved process now includes:

- Requests – Counties and tribes are not required to submit requests for individual locations.
- Shipments – Now, shipments are made to one location in each county or tribe. However, if allotment is too small to ship, it may be delayed to the next shipment.
- Urgent need – If counties or tribes identify an urgent need, they need to submit an Operations Center request marked as *urgent*.
    - An urgent need is defined as inventory on hand for 3 or fewer days within the county or tribe.
- State supply - The state will retain 30 percent of the supply for state agencies; requests in the Operations Center and for OHA operations missions, such as responding to a specific outbreak; and life safety requests, such as an urgent hospital or EMS request that is over and above the distribution a county is able to provide.

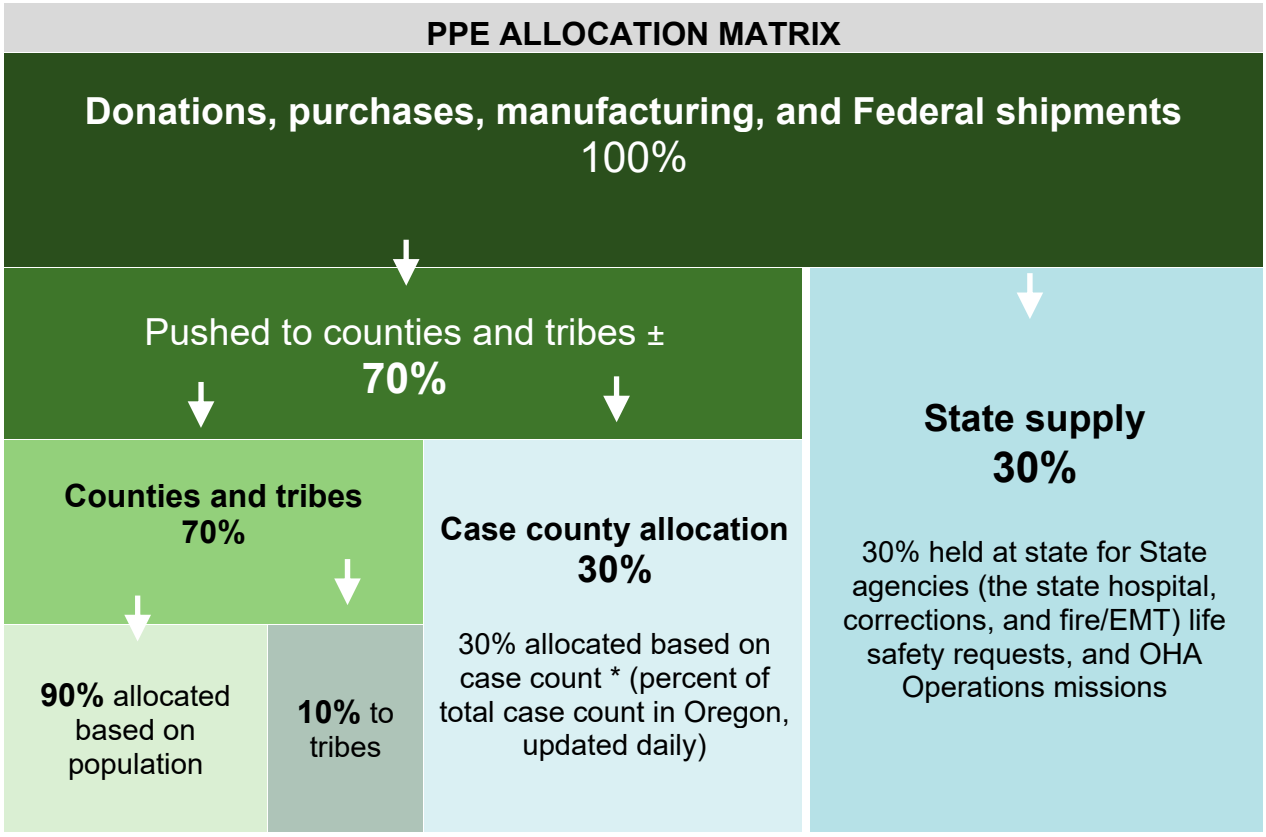
The advisory group plans to meet as needed to update the allocation. A reallocation could account for any additional supplies received from federal or other sources, or for greater impact of COVID-19 in some communities, as compared to others. If the advisory group meets and updates the guidance, it will be distributed through the PPE Branch of the COVID Statewide Response Team within the Emergency Coordination Center (ECC).

This basic structure is consistent across emergency management for all types of incidents, including the relationship between community partners, county authorities, and state agencies, and also the relationship of state agencies communicating with federal agencies.

The current allocation structure does not account for certified versus non-certified PPE. For clarity, OSHA certifies PPE used by healthcare workers while homemade PPE is not certified for use at healthcare setting. If/when the state decides to account for those items separately, OHA will convene the advisory group to review and provide updated guidance.

Allocation Matrix

The Allocation Chart is based on two factors: Population and case count.



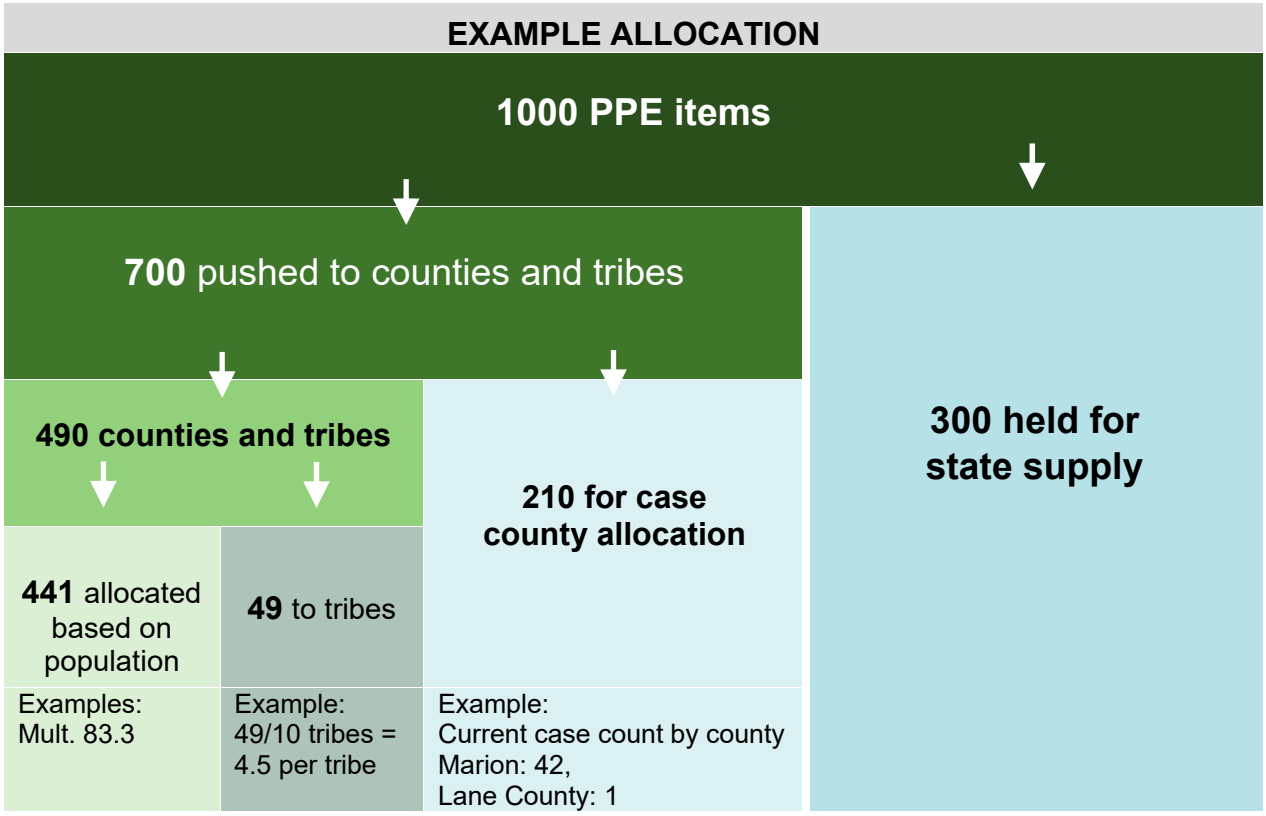
* Allocation chart is held by OHA and updated daily to reflect current case count.

Matrix description

- 70% of the existing inventory is allocated to counties and tribes.
  Existing inventory will fluctuate based on incoming purchases, donations, and shipments.
  - 70% of this inventory is automatically split between county and tribes:
    - 90% is allocated based on county population
    - 10% is allocated to Tribes as a flat rate
    - The 90/10 split is based on historical splits of Public Health Emergency Preparedness (PHEP) funding
  - 30% is allocated to counties based on current COVID+ case count
- 30% of the existing inventory is held for state agencies

Allocations from this inventory are approved by the ESF-8 desk at the ECC

Priority for state agencies are:



* Items will be rounded up/down to ship according to package size

* Tribes includes 9 Oregon Tribes and the Urban Indian Health Program.

Oregon State Hospital

Oregon Department of Corrections

Oregon Youth Authority

Fire, life safety

OHA Operations

Other state healthcare providers

County Monitoring and Adjustments to Push Methodology

County emergency managers will collect from all county stakeholders who will receive PPE distributions from the county an inventory capacity number, i.e. what number of PPE would they consider themselves to be fully stocked.

Currently, three times per week, county emergency managers will request an inventory count and burn rate calculation across county stakeholders who have received PPE from the county. This count will support the counties ability to adjust their distribution of PPE. On a schedule developed by the ECC, emergency managers will submit the count and burn rate weekly. If the numbers are not received, ECC leadership will consider suspending push orders to that county on a case by case basis.

In such time as counties report that their stakeholders are at 50% inventory goals, they will notify the ECC who will consider reductions to their push distribution calculation. When the county achieves a 75% stakeholder inventory goal, the county PPE distribution will be placed on hold until they reach 50% inventory or less.

County Allocation Guidance

County public health authorities/emergency management officials and local health care providers work together to assess their local PPE supply and needs. Counties should also work with providers on PPE optimization strategies.

This guidance is provided to instruct county emergency managers on how to prioritize PPE distribution to county stakeholders.

*In Region 1, allocations are distributed for the region to Multnomah County. Allocations are then distributed 2/3 to the Region 1 hospital systems with the remaining 1/3 being held by the Emergency Manager for distribution according to the guidance below.

Priority #1

1. Healthcare facilities and personnel providing care for people with confirmed COVID-19
2. Healthcare providers (see below), including EMS and fire, that will not be able to continue day-to-day operations without the allocation
3. For N95 respirator requests, recommend priority to facilities that perform aerosol-generating procedures (mostly hospitals)

Priority #2

4. Healthcare providers (see below), including EMS and fire, who will be out of requested PPE within 48 hours, and have known COVID-19 transmission in their close vicinity

Priority #3

5. Healthcare providers (see below), including EMS and fire, who will be out of requested PPE within 48 hours, and have *no* cases of COVID-19 infection in their close vicinity
6. Healthcare providers (see below), including EMS and fire, who request additional supply due to non-critical shortages in PPE due to limited allocations through their usual supply chain and which have known COVID-19 transmission in their close vicinity

Priority #4

7. Healthcare providers (see below), including EMS and fire, who request additional supply due to non-critical shortages in PPE due to limited allocations through their usual supply chain and which have *no* cases of COVID-19 infection in their close vicinity
8. For N95 masks, law enforcement agencies

Other Considerations

- Consider distributions to stakeholders who provide healthcare to vulnerable populations in the county community
- Differentiation of prioritization for masks—Recommend the locations that perform aerosol generating procedures have highest risk for transmission.
- Assure adequate distribution to agencies geographically reflected by population and need.

Stakeholder Details

Health Care Providers

- Health care providers send requests for PPE to their county public health authority/emergency management officials (please see the County Emergency Management Contact Page.) They are strongly urged to implement all applicable PPE optimization strategies. (Current CDC guidance on optimization strategies)
- For this purpose, health care providers include local public health authorities, hospitals, clinics, skilled nursing facilities and homes, fire and emergency medical services (EMS), assisted living facilities and adult foster homes, physicians' offices, Tribal medical clinics (which send requests to Tribal authorities), urgent care centers, home health care, outpatient clinics, correctional facility medical clinics, IDD direct support providers, home and community based behavioral health providers (including ACT teams, Behavioral health Crisis teams), behavioral health residential facilities (such as mental health and drug treatment facilities), long-term care facilities, and similar health care facilities or services where adherence to physical distancing is not possible.
- CDC-developed Burn Calculator.